Issue Brief

Reaching for the Stars:

Quality Ratings of Medicare Advantage Plans, 2011

February 2011

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Introduction

The Centers for Medicare and Medicaid Services (CMS) posts quality ratings of Medicare Advantage plans to provide Medicare beneficiaries with additional information about the various Medicare Advantage plans offered in their area. The health reform law of 2010 required the ratings to be used to award quality-based payments to Medicare Advantage plans, beginning in 2012.[1] In November of 2010, the CMS posted the agency's ratings of the Medicare Advantage plans that are available to beneficiaries for the 2011 plan year on the Medicare.gov website. The CMS has proposed a demonstration that would modify the rating system and provide additional quality-based payments to the Medicare Advantage plans for 2012 to 2014. All Medicare Advantage plans would be included in the demonstration.

This issue brief summarizes the quality-based payments as described in the health reform law and the proposed demonstration. The brief documents the location of highly-rated Medicare Advantage plans across the country, identifies which types of plans receive higher quality ratings, and explains how the proposed demonstration would modify the quality-based ratings and payments.

The analysis does not attempt to assess the validity of the quality ratings, nor does it quantify the expected increase in Medicare payments to plans that are expected to result either from PPACA or the proposed demonstration because such calculations at this time would be speculative; the CMS is expected to publish the quality-based payments during the spring of 2011. Like our previous analyses, it examines the data posted by the CMS to consider the implications for consumers and policymakers.[2] A description of how the CMS calculates the quality ratings for the Medicare Advantage plans, including recent changes in the calculations, is included in the **Appendix**.

Background

The CMS rates Medicare Advantage plans on a scale of one to five stars, with five stars representing the highest quality. The CMS defines the star ratings in the following manner:

5 Stars	Excellent performance
4 Stars	Above average performance
3 Stars	Average performance
2 Stars	Below average performance
1 Star	Poor performance

All rated plans, including Health Maintenance Organizations (HMOs), Point of Service (POS) plans, local Preferred Provider Organizations (PPOs), regional PPOs, and Private Fee-for-Service (PFFS) plans, receive both summary scores and overall scores.

The summary score for Medicare Advantage plans:

- Is used under the health reform law to provide quality-based payments;
- Provides an overall measure of a plan's quality, based on indicators of the quality of care, access to care, responsiveness, beneficiary satisfaction, and customer service; and
- Does not include plans' Part D (prescription drug plan) ratings.

The overall score for Medicare Advantage plans differs from the summary score because it combines a plan's summary score with its Part D plan rating. The CMS uses the overall score for the 2011 ratings, and proposes to use the overall score under the proposed demonstration.

How Did the Health Reform Law of 2010 Design the Quality-Based Payments?

The health reform law made many changes to payments for Medicare Advantage plans to achieve Medicare savings, primarily by lowering county benchmarks and tying them to the relative costs of traditional Medicare. The new benchmarks will be phased-in over two, four, or six years, with longer phase-in periods for counties with large changes in benchmarks **(Table 1)**. Most counties will have benchmark changes phased-in over six years.

Table 1. Changes in benchmarks under the health reform law of 2010

Reduction in benchmarks	Phase-in period	Number of counties (est.)	Share of Medicare Advantage enrollees (est.)
Less than $30	2 years	222	16%
$30 to $49	4 years	238	4%
$50 or more	6 years	2787	80%

Source: Kaiser Family Foundation analysis of the CMS fee-for-service expenditures in 2008 (excluding IME Medicare payments), benchmarks for 2011, and November 2010 enrollment.

The health reform law also introduced quality-based payments for plans, providing additional funds to plans receiving at least 4 stars. Specifically, plans with higher quality ratings will receive higher rebates: a 70 percent rebate for plans receiving 4.5 or 5 stars; a 60 percent rebate for plans receiving 3.5 or 4 stars; and a 50 percent rebate for plans receiving 3 stars or fewer.[3] Plans with 4 or more stars will also receive bonus payments (i.e., additional amounts added to the plan's benchmark), and in certain counties, they will receive double bonuses.[4] The bonus payment is applied only to the new benchmarks, rather than the blended benchmark, providing plans only part of the bonus amount until the new benchmarks are fully phased-in **(Appendix Table A1)**. The combination of the bonuses and the blended benchmarks will not be allowed to exceed the benchmarks in place prior to health reform law ("bonus cap"). All bonuses are required to be used towards providing extra benefits or lowering premiums for enrollees.

How Would the Proposed Demonstration Change the Design of the Quality-Based Payments?

The proposed demonstration would make several changes to the bonus payments authorized under the health reform law **(Table 2)**. First, all ratings would be based on the contracts' overall scores, rather than the summary scores. Second, bonus payments would be provided to contracts that are rated as average performers (3 or 3.5 stars), in addition to those that receive 4 or more stars. Third, contracts that receive 4 or more stars would receive higher bonus payments than those authorized under the health reform law. Fourth, contracts that receive 5 stars would receive higher bonus payments than the 4 and 4.5 star contracts and would not be subject to the bonus cap; the cap would still apply to all other contracts. Lastly, bonuses for contracts that receive 5 stars would be applied to the blended benchmark, rather than just the new benchmark, providing the 5 star plans the full bonus amount before the changes are fully phased-in. Bonuses for all other contracts would be applied to only the new benchmark.

Table 2. Differences between bonuses under the health reform law versus the proposed demonstration, 2012

Quality rating	Under health reform of 2010		Under proposed demonstration	
	Bonus	Applied to:	Bonus	Applied to:
5 star plans	1.5%	new benchmark only	5%	blended benchmark
4 and 4.5 star plans	1.5%	new benchmark only	4%	new benchmark only
3.5 star plans	None	N/A	3.5%	new benchmark only
3 star plans	None	N/A	3%	new benchmark only
2 and 2.5 star plans	None	N/A	none	N/A
1 star plans	None	N/A	none	N/A
Unrated: Plans that are too new	1.5%	new benchmark only	3%	new benchmark only
Unrated: Plans with too few enrollees	1.5%	new benchmark only	3%	new benchmark only

Source: The CMS explanation of the changes made by the proposed demonstration. Note: N/A means not applicable.

Together, these changes: (1) increase the number of Medicare Advantage plans that receive bonus payments, mainly by adding plans that receive average ratings; (2) increase the bonus payments to plans that receive the highest quality ratings; and (3) provide higher bonus payments to the 5 star plans than to the 4.5 and 4 star plans. The proposed demonstration will reportedly cost $1.3 billion from 2012 to 2014, and would be evaluated relative to a CMS model showing how quality scores would have increased under the health reform law.[5]

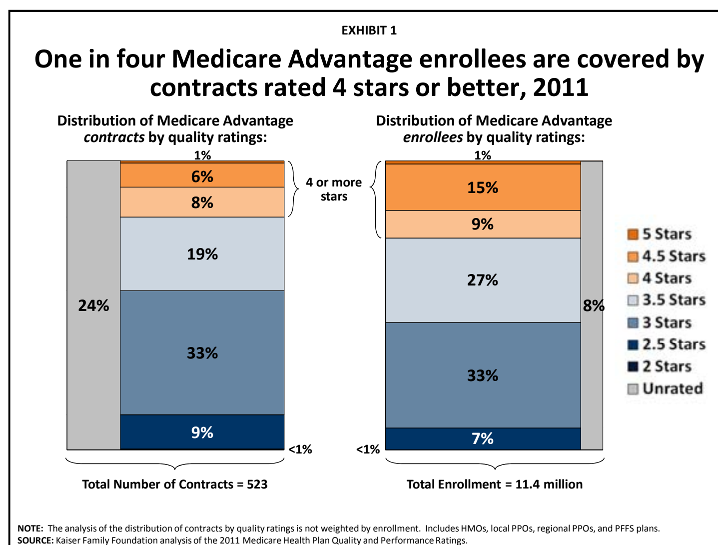
Analysis Overview

This analysis uses the five-star rating system and additional information from the CMS Plan Directory and the November 2010 enrollment files to examine the plans' overall ratings, including where the highly rated plans are located, which types of plans receive higher quality ratings, and how the ratings will differ under the proposed demonstration versus the health reform law. The analysis includes all HMOs, POS plans, local PPOs, regional PPOs, and PFFS plans. Cost plans, Medicare Medical Savings Accounts (MSAs), Health Care Prepayment Plans (HCPPs), demonstrations, Program of All-Inclusive Care for the Elderly (PACE) plans, and Religious Fraternal Benefit (RFB) plans are excluded because they did not receive overall ratings. All reported differences are significant at the 95 percent confidence level.

The results from this analysis are not directly comparable to our previous analyses because this analysis focuses on the overall ratings for contracts, rather than the contracts' summary ratings, which results in two important differences: the ratings include information about the prescription drug plan, if one is offered; and cost plans are excluded (because they did not receive overall ratings). The brief includes a discussion of the difference between summary scores and overall scores.

What Share of Medicare Advantage Enrollees is In Highly-Rated Plans?

- Nearly one-quarter (24%) of all Medicare Advantage enrollees are covered by contracts that received an overall rating of 4 or more stars **(Exhibit 1)**. However, 60 percent of Medicare Advantage enrollees are covered by contracts that received 3 or 3.5 stars, which the CMS defines as average performance, and seven percent of enrollees are in contracts that received fewer than 3 stars. The average overall rating in 2011 is 3.47 stars, weighted by 2010 plan enrollment.
- Nearly one-quarter (24%) of contracts were not rated by the CMS in 2011. These contracts covered nine percent of Medicare Advantage enrollees in 2010. Contracts are unrated if they do not have sufficient data for ratings because they have too few enrollees or are too new (i.e., offered by an organization that did not have a Medicare Advantage contract in the previous three years). All unrated contracts will receive bonus payments in 2012 under both the health reform law and the proposed demonstration.

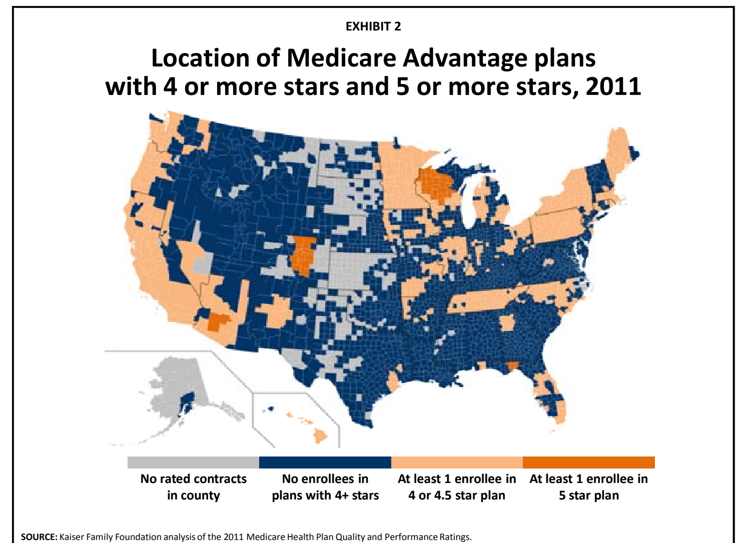


NOTE: The analysis of the distribution of contracts by quality ratings is not weighted by enrollment. Includes HMOs, local PPOs, regional PPOs, and PFFS plans.
SOURCE: Kaiser Family Foundation analysis of the 2011 Medicare Health Plan Quality and Performance Ratings.

- In 2011, the CMS will flag "low performing" contracts by displaying a warning icon next to the plans' information on Medicare.gov for the first time; five percent of contracts (28 out of 523 contracts), which cover approximately 7 percent of enrollees, will receive this warning symbol in 2011. Low performing contracts are defined as those that receive less than 3 stars for three or more consecutive years.
    - Only one contract, Unison Advantage in Tennessee (owned by UnitedHealth Group), received an overall rating of 2 stars; 47 contracts (with 7 percent of Medicare Advantage enrollees) received 2.5 stars.

Which Contracts Received High Ratings?

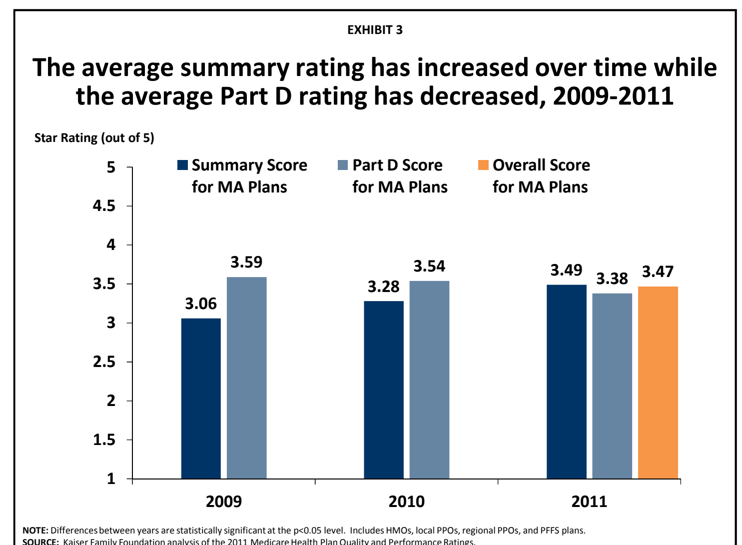
- For 2011, just three contracts (out of a total of 523 contracts nationwide) received an overall rating of 5 stars: Capital Health Plan in northern Florida (owned by Blue Cross Blue Shield of Florida), Security Health Plan of Wisconsin (owned by the Marshfield Clinic), and Kaiser Permanente's Senior Advantage, which operates in Colorado and parts of Arizona. Each of these contracts is operated by not-for-profit organizations, and is an HMO.



- Seventy-four contracts received 4 or 4.5 stars in 2011; plans covered under these contracts are mainly located on the west coast and in the Northeast, with others located in Wisconsin, Minnesota, Tennessee, Florida, and North Carolina **(Exhibit 2)**.
- In the central part of the country, many counties do not have Medicare Advantage contracts rated by the CMS because either plan enrollment was too low or the plans were too new.

How Have the Star Ratings Changed Over Time?

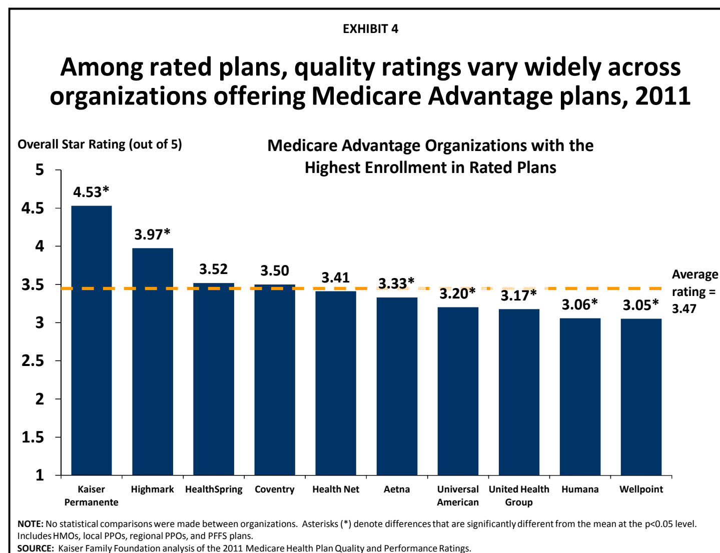
- Average summary ratings for Medicare Advantage have increased since 2009, from 3.06 stars in 2009 to 3.49 stars in 2011; however, the years are not directly comparable because some of the ratings measures and scoring methods have changed over the years **(Exhibit 3**, summary ratings shown in **Appendix Table A2)**.
- Average Part D ratings for Medicare Advantage plans have decreased, from 3.59 stars in 2009 to 3.38 stars in 2011.



- The 2011 plan year is the first year that uses the overall score, which combines the summary rating and the Part D plan rating. The effect of including Part D ratings varies across contracts.
  - Ratings for 62 contracts (which account for 7 percent of enrollees) increased after Part D plan ratings were included. For example, the Kaiser Permanente Senior Advantage HMO received a 4.5 star summary rating, but a 5 star rating on its overall score. MediGold's HMO in Ohio received a summary rating of only 3.5 stars, but 4 stars on its overall score. The shift to an overall score that includes Part D plan ratings will boost quality payments to these contracts under the demonstration.
  - For 45 contracts (which account for 13 percent of enrollees), the Part D ratings decreased the overall rating. KelseyCare Advantage, a POS plan in Houston, Texas, received a summary rating of 5 stars, but an overall rating of 4.5 stars because the contract received only 4 stars for its Part D plan. Universal Health Care's PFFS contract in Nevada received a summary rating of 3 stars, but an overall rating of only 2.5 stars because its Part D rating was 2.5 stars.

Which Organizations Received Higher Ratings?

- Average overall quality ratings vary widely across the organizations with the most Medicare Advantage enrollees, ranging from 4.53 stars averaged across Kaiser Permanente's rated plans and 3.97 stars averaged across Highmark's rated plans to an average of 3.06 stars for Humana's rated plans and an average of 3.05 stars for Wellpoint's rated plans **(Exhibit 4)**. All ratings were weighted by the contracts' enrollment in November of 2010.



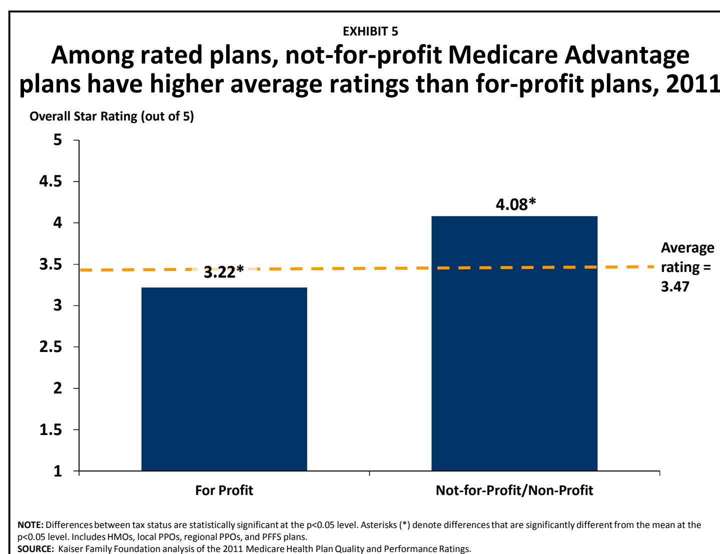
- Overall quality ratings often vary across plan type within the same organization. For example, among Aetna's rated Medicare Advantage contracts, the average overall rating for HMOs is 3.17 stars, but 3.49 stars for its local PPOs.

- The average summary rating, by plan type, weighted by 2010 enrollment, increased or remained approximately the same between 2010 and 2011 for organizations with the highest enrollment in rated Medicare Advantage plans **(Appendix Table A3)**. In contrast, the change in average rating for the Part D plans between 2010 and 2011 was less consistent by plan type **(Appendix Table A4)**.

Which Plan Characteristics are Associated with Higher Ratings?

- **Not-for-profit** organizations have higher average overall ratings than for profit organizations (4.08 stars versus 3.22 stars), weighted by the 2010 enrollment **(Exhibit 5)**.

- **More experienced** plans (with contracts beginning before 2004) have higher ratings than newer plans (3.68 stars versus 3.14 stars), weighted by the 2010 enrollment.

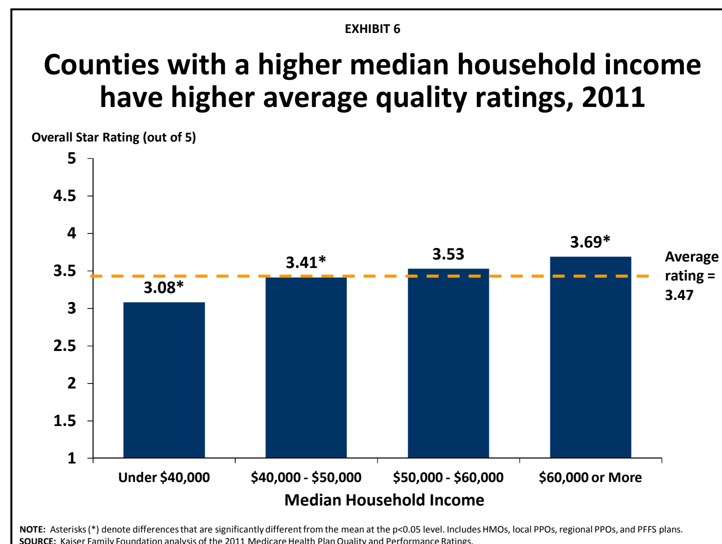


- **HMOs** have higher average ratings (3.59 stars) than the average overall rating for local PPOs (3.46 stars), PFFS plans (3.07 stars), and regional PPOs (2.76 stars) – all weighted by 2010 enrollment. Of note, only 50 percent of enrollees in PFFS plans were in rated plans. These findings are consistent with our 2010 findings, which were based on the summary scores.

- Contracts in **urban areas** are covered by contracts that have higher average overall ratings (3.49 stars) than contracts in rural areas (2.97 stars).

- In counties with **relatively high Medicare Advantage penetration** (more than 40 percent enrolled in plans), contracts had higher average overall ratings in 2011 (3.61 stars) than the average overall rating for counties with between 10 and 20 percent of beneficiaries in Medicare Advantage (3.21 stars) and counties with less than 10 percent of beneficiaries in Medicare Advantage (3.00 stars), similar to 2010.

- Average quality ratings tend to be higher in counties with **higher median household income**. In counties with median household incomes of more than $60,000, the average overall quality rating is 3.69 stars, while in counties with median household incomes of less than $40,000, the average overall rating is 3.08 stars **(Exhibit 6)**.
- Average quality ratings are higher in areas with **more Medicare Advantage plans** than in areas with fewer plans. In areas with more than 35 plans, the average overall quality rating is 3.54 stars in 2011. In comparison the average quality rating is 3.18 stars in areas with 15 or fewer plans.



NOTE: Asterisks (*) denote differences that are significantly different from the mean at the p<0.05 level. Includes HMOs, local PPOs, regional PPOs, and PFFS plans.
SOURCE: Kaiser Family Foundation analysis of the 2011 Medicare Health Plan Quality and Performance Ratings.

In a multivariate, ordered logit model, the contract's tax status and experience were most strongly and significantly associated with the number of stars received by the contracts, controlling for other factors.

Policy Implications

For the first time, the Medicare Advantage quality ratings will be used to identify and reward highly-rated plans in 2012. As we found in our analysis of the 2010 ratings, approximately one-quarter of Medicare Advantage enrollees nationwide are covered by contracts that received four or more stars in 2011, with not-for-profit and more experienced contracts receiving higher ratings than others. The proposed demonstration will increase the share of contracts receiving bonuses by including plans rated as average performers; it will also increase bonus payments for the most highly-rated plans. Rewarding and incentivizing plans in this manner may put plans on a trajectory towards higher ratings, but it also introduces rewards for average quality performance. As the quality bonus payments from the law and demonstration are phased in, it will be useful to assess the extent to which the new financial incentives result in higher quality ratings among Medicare Advantage plans, and improved outcomes for enrollees.

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[1] Hereinafter, the health reform law refers to the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148; PPACA) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).
[2] See Jacobson G, Damico A, Neuman T, and Huang J. "What's in the Stars? Quality Ratings of Medicare Advantage Plans, 2010" December 2009; see also Jacobson G, Damico A, Neuman T, and Huang J. "Quality Ratings of Medicare Advantage Plans: Key Changes in the Health Reform Law and 2010 Enrollment Data," September 2010.
[3] Rebates are the share of the difference between the plan bid and the benchmark that is retained by the plan, if the plan bid is lower than the benchmark.
[4] See Kaiser Family Foundation, "Explaining Health Reform: Key Changes in the Medicare Advantage Program," May 2010.
[5] Centers for Medicare and Medicaid Services, "Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Demonstration on Quality Bonus Payments," November 7, 2010; see also Julie Appleby, "Effort to Reward Medicare Advantage Plans Draws Criticism," Kaiser Health News, January 10, 2011.

Appendix: How the CMS Rated Medicare Advantage Plans for Plan Year 2011

Medicare Advantage Plan Ratings. The quality scores for Medicare Advantage plans are based on 36 standard performance measures that are derived from four sources: (1) the Healthcare Effectiveness Data and Information Set (HEDIS®), (2) the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), (3) the Health Outcomes Survey (HOS), and (4) the CMS administrative data, including information about member satisfaction, plans' appeals processes, audit results, and customer service. The ratings for the 2011 plan year use plan and beneficiary information collected in 2009 (HEDIS® and HOS) and 2010 (CAHPS® and administrative data).

The CMS groups the quality measures into five domains: (1) staying healthy: screenings, tests, and vaccines; (2) managing chronic (long-term) conditions; (3) ratings of health plan responsiveness and care; (4) health plan members' complaints and appeals; and (5) health plan telephone customer service. The CMS dropped one measure from the 2011 ratings that was used in the 2010 ratings --- the share of members who chose to leave the health plan --- and split two measures into six; Cholesterol screening was split into cardiovascular care – cholesterol screening and diabetes care – cholesterol screening, and providing care to members with diabetes was split into diabetes care – eye exam, diabetes care – kidney disease monitoring, diabetes care – blood sugar controlled, and diabetes care – cholesterol controlled. As a result, the total number of measures for the plan ratings increased from 32 in 2010 to 36 in 2011.

The CMS assigns stars for each measure and then averages all the measures to calculate the summary score. The quality measures are adjusted for patient characteristics, when possible. The summary score also takes into account whether contracts have demonstrated both high and stable quality ratings across all measures, relative to other contracts. The summary scores and quality ratings are assigned for each Medicare Advantage contract, rather than for each plan covered under a contract, since much of the data is only available to the CMS at the contract level. This means that every Medicare Advantage plan covered under the same contract received the same quality rating (and most contracts cover multiple plans).

The CMS altered how the stars are assigned for some of the measures. In the past, contracts were "graded on a curve," such that contracts were scored on a relative scale for each measure. For some measures, contracts continue to be graded on a curve in 2011. For other measures, minimum thresholds are set, and contracts that exceed the threshold for the measure are assigned at least four stars for that measure; contracts that do not exceed the threshold are assigned no more than 3.5 stars for the measure. The other star values are assigned based on the distribution of the contracts above and below the thresholds. The thresholds are assigned based upon either regulatory standards or plan performance in prior years. However, where the threshold is set affects how many plans receive 4 or 5 stars. For example, the measures "Improving or Maintaining Physical Health" and "Improving or Maintaining Mental Health," which are computed as the percent of enrollees who physical/mental health status was maintained or improved, have similar national averages (67% and 77%, respectively); however, the physical health measure has a much lower threshold for receiving 4 or more stars than the mental health measure (60% versus 85%, respectively). Thus, many more plans received 4 or more stars for "Improving or Maintaining Physical Health" than for "Improving or Maintaining Mental Health."

Prescription Drug Plan Ratings. The quality ratings for both Medicare Advantage Prescription Drug plans (MA-PDs) and stand-alone prescription drug plans (PDPs) are derived from three sources: (1) the CAHPS® survey, (2) the prescription drug event (PDE) data submitted to the CMS by the drug plans, and (3) administrative data, including information about plans' customer service, appeals processes, member satisfaction, audit results, and plans' identification of low income subsidy (LIS) recipients. The CMS groups the measures into four domains: (1) drug plan customer service; (2) drug plan member complaints, members who choose to leave, and Medicare audit findings; (3) member experience with drug plan; and (4) drug pricing and patient safety. Similar to the Medicare Advantage plan summary ratings, the prescription drug plan ratings are calculated by averaging the number of stars a contract receives for each of the 17 measures, and the score takes into account whether contracts have demonstrated both high and stable quality ratings across the measures.

Overall Ratings. The overall rating for a MA-PD contract is the average of the 53 measures (36 for Medicare Advantage plans plus 17 for prescription drug plans). In this manner, the prescription drug plan measures comprise about one-third of the measures for the overall rating. The exact share will vary by contract because some contracts do not have enough information to receive stars for all measures. Only HMOs, local PPOs, regional PPOs, and PFFS plans receive overall ratings; although 1876 cost contracts receive summary scores, they do not receive overall ratings.

Table A1. Bonus payment percentages under the proposed demonstration and the health reform law, 2012-2015

Quality Rating	Bonus payments under Demonstration, after blending benchmarks			Bonus payments under Health Reform Law, after blending benchmarks		
	2 year counties	4 year counties	6 year counties	2 year counties	4 year counties	6 year counties
5 star plans						
2012	5.00%	5.00%	5.00%	0.75%	0.38%	0.25%
2013	5.00%	5.00%	5.00%	3.00%	1.50%	1.00%
2014	5.00%	5.00%	5.00%	5.00%	3.75%	2.50%
2015 (ACA rules)	5.00%	5.00%	3.33%	5.00%	5.00%	3.33%
4 and 4.5 star plans						
2012	2.00%	1.00%	0.67%	0.75%	0.38%	0.25%
2013	4.00%	2.00%	1.33%	3.00%	1.50%	1.00%
2014	5.00%	3.75%	2.50%	5.00%	3.75%	2.50%
2015 (ACA rules)	5.00%	5.00%	3.33%	5.00%	5.00%	3.33%
3.5 star plans						
2012	1.75%	0.88%	0.58%	None	None	None
2013	3.50%	1.75%	1.17%	None	None	None
2014	3.50%	2.63%	1.75%	None	None	None
2015 (ACA rules)	None	None	None	None	None	None
3 star plans						
2012	1.50%	0.75%	0.50%	None	None	None
2013	3.00%	1.50%	1.00%	None	None	None
2014	3.00%	2.25%	1.50%	None	None	None
2015 (ACA rules)	None	None	None	None	None	None
New plans						
2012	1.50%	0.75%	0.50%	0.75%	0.38%	0.25%
2013	3.00%	1.50%	1.00%	2.50%	1.25%	0.83%
2014	3.50%	2.63%	1.75%	3.50%	2.63%	1.75%
Low enrollment / small plans						
2012	1.50%	0.75%	0.50%	0.75%	0.38%	0.25%

Note: Quality bonus payment percentages are double for plans in qualifying counties.
Source: The CMS explanation of the changes made by the proposed demonstration, November 2010.

Table A2. Average summary star quality ratings for Medicare Advantage plans in 2010 and 2011

		2010					2011					
		Plans rated	Enrollees in rated plans	Average summary score	Percent of enrollees in plans not rated	Different from reference?	Plans rated	Enrollees in rated plans	Average summary score	Percent of enrollees in plans not rated	Different from reference?	Difference between 2010 and 2011?
Overall		355	9,379,665	3.28	12.6%		396	10,074,441	3.49	9.4%		Yes
Tax Status	For Profit	266	6,597,731	3.04 *	14.7%	Reference	303	7,158,298	3.26 *	10.5%	Reference	Yes
	Not-for-Profit/Non-Profit	89	2,781,934	3.86 *	7.4%	Yes	93	2,916,143	4.06 *	6.5%	Yes	Yes
Plan began before 2004	No	218	3,263,766	2.96 *	29.3%	Reference	264	3,970,215	3.18 *	19.8%	Reference	Yes
	Yes	137	6,115,899	3.45 *	0.1%	Yes	132	6,104,226	3.70 *	1.0%	Yes	Yes
Plan began before 2005	No	206	3,104,704	2.95 *	29.6%	Reference	251	3,759,789	3.17 *	20.7%	Reference	Yes
	Yes	149	6,274,961	3.45 *	0.8%	Yes	145	6,314,652	3.69 *	1.0%	Yes	Yes
Plan type	HMO/HMOPOS	263	7,069,030	3.40 *	2.0%	Reference	272	7,243,626	3.60 *	2.3%	Reference	Yes
	Local PPO	70	1,063,794	3.28	16.4%	Yes	97	1,257,723	3.49	7.8%	Yes	Yes
	PFFS	11	537,433	2.62 *	64.5%	Yes	15	747,132	3.32 *	50.4%	Yes	Yes
	Regional PPO	11	709,408	2.63 *	4.0%	Yes	12	825,960	2.76 *	1.5%	Yes	Yes
Area of Residence	Rural	341	483,771	2.89 *	7.7%	Reference	376	514,671	3.02 *	6.2%	Reference	Yes
	Urban	355	8,895,894	3.30	12.9%	Yes	396	9,559,770	3.52	9.6%	Yes	Yes
Number of plans in county	15 or Less	352	790,170	3.02 *	30.2%	Reference	394	929,244	3.25 *	21.8%	Reference	Yes
	16 - 25	355	1,085,911	3.23 *	21.3%	Yes	396	1,238,017	3.40 *	13.9%	Yes	Yes
	26 - 35	354	1,408,895	3.27	13.6%	Yes	395	1,542,521	3.43 *	9.1%	Yes	Yes
	36 or More	355	6,094,689	3.33	7.6%	Yes	396	6,364,659	3.56 *	6.3%	Yes	Yes
Penetration Category	Less than 10%	351	270,011	2.75 *	31.8%	Yes	393	318,570	3.01 *	23.6%	Yes	Yes
	10-20%	353	1,266,343	3.04 *	28.6%	Yes	394	1,509,383	3.28 *	19.5%	Yes	Yes
	20-30%	354	1,636,830	3.21 *	18.2%	Reference	395	1,820,810	3.45	12.6%	Reference	Yes
	30-40%	354	2,638,363	3.29	7.3%	No	396	2,732,417	3.53	6.7%	No	Yes
	40% or More	355	3,568,118	3.44 *	4.1%	Yes	396	3,693,261	3.62 *	3.3%	Yes	Yes
Market share of largest plan in county	Less than 30%	355	6,392,950	3.32	12.0%	Reference	396	6,910,922	3.51	8.2%	Reference	Yes
	30 - 40%	355	1,808,896	3.25	11.7%	No	396	1,936,992	3.52	8.7%	No	Yes
	40 - 50%	345	703,354	3.24	17.1%	No	389	719,375	3.42	17.9%	Yes	Yes
	50% of More	346	474,439	3.00 *	17.3%	Yes	388	507,152	3.32 *	14.6%	Yes	Yes
County Median Household Income	Under $40,000	350	1,213,383	2.98 *	15.3%	Yes	394	1,339,022	3.13 *	10.8%	Yes	Yes
	$40,000 - $50,000	355	3,121,771	3.26	14.8%	Yes	396	3,393,792	3.45	10.4%	Yes	Yes
	$50,000 - $60,000	354	3,006,900	3.29	10.4%	Yes	395	3,159,013	3.55	8.9%	Yes	Yes
	$60,000 or More	354	2,037,611	3.47 *	10.7%	Reference	395	2,182,614	3.71 *	7.7%	Reference	Yes
Part D	No	265	1,012,642	3.19 *	17.7%	Reference	300	1,147,529	3.43 *	8.8%	Reference	Yes
	Yes	355	8,367,023	3.29	12.0%	Yes	396	8,926,912	3.50	9.5%	Yes	Yes
Double bonus county	No	355	7,092,583	3.20 *	13.3%	Reference	396	7,652,006	3.44 *	9.9%	Reference	Yes
	Yes	354	2,287,082	3.52 *	10.6%	Yes	396	2,422,435	3.67 *	7.9%	Yes	Yes
Organizations with the largest share of Medicare Advantage enrollment in rated plans in 2010	UnitedHealth Group	61	1,908,762	2.91 *	2.6%	N/A	68	1,971,031	3.25 *	3.6%	N/A	Yes
	Humana	31	1,174,951	2.83 *	30.0%	N/A	42	1,258,937	3.05 *	26.3%	N/A	Yes
	Kaiser Permanente	6	894,402	4.07 *	0.0%	N/A	5	918,842	4.48 *	0.2%	N/A	Yes
	Wellpoint	15	396,245	2.84 *	10.8%	N/A	16	449,811	3.13 *	3.3%	N/A	Yes
	Aetna	12	322,103	3.30	23.4%	N/A	15	329,146	3.71 *	21.3%	N/A	Yes
	Highmark	4	300,186	3.79 *	0.0%	N/A	3	290,451	3.97 *	5.4%	N/A	Yes
	Health Net	4	269,717	3.17 *	0.3%	N/A	4	276,250	3.41 *	0.3%	N/A	Yes
	Universal American	3	61,907	2.88 *	74.7%	N/A	5	228,899	3.17 *	10.2%	N/A	Yes
	Coventry Health Care	12	190,005	3.26	10.7%	N/A	18	217,861	3.55	1.4%	N/A	Yes
	HealthSpring	6	189,137	3.32	1.7%	N/A	7	195,421	3.48	0.4%	N/A	No
	All Other organizations	201	3,672,250	3.44 *	10.8%	N/A	213	3,937,792	3.54	8.6%	N/A	Yes

NOTE: Asterisks (*) denote values that are significantly different from the respective year's mean summary score, at the 95% confidence level. N/A denotes when the comparison to the reference group is not applicable; no organization was designated as the reference group and no statistical comparisons were made between organizations. 2010 plan ratings were weighted by county enrollment in March 2010. 2011 plan ratings were weighted by county enrollment in November 2010.
SOURCE: Kaiser Family Foundation analysis of the 2011 Medicare Health Plan Quality and Performance Ratings.

Table A3. Summary star ratings of the organizations with the largest share of Medicare Advantage enrollment in rated plans in 2010, by plan type, 2010 and 2011

Plan type	Organization	2010				2011				Difference between 2010 and 2011?
		Plans rated	Enrollees in rated plans	Average summary score	Percent of enrollees in plans not rated	Plans rated	Enrollees in rated plans	Average summary score	Percent of enrollees in plans not rated	
HMOs	UnitedHealth Group	40	1,349,690	3.02 *	1.5%	42	1,333,910	3.25 *	4.9%	Yes
	Humana	12	606,487	3.06 *	2.5%	13	614,172	3.38 *	2.6%	Yes
	Kaiser Permanente	6	894,402	4.07 *	0.0%	5	918,842	4.48 *	0.2%	Yes
	Wellpoint	6	172,110	3.14 *	0.3%	6	169,233	3.16 *	0.4%	No
	Aetna	10	158,987	3.12 *	7.3%	13	165,304	3.45	2.8%	Yes
	Highmark	1	156,310	4.00 *	0.0%	1	151,680	4.00 *	0.0%	No
	Health Net	3	234,549	3.12 *	0.0%	3	237,166	3.40 *	0.0%	Yes
	Universal American	3	61,907	2.88 *	0.2%	3	63,415	3.27 *	0.2%	Yes
	Coventry Health Care	9	127,088	3.19	4.0%	11	134,969	3.55	0.0%	Yes
	HealthSpring	6	189,137	3.32	0.3%	6	192,093	3.50	0.4%	No
	All Other organizations	167	3,118,363	3.47 *	2.7%	169	3,262,842	3.57 *	2.2%	Yes
Local PPOs	UnitedHealth Group	16	113,532	2.72 *	7.5%	20	123,878	3.07 *	2.5%	Yes
	Humana	15	150,411	2.81 *	34.1%	26	215,728	3.10 *	12.2%	Yes
	Wellpoint	4	36,411	3.00 *	16.0%	5	47,137	3.28 *	11.4%	Yes
	Aetna	2	163,116	3.47 *	0.7%	2	163,842	3.97 *	0.7%	Yes
	Highmark	2	127,313	3.50 *	0.0%	2	138,771	3.94 *	0.0%	Yes
	Health Net	1	35,168	3.50 *	2.0%	1	39,084	3.50	1.8%	No
	Universal American	NR	NR	NR	100.0%	NR	NR	NR	100.0%	NR
	HealthSpring	NR	NR	NR	100.0%	1	3,328	2.50 *	0.0%	NR
	All Other organizations	27	374,926	3.47 *	16.6%	33	443,063	3.51	7.7%	No
PFFS plans	UnitedHealth Group	1	304,591	2.50 *	0.6%	1	325,249	3.50	0.6%	NR
	Humana	3	51,343	2.55 *	88.9%	2	30,417	3.18 *	93.0%	Yes
	Wellpoint	3	68,409	2.50 *	37.3%	3	96,488	3.20 *	8.0%	Yes
	Aetna	NR	NR	NR	100.0%	N/A	N/A	N/A	N/A	N/A
	Highmark	1	16,563	4.00 *	0.3%	N/A	N/A	N/A	N/A	N/A
	Universal American	NR	NR	NR	100.0%	2	165,484	3.13 *	0.0%	NR
	All Other organizations	3	96,527	2.88 *	73.9%	7	129,494	3.25 *	65.5%	Yes
Regional PPOs	UnitedHealth Group	4	140,949	2.92 *	11.9%	5	187,994	2.97 *	0.0%	Yes
	Humana	1	366,710	2.50 *	0.0%	1	398,620	2.50 *	0.0%	No
	Wellpoint	2	119,315	2.55 *	0.0%	2	136,953	3.00 *	0.0%	Yes
	All Other organizations	4	82,434	2.86 *	11.0%	4	102,393	3.03 *	10.7%	Yes

NOTE: Asterisks (*) denote values that are significantly different from the respective year's mean summary score, at the 95% confidence level. N/A denotes when the company did not offer this type of plan in the year. NR denotes organizations that offered at least one plan of this type in the year, of which none of these plans were rated. 2010 plan ratings were weighted by county enrollment in March 2010. 2011 plan ratings were weighted by county enrollment in November 2010.

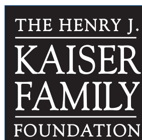
SOURCE: Kaiser Family Foundation analysis of the 2011 Medicare Health Plan Quality and Performance Ratings.

Table A4. Part D star ratings of the organizations with the largest share of Medicare Advantage enrollment in rated plans in 2010, by plan type, 2010 and 2011

		2010				2011				
		Plans rated	Enrollees in rated plans	Average Part D score	Percent of enrollees in plans not rated	Plans rated	Enrollees in rated plans	Average Part D score	Percent of enrollees in plans not rated	Difference between 2010 and 2011?
HMOs	UnitedHealth Group	45	1,357,085	3.38 *	1.0%	49	1,347,273	3.23 *	3.9%	Yes
	Humana	13	609,146	3.59	2.1%	15	616,752	3.35	2.1%	Yes
	Kaiser Permanente	6	894,402	4.54 *	0.0%	5	918,842	4.58 *	0.2%	Yes
	Wellpoint	6	172,110	3.26 *	0.3%	6	169,233	2.56 *	0.4%	Yes
	Aetna	17	169,997	2.98 *	0.9%	16	169,429	3.00 *	0.4%	No
	Highmark	1	156,310	4.00 *	0.0%	1	151,680	4.00 *	0.0%	No
	Health Net	3	234,549	3.38 *	0.0%	3	237,166	3.00 *	0.0%	Yes
	Universal American	3	61,907	3.32 *	0.2%	3	63,415	3.77 *	0.2%	Yes
	Coventry Health Care	11	132,284	3.24 *	0.0%	11	134,969	3.35	0.0%	Yes
	HealthSpring	6	189,137	4.24 *	0.3%	6	192,093	3.60 *	0.4%	Yes
	All Other organizations	186	3,170,940	3.69 *	1.1%	190	3,298,690	3.51 *	1.2%	Yes
Local PPOs	UnitedHealth Group	19	118,726	2.95 *	3.3%	22	127,010	3.11 *	0.0%	Yes
	Humana	21	182,900	3.02 *	19.8%	30	231,843	3.10 *	5.6%	Yes
	Wellpoint	5	38,168	3.28 *	11.9%	7	52,363	2.69 *	1.6%	Yes
	Aetna	3	163,802	2.99 *	0.3%	2	163,842	3.47 *	0.7%	Yes
	Highmark	2	127,313	4.00 *	0.0%	2	138,771	3.94 *	0.0%	Yes
	Health Net	2	35,894	3.99 *	0.0%	2	39,812	3.49 *	0.0%	Yes
	Universal American	NR	NR	NR	100.0%	2	25,874	2.97 *	0.0%	NR
	HealthSpring	NR	NR	NR	100.0%	1	3,328	3.00 *	0.0%	NR
	All Other organizations	35	414,634	3.83 *	7.8%	39	464,247	3.41	3.3%	Yes
PFFS plans	UnitedHealth Group	1	304,591	3.00 *	0.6%	1	325,249	3.00 *	0.6%	No
	Humana	2	51,220	3.00 *	88.9%	3	429,669	2.97 *	0.9%	Yes
	Wellpoint	5	106,949	2.99 *	2.0%	3	96,488	2.70 *	8.0%	Yes
	Aetna	1	84,603	2.50 *	0.0%	N/A	N/A	N/A	N/A	N/A
	Highmark	2	16,611	4.50 *	0.0%	N/A	N/A	N/A	N/A	N/A
	Universal American	2	165,236	2.50 *	0.0%	2	165,484	2.63 *	0.0%	Yes
	All Other organizations	16	324,012	3.18 *	12.3%	7	129,494	3.01 *	65.5%	Yes
Regional PPOs	UnitedHealth Group	4	140,949	3.33 *	11.9%	5	187,994	2.99 *	0.0%	Yes
	Humana	1	366,710	2.50 *	0.0%	1	398,620	2.50 *	0.0%	No
	Wellpoint	2	119,315	3.27 *	0.0%	2	136,953	2.50 *	0.0%	Yes
	All Other organizations	4	82,434	3.41 *	11.0%	4	102,393	3.13 *	10.7%	Yes

NOTE: Asterisks (*) denote values that are significantly different from the respective year's mean Part D score, at the 95% confidence level. N/A denotes when the company did not offer this type of plan in the year. NR denotes organizations that offered at least one plan of this type in the year, of which none of these plans were rated. 2010 plan ratings were weighted by county enrollment in March 2010. 2011 plan ratings were weighted by county enrollment in November 2010.

SOURCE: Kaiser Family Foundation analysis of the 2011 Medicare Health Plan Quality and Performance Ratings.



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