

MEDICARE

ISSUE BRIEF

MEDICARE ADVANTAGE IN 2008

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EXECUTIVE SUMMARY

Medicare Advantage, established as part of the Medicare Prescription Drug and Modernization Act of 2003 (MMA), replaced the Medicare+Choice (M+C) program as a means of delivering traditional Medicare benefits to enrollees through private health plan sponsors. Medicare Advantage is not a new program—it builds on prior policy efforts that aimed to establish private plan options in Medicare intended to operate in a competitive marketplace. The original intent was to provide access to health maintenance organizations (HMOs), but choice of plan type has expanded substantially, giving beneficiaries access to a broad range of private plans for their Medicare benefits. In this issue brief, we review the trends in the Medicare Advantage program as it has evolved in recent years. Such analysis is particularly relevant given the rapid increase in Medicare Advantage enrollment in recent years, the surge in the number of plans contracting with Medicare, the on-budget costs associated with current payment policy, and the potential for policy action in this area, pending the outcome of the forthcoming national election.

The data in this brief are based on analytical files created by Mathematica Policy Research, Inc. (MPR) over time from publicly available Medicare Advantage data released by the Centers for Medicare and Medicaid Services (CMS). The analysis includes Medicare Advantage plan participation and enrollment in the 50 states and the District of Columbia. The brief first gives an overview of Medicare Advantage—how many beneficiaries are served by Medicare Advantage plans, what share of the total Medicare population is in a Medicare Advantage plan, and how these factors have changed over time. We then present information on selected topics, including trends in firm participation and market share, how beneficiary choice has changed over time, and growth in Medicare Advantage plans available to employer groups. We conclude by summarizing key trends, highlighting implications for beneficiaries, and describing critical issues for policymakers regarding the role of private plans in Medicare.

KEY FINDINGS

Medicare Advantage Enrollment

- The number of Medicare beneficiaries in Medicare Advantage (MA) plans continues to grow, with 8.2 million beneficiaries at the end of 2007, up from 5.4 million in March 2005, and continued growth in 2008.¹ In the first four months of 2008, enrollment has increased by more than 800,000. Private fee-for-service (PFFS) plans account for more than half of this new growth in the beginning of 2008.
- About one in five Medicare beneficiaries (19 percent) is enrolled in an MA plan. One in three Medicare beneficiaries enrolled in a Part D plan is in an MA plan.

¹ While there are approximately 9.8 million beneficiaries in MA overall, our analysis is limited to the 50 states and the District of Columbia and also excludes contracts whose plans are not available to all Medicare beneficiaries (i.e. contracts with only Special Needs Plans and Employer Direct Contracts).

- MA enrollment is far more common in urban than rural counties, with just ten percent of beneficiaries in rural counties enrolled in a MA plan at the end of 2007, less than half the rate in urban counties (22 percent). Just over half of all rural beneficiaries in MA plans are enrolled in PFFS plans. MA enrollment in rural counties has grown from 2 percent in 2003 to 9.8 percent in 2007.

Firm Participation and Market Share

- Three firms—UnitedHealthcare, Humana, and Kaiser—plus firms affiliated with BCBS account for more than half (53 percent) of MA enrollment at the end of 2007. The role of two previously dominant firms, Aetna and Cigna, is now much reduced.
- While the combined market share among the four major firms is relatively stable, additional competitors, such as Wellpoint, Universal American, Coventry, and Wellcare, have moved aggressively into the MA market on a nationwide basis, particularly with insurance products not requiring a network (PFFS plans and medical savings accounts [MSAs]). Many also offer nationwide stand-alone prescription drug plans (PDPs).
- In selected local markets, particularly those with a long history of involvement with Medicare, local competitors remain important in offering HMOs. Local preferred provider organizations (PPOs) in particular are important in the Blue Cross-affiliated segment of the market.
- The number of firms offering PFFS plans has more than quadrupled over the past three years. Eleven firms offered a PFFS product in 2006, 27 in 2007 and almost 50 in 2008. Several of these are firms making PFFS plans available in most parts of the country to a large proportion of beneficiaries. Most firms offering PFFS plans offer at least one group plan under their contracts.

Beneficiary Choice

- Nationwide, virtually all Medicare beneficiaries have plans from two or more MA contract types available in their area and most have at least three available choices. Almost always this includes at least one PFFS plan and an MSA. PFFS choice is especially common, with 82 percent of beneficiaries having such plans available to them from 6 or more sponsors in 2008 (up from 52 percent in 2007), and with little variation between urban and rural areas. Regional preferred provider organizations (R-PPOs) also are widely available, although few beneficiaries are enrolled in this type of MA plan.
- The major source of variation across the country, and particularly between urban and rural areas, rests in the available choices of coordinated care plans (CCPs) including local HMOs and PPOs.

- In 2008, 93 percent of urban beneficiaries have at least one local CCP choice, including 90 percent with an HMO available and 72 percent with a local PPO. Almost half (46 percent) have a choice of six or more such options.
- By contrast, 55 percent of rural beneficiaries can choose a local CCP. This is up substantially from 2005, although the total number of choices available in rural areas is much lower than in urban areas.
- Despite expanded MA plan availability, rural enrollment in local CCPs remains relatively low (less than 3 percent penetration). More than half of rural CCP enrollment is concentrated in a few contracts and geographic locales. MA plan availability also varies substantially across states.

Role of Medicare Advantage Plans for Employers

Employers have always had the option to contract with Medicare Advantage plans to provide retiree health benefits that wrap-around Medicare benefits, although most do not use this approach (Kaiser/Hewitt 2006). Until recently, group enrollment in MA plans appears to reflect long-standing arrangements with health maintenance organizations (HMOs) and similar plans to facilitate continuous coverage for retirees and provide an additional option to Medicare beneficiaries.

- In mid-2007, 1.33 million of the 8.55 million MA enrollees (about 15.6 percent) were in employer plans, according to CMS's Annual Plan Report.
- Of the 1.3 million MA enrollees in employer plans, most (1.0 million) were in HMOs or cost contract plans. About 241,000 group enrollees were in PFFS plans, with a disproportionate number in plans offered by Blue Cross-Blue Shield (BCBS) of Michigan (47 percent), Aetna (21 percent), and Humana (20 percent).
- In 2007, 75 percent of all PFFS contracts included at least one employer group plan.
- There is indication of increasing employer interest in PFFS plans. Unlike other MA plans, PFFS plans have no network restrictions and are able to serve retirees living throughout the country, which may be appealing to employers with broadly dispersed retirees.

DISCUSSION

Most Medicare beneficiaries receive their health coverage through the traditional Medicare program but an increasing number are enrolling in MA plans. Among those choosing a Medicare Part D plan of any type, one-third are enrolled in an MA plan. While more beneficiaries have access to HMOs and other local coordinated care plans than previously, market penetration among these plans actually was higher in 1999 (15.5%) than in 2007 (13.3%).

Under current policy, MA enrollment is projected to continue to grow (CBO 2007; CMS Trustees Report, 2008). MA plans can be attractive to Medicare beneficiaries, since Medicare

policy generates higher payments to plan sponsors than Medicare spends under the traditional program in provider payments (MedPAC 2008; Biles et al. 2008). High payments allow sponsors to offset cost sharing for Medicare benefits and cover additional services that traditional Medicare is not authorized to offer (MedPAC 2007; Gold 2007a; Merlis 2008; GAO 2008). Major firms in MA also dominate PDP offerings, and have the potential to encourage transition from enrollment in stand-alone PDPs to more profitable MA plans. Enrollment in two relatively new MA products—PFFS plans and Special Needs Plans (SNPs)—has grown rapidly and may continue to climb in the near future. The increasing availability of PFFS plans could result in employers shifting retirees into MA plans, as is already occurring in Michigan and Pennsylvania. Market penetration within MA has been encouraged by the growth of SNPs that serve dually eligible beneficiaries, most of whom previously were in traditional Medicare.

Today, a disproportionate share of the growth in MA appears to reflect industry response to higher payments, the ease of establishing PFFS plans that involve no networks, and the ability to piggyback on existing administrative structures used to market Medigap and other insurance products. It is possible that some of the PFFS growth could migrate eventually to more managed options. Lack of traction among regional PPOs suggests that any such migration would be most likely in local plans, as long as that option remains. The growth in local CCP availability is moderately encouraging, but also contrasts with the relatively stagnant state of current CCP enrollment and limited national scope of offerings currently available in the CCP market through most major MA firms. While this analysis does not address this aspect, there is the possibility that PFFS itself is eroding the more managed segments of the MA market. Such erosion would run counter to the interest of some policymakers who support transitioning beneficiaries to more managed products that are presumed to more effectively manage patient care at a lower cost to Medicare.

In sum, MA plans are offering expanded choice which is potentially attractive to some beneficiaries and to some employers who offer group retiree coverage. The issue for policymakers is whether such expansion also holds long-term promise for Medicare's financial condition and overall stability. If it does not, policymakers soon may have limited ability to alter course since continued growth in Medicare Advantage plan enrollment will generate entrenched interests and shifts in money flow that could be hard to reverse.

INTRODUCTION

Medicare Advantage (MA), established as part of the Medicare Prescription Drug and Modernization Act of 2003 (MMA), replaced the Medicare+Choice (M+C) program in 2004 and became fully operational in 2006 (MedPAC 2007, 2007; Gold 2005, 2007a). MA is a voluntary program that provides beneficiaries with an alternative way to access traditional Medicare benefits. MA plans are offered by private contractors, integrate all Medicare benefits, and typically provide supplemental coverage of Medicare's cost sharing and excluded services. MA is not a new program—it builds on prior policy efforts that aimed to establish private plan options in Medicare intended to operate in a competitive marketplace. The original intent was to provide access to health maintenance organizations (HMOs), but choice of plan type has expanded substantially, giving beneficiaries access to a broad range of private plans for their Medicare benefits (see Box).²

In this issue brief, we review the trends in the MA program as it has evolved recently. Such analysis is particularly relevant given the rapid increase in MA enrollment in recent years, the surge in the number of plans contracting with Medicare, the on-budget costs associated with current payment policy, and the potential for policy action in this area, as Congress and the next administration move to address Medicare's future.

² The Balanced Budget Act of 1987 (BBA) authorized other coordinated care models (such as preferred provider organizations [PPOs]), private fee-for-service (PFFS) plans, and a limited medical savings account (MSA) demonstration as part of an M+C program. The MMA, in establishing MA, absorbed these options, made MSA a permanent option, and added new options, including regional PPOs and Special Needs Plans (SNPs). (For information on SNPs, see Verdier et al. 2008; for more information on other MA options, see Gold 2006a, 2007b).

Major Types of Stand-Alone Prescription Drug Plans and Medicare Advantage Plans

Prescription Drug Plans (PDPs) are private plans that cover only the Medicare Part D prescription drug benefit. Stand-alone PDPs are offered in one or more of 34 defined regions comprised of aggregations of states. Benefits and premiums must be uniform and available to beneficiaries across the regions, but can differ across regions. Beneficiaries in these plans continue to receive Medicare Part A and Part B benefits through the traditional fee-for-service Medicare program. Some enrollees may be in Medicare Advantage (MA) plans of a type that are not allowed to offer a prescription drug benefit, or have the option not to do so (see below).

Medicare Advantage Plans

Local Coordinated Care Plans (CCPs) are network-based plans offered in defined aggregations of counties. Health Maintenance Organizations (HMOs) have been available as an option under Medicare for several years; in 1997, the Balanced Budget Act authorized other types of CCPs. CCPs, as well as private fee-for-service (PFFS) plans, are called “local plans” because they define their service areas on a county-by-county basis.

- **Health Maintenance Organizations (HMOs)** are typically the most tightly managed plans. They have a defined network of providers that beneficiaries generally must use to receive coverage (with some exceptions, such as emergency care). These plans account for the largest share of MA enrollment.
- **Preferred Provider Organizations (PPOs)** also are network-based plans. In a PPO, enrollees may generally go to any provider they choose. However, using providers outside of the network will result in higher out-of-pocket costs. The count of PPOs also includes other authorized plan types, particularly the few Provider-Sponsored Organization Plans (PSOs) that are offered.

Regional Preferred Provider Organizations (R-PPOs) are PPOs that serve large areas in 26 defined regions comprising one or more states. R-PPOs must offer the same plan (with the same benefits and premiums) across an entire region. Benefits must be restructured to integrate cost sharing across traditional Medicare benefits (Parts A and B) and to include an annual out-of-pocket limit on cost sharing for these benefits, a feature not included in traditional Medicare. (Local plans may set such a limit, but this is not required.) To encourage growth of the R-PPO market, the MMA allowed Medicare to share financial risk with sponsors in 2006 and 2007, provided selected provisions to encourage the establishment of networks in rural areas, and created a regional stabilization fund starting in 2007 to encourage entry of new plans and retention of existing ones.

Private Fee-for-Service (PFFS) Plans, in contrast to HMOs and PPOs, place no restrictions on the providers that a Medicare beneficiary can use, although providers may limit their willingness to see Medicare beneficiaries in such plans. PFFS plans must pay providers on a fee-for-service basis and accept all of those willing to meet their payments. Payment rates do not have to match those of Medicare, as long as CMS concludes that the rates will afford adequate provider access. Plans also have the authority to allow providers to balance-bill beneficiaries up to 15 percent of the difference between payments and charges, if they choose; however, use of Medicare rates and billing practices is common. PFFS plans are not required to offer the Medicare drug benefit, but may do so.

Medical Savings Accounts (MSAs) have high deductibles accompanied by an annual deposit in an interest-bearing checking account that can be used to cover qualified medical expenses. MSAs do not provide drug coverage, but beneficiaries can purchase it through a stand-alone PDP.

Special Need Plans (SNPs) are designed to serve one or more of three subgroups of individuals with certain special needs: dual eligibles, those who are institutionalized, and those with serious chronic or disabling conditions. SNPs may be offered through separate contracts, or as unique plans under existing HMO, PPO, or other contracts. Some SNPs have been approved under demonstration authority.

Other Types of Plans include cost contracts and various demonstrations that may be offered in particular locales. For more information on available types of plans, see Gold (2006a).

Organization of the Brief

The brief is organized in several sections. After first reviewing the data sources used, we give an overview of MA—how many beneficiaries it serves, what share of Medicare enrollment it represents, and how these factors have changed over time. For simplicity, when examining trends we use the term “MA” to refer both to the current program and earlier programs involving Medicare private plans. We then present information on selected topics of interest to the program, including:

- Firms’ participation in offering MA plans, trends in market share as aggressive new competitors enter the market, and distinctions between the national market and local markets.
- What MA expansion means for beneficiaries in terms of the number and kinds of choices they have, and how this differs for urban and rural beneficiaries, and across states.
- The role of employer-sponsored retiree group enrollment in the MA program overall, the current status of group enrollment, and future prospects.

We conclude by summarizing key trends, and highlight their implications as policymakers debate critical issues pertaining to the role of private plans in Medicare now and in the future.

DATA SOURCES

The data upon which this brief is based come from files that Mathematica Policy Research, Inc. (MPR) has developed over time using publicly available data from the Centers for Medicare & Medicaid Services (CMS). The analysis historically relied on files created around the monthly “Geographical Service Area” (GSA) report on MA contracts and enrollment in each county. Because CMS has not consistently reported these data since 2006, however, the current analysis relies on other publicly available data files from CMS, as described below. The analysis excludes Puerto Rico and the territories because of their unique circumstances with regard to Medicare.

The MA plan availability estimates for 2006 and 2007 rely on the CMS Medicare Personal Plan Finder file.³ Because CMS did not release a downloadable version of that file for 2008 until February 2008, the 2008 estimates are based on data constructed from the Landscape files.⁴ For all three years we exclude from this analysis those contracts offering *only* SNP plans, since these are not available to the general population.⁵

Analysis of MA enrollment for 2006 used the first (November) release of such data through a revised GSA file (the State, Contract, County file). We also used this file in 2007.⁶ We focus on December 2007 here to make this brief as timely as possible.⁷ (Enrollment for 2008 was not incorporated because reliable data on this topic were not yet available at the time of this analysis.⁸) All of the data on the number of Medicare beneficiaries used to calculate penetration rates were from the December 2005 files because CMS has not released comparable data since then. While this overstates growth in penetration to the extent that it does not account for overall enrollment growth in the Medicare program, the data provide the most consistent basis available for trending over time.⁹

³ We chose not to use the monthly file to examine availability in 2007 and 2008 because doing so would require waiting until at least January of the actual contract year. (In 2006 CMS did not release these data until November. The Plan Finder, in contrast, is typically posted in October of the prior year, since it is used to support beneficiary choice in the open enrollment season).

⁴ There are limited inconsistencies between the Plan Finder and Landscape files. Because the Plan Finder files are used to support beneficiary choice, they do not include contracts not open for new enrollment (of which there are few). They also do not include contracts available only for employer groups; we exclude these contracts from our analysis regardless of data source, since they are not available to all beneficiaries.

⁵ The file includes all types of contracts—local CCPs, PFFS, MSA, cost, health care prepayment plans (HCPP), and demonstration—with the exception of PACE and pilot plans.

⁶ The definitions used in the analysis mean that the number of enrollees reported here is less than the number program-wide that CMS reports monthly. While there are about 9 million beneficiaries in MA overall, our analysis is limited to the 50 states and the District of Columbia and also excludes contracts whose plans are not available to all Medicare beneficiaries (i.e. contracts with only Special Needs Plans and Employer Direct Contracts).

⁷ Because we have focused on March data in prior analyses, we also examined these trends but decided the December 2007 data provided a better focus for the current analysis. Only enrollment, not availability, changes over time within a contract year.

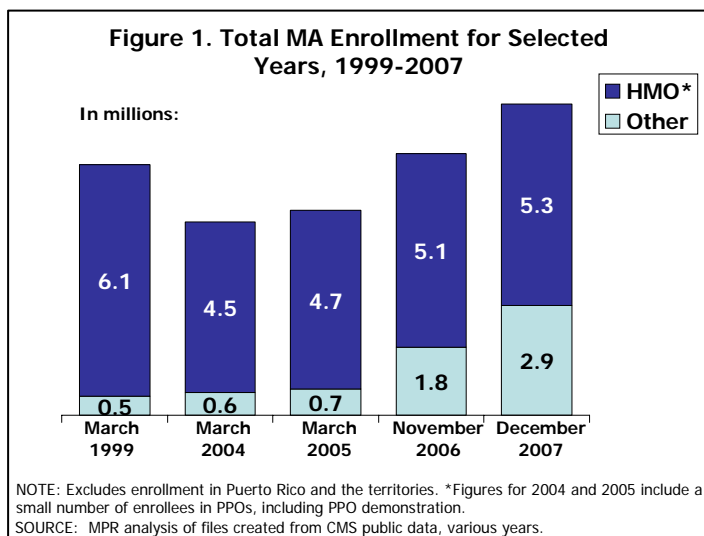
⁸ We selectively report aggregate data for February 2008 in the text to give readers some sense of 2008 enrollment trends.

⁹ Before 2006, CMS issued quarterly releases of what it termed “MA eligible beneficiaries by county.” When CMS resumed releasing MA data in November 2006 after a hiatus, the new files did not provide this information. In December 2006, CMS released a different file with seemingly similar estimates. However, the estimates of

Other selected data sources are used to supplement the analysis. We present firm counts, which have been developed over time using a variety of sources, including CMS-reported contract names, InterStudy data, Blue Cross and Blue Shield (BCBS) Association reports for their members, and our own industry knowledge. We used the CMS Annual Plan Report from July 2007 to address selected topics, particularly the role of employer/union groups within MA.¹⁰ This is the only CMS file that reports plan-level data (versus contract data only), but it does not break down plan data geographically across counties within a service area, so it does not support most of the measures we examine here.

OVERVIEW OF MA ENROLLMENT

Overall Growth. MA enrollment continues to grow since enactment of the Medicare Modernization Act. At the end of 2007, there were 8.2 million beneficiaries enrolled in MA plans, up 34 percent from March 2004, after the MMA was enacted, and up 24 percent from 1999, the previous high year for Medicare enrollment in private plans (Figure 1).¹¹



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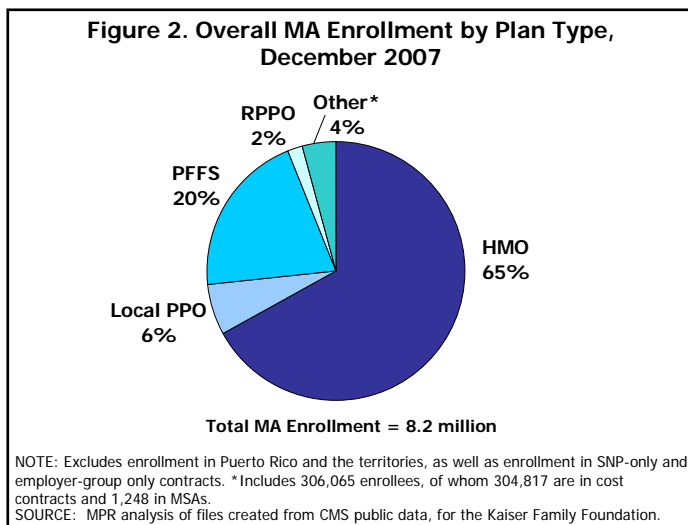
penetration calculated using data from the two files differ dramatically, because the former file included only those with Part A and Part B (a requirement for MA enrollment), whereas the latter include all those with Medicare Part A or Part B. (The estimates differ in several other ways.) Our decision to continue use of the earlier data was made after consulting with the Medicare Payment Advisory Commission (MedPAC), which also uses the earlier file due to concern about producing estimates showing artificial declines in penetration.

¹⁰ Note that this data source differs from others in the report in that it includes Puerto Rico and the territories; counts also may differ in other ways.

¹¹ Preliminary data indicate that growth continues in 2008. CMS's summary report for April 2008 reports 9.8 million enrollees across all types of contracts, up from 9.0 million in December 2007 for the same population. The summary annual report includes enrollment which we do not include in this analysis, including Puerto Rico and the territories, all SNPs (including SNP- and employer-only contracts), and the CMS pilot demonstrations, in which beneficiaries are enrolled in traditional Medicare, not MA plans.

A disproportionate share of the growth in enrollment was outside of the traditional HMO sector.

While HMO enrollment has grown 18 percent from 2004-2007, year-end 2007 HMO enrollment remained below that of March 1999. Further, much of that growth reflected new SNP offerings, particularly for dual eligible beneficiaries who often were enrolled automatically in such plans.¹² In December 2007, HMOs



reflected 65 percent of MA enrollment. Most of the rest (20 percent) was in PFFS plans (Figure 2).

Market Penetration. As a sector, MA remains a small segment of the Medicare market but its role is growing (Table 1). In December 2007, almost a fifth of all Medicare beneficiaries (19 percent) were in MA plans, up from 12 percent in 2004, and the previous program high of 17 percent in 1999. This penetration understates MA's role among Medicare beneficiaries who elect the Part D prescription drug benefit, a choice most likely for those without other subsidized sources of coverage. The CMS Annual Enrollment Report for July 2007 indicates that among all Part D enrollees, MA represents 33 percent of the subset of beneficiaries in either MA drug plans (MA-PD plans) or stand-alone PDPs.¹³

As has been the case historically, MA remains much more relevant in urban than rural areas. At the end of 2007, 22 percent of all Medicare beneficiaries in urban counties were enrolled in

¹² Of the July 2007 total MA enrollment of 5.7 million in HMOs nationwide (including Puerto Rico), 0.7 million were in SNPs, and 0.6 million were in MA contracts that include non-SNPs alongside SNP plans (see Verdier et al. 2008, p. 22).

¹³ Certain MA beneficiaries—mainly those in PDPs or certain PFFS plans—have the option to obtain their Part D coverage separately through a free-standing PDP. In CMS's report, they are counted twice.

MA, as opposed to only 10 percent of beneficiaries in rural counties. However, MA is growing more rapidly in rural areas, a growth markedly driven by an expansion in PFFS offerings and enrollment. Almost 6 of every 10 MA enrollees in rural areas are in PFFS plans, which is double the number in urban counties. While HMO enrollment is higher in rural counties currently than in 2004 (in contrast to the situation in urban counties), the HMO penetration in rural areas (2.8 percent) is only slightly higher than in 1999, when it was 2.4 percent.

SELECTED TOPICS

Firm Participation and Market Share

Historically Dominant Firms. Historically, a small number of firms and affiliates have dominated Medicare enrollment in the MA sector nationwide (Draper et al. 2002). In 1999, 75 percent of enrollment was in seven firms (Aetna, Cigna, Health Net, Humana, Kaiser Permanente, PacifiCare, and UnitedHealthcare) or in BCBS affiliates (Table 2). As firms reduced participation in the early 2000s, each of these firms, except Kaiser Permanente and the BCBS affiliates, had some decline in enrollment; for two firms (Aetna and Cigna), the decline was quite substantial. By 2005, the seven firms and BCBS affiliates still dominated private plan enrollment in Medicare, albeit somewhat less pronounced (with 65 percent of all enrollees), and their decline in this sector continues, with the firms having 58 percent of the MA market in 2007. Of the original dominant firms and affiliates, three firms—UnitedHealthcare (now merged with PacifiCare), Humana, Kaiser—and the BCBS affiliates still are clearly dominant players in the MA market, retaining 53 percent of all MA enrollment in 2007, down only slightly from 55 percent in 1999.

Emerging National Competitors. Since passage of the MMA, the Medicare Advantage market has been dynamic, with extensive entry by some new competitors, some of which has been quite aggressive (Table 3). Wellpoint, particularly through its non-Blues brand (UniCare),

is making MA plans available to at least 70 percent of beneficiaries in 2008. These offerings are the reason that MSAs are now available to most Medicare beneficiaries.¹⁴ Universal American, an insurance holding company with subsidiaries such as Pennsylvania Life, Pyramid Life, and American Progressive, principally sells Medicare health insurance products. It offers PFFS products nationwide; several HMOs in four states, along with Medicare supplement plans; and a stand-alone PDP that is available nationwide in 2008. Coventry is another aggressive competitor, with plans available to 84 percent of beneficiaries, and an emphasis on PFFS. Wellcare also has been competing both in PFFS and HMO markets (particularly for SNPs), although recent legal events have complicated its future.¹⁵

With the exception of Kaiser and BCBS affiliates (other than Wellpoint), the major firms in MA also offer stand-alone PDPs, and an increasing share do so on a national basis (Table 4). Humana and UnitedHealthcare have captured 47 percent of the PDP market. Nationally, there are twice as many Medicare beneficiaries enrolled in PDPs as in MA plans, and PDP enrollment also dominates most MA companies' total Medicare enrollment. Because the same companies dominate PDP and MA enrollment, it is possible that enrollment may shift between the two sectors. As long as MA plans are reasonably paid, from the point of view of industry, firms have an incentive to encourage such a shift if they can manage the risk, because more revenue is at stake in MA (which covers all Medicare benefits) as opposed to the stand-alone PDPs (which involve only prescription drugs).

National versus Local Markets. The national profile of MA does not carry over to some local markets, especially those with high MA concentrations and long MA histories. Although a

¹⁴ Wellpoint's UniCare MSA contract, begun in 2007, has expanded from 2,118 counties that year to 2,186 in 2008, and Wellpoint's Blues-branded MSA contracts account for all but 2 of the 9 MSA contracts in 2008. (The others are Coventry and Geisigner.) Appendix Table A.3 has further detail on such contracts.

¹⁵ Wellcare offices were raided in fall 2007, with authorities investigating reinsurance arrangements and other aspects of their practices. According to the January 28, 2008 industry newsletter Health Plan Week the Wellcare

national scope can generate economies of scale, these are fewer when networks must be built separately in each locale, and care management must be coordinated across delivery systems that vary greatly. Thus, local competitors offering tightly managed care, particularly through HMOs in which the MA program originated, are still major competitors in some large urban markets. In 2007, 14 percent of all HMO enrollees within MA were in Kaiser, and several hundred thousand more were in strong locally based plans such as HIP, Group Health Cooperative, Health Partners, Health Alliance Plan, Tufts, and Fallon (Table 5). The local base of BCBS affiliates also provides benefits when such MA sponsors can leverage long-term provider contracts in the commercial market. Blues affiliates account for a disproportionate share (37 percent) of local PPO enrollment within MA, and some affiliates, such as Pennsylvania-based Highmark (and Independence, with whom it currently is merging), have large HMO enrollments. Because they build mainly on HMOs and benefit from relationships with state Medicaid agencies (see Verdier et al. 2008), SNPs also may benefit from a local presence. Later, we consider these facts in discussing the future outlook of the MA program, including the ease of transitioning from PFFS plans to more managed MA plan types.

Beneficiary Choice Under MA

Overall Availability. There is no doubt that MA has expanded the number and types of plan choices available to Medicare beneficiaries. Virtually all Medicare beneficiaries, including those in rural areas, now have some choice of an MA plan (Table 6). The vast majority have access to plans under at least three contract types (PFFS, MSA, R-PPO). Regardless of their area of residence, virtually all beneficiaries have coverage available under MA plans from at least one PFFS sponsor (Table 7), and 83 percent of them have plans from 6 or more sponsors in 2008, up

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company is negotiating the departure of three top executives and potential sale of the company.

from 52 percent in 2007. While MSAs are new, and few beneficiaries are as yet enrolled, virtually all have the option to choose one of these plans in 2008. Eighty-seven percent of Medicare beneficiaries can choose a regional PPO in 2008, although sponsorship of such plans has been essentially unchanged since 2006 when they were first offered and enrollment remains low (see Appendix Table A.4 for 2008 contracts).

The main source of variation across the nation rests in availability of local CCPs. However, while availability of these plans nationally is growing, enrollment is expanding much less. Indeed, in their March 2008 *Report to Congress*, the Medicare Payment Advisory Commission concludes that, for many local CCPs, enrollment has shifted from a base of individual beneficiaries to employer retiree groups and the target populations for SNPs.

Local Coordinated Care Plans in Urban Areas. In 2008, 93 percent of beneficiaries in urban areas have some choice involving a local CCP, up from 78 percent in 2005 (see Table 6). Although such a choice in 2005 often was only an HMO (only 47 percent had a local PPO available), by 2007, 72 percent could choose a local PPO (versus 90 percent with an HMO choice). By 2008, 78 percent of urban beneficiaries have plans available from at least 3 local coordinated care contracts, and 46 percent have them from six or more (Table 7).¹⁶

Local Coordinated Care Plans in Rural Areas. In 2008, 55 percent of beneficiaries in rural counties have some MA choice, up from 18 percent in 2005, as reflected in increases in both available HMOs and local PPOs (see Table 6). In 2008, 43 percent of beneficiaries in rural areas have a choice of HMO, and 32 percent have a PPO choice. The number of choices remains substantially below those in urban areas. In contrast to the 78 percent of urban beneficiaries with

¹⁶ Beneficiaries have many more plan choices, since more than one benefit package (or plan) often is offered under a single contract in the same county. HMOs and PPOs have separate contracts, so a person with three available contract offerings might have these options available from three different companies, or from fewer companies, if some offer both an HMO and PPO.

three or more choices, only 17 percent of beneficiaries in rural areas have such a choice (Table 7).

Because there has been considerable congressional interest in expanding choice in rural areas, the fact that such choice in rural areas *is* expanding—although it is still much more limited than in urban areas—is likely to be encouraging to policymakers. However, several cautions are in order.

First, as discussed at the outset of this paper (see Table 1), the actual enrollment of rural beneficiaries in local CCPs remains relatively low nationwide, despite the growth in offerings. At the end of 2007, penetration was more than twice as high as in 2003, but still fewer than 3 percent of all Medicare beneficiaries were in any local CCP (2.8 percent, or 258,309 beneficiaries). As is the case nationally, most of these were in HMOs, where penetration was 2.4 percent (versus 0.4 percent for local PPOs). Additional research is needed to determine how much of the lower enrollment is due to beneficiary response to features of these plans in rural areas (networks, benefits) and how much to the absence of firms actively marketing available products in rural areas.

Second, previous experience of private plans in Medicare suggests that rural offerings of network-based products are tenuous and not very stable. Under the predecessor program to Medicare Advantage, Medicare+Choice, higher “rural floor” payments resulted in more HMOs being offered in rural counties, but most of these were adjacent to urban areas and had lesser benefits than plans in urban areas (MedPAC 2001; Gold 2001). Firms entering rural areas also were more likely to withdraw and when they did, their enrollees were much more likely to be left with no supplemental coverage (Casey et al. 2002). Even in states with extensive managed care experience, such as California, Medicare HMOs have had a hard time taking hold in rural areas (Gold and Lake 2002).

Appendix Table A.5 shows which HMO contracts have included one or more rural counties since 2005, and the states where they are offered. In July 2007, three contracts had 10,000 or more such enrollees in rural counties: KeyStone Health Plan (PA, around 11,000), Caretin Health Plan (TN, about 11,000) and Geisinger Gold (PA, about 21,000). Another 10 contracts had between 5,000 and 10,000, with enrollment typically tending towards the lower end.¹⁷ These contracts account for more than half of all rural MA enrollees (approximately 140,000). (For information on availability by state in urban areas, see Appendix Table A.6.)

Variation in Choice across States. While Alaska is the only state in which some beneficiaries may have no MA choice of any type (Table 8), there is no choice of local CCP in 4 states (Alaska, New Hampshire, North Dakota, and Vermont); in South Dakota and Wyoming only 2 to 3 percent of beneficiaries have such choices (Table 9). An additional 8 states have fewer than 25 percent of rural beneficiaries with such a choice: California (19 percent), Colorado (17 percent), Georgia (15 percent), Kansas (5 percent), Kentucky (9 percent), Maryland (0 percent), Massachusetts (0 percent), and Nebraska (3 percent) (Table 9). Because they allow more of an “opt out,” in terms of access to non-network providers, one might think that PPOs would be more common in rural areas than HMOs. In most states, however, this is not the case, a fact that may reflect the historical base of CCP in the HMO model.

The Role of MA Plans in the Employer Market

While MA is targeted, for the most part, to individual beneficiaries, there always has been an option for employers to offer their retirees a Medicare private plan product that combines Medicare and the employer’s retiree health coverage. Mostly, employers have used this option to allow their retirees to continue enrollment in a Medicare-contracting HMO that they might

¹⁷ These are: Kaiser Foundation Health Plan (HI), Gunderson Lutheran Health Plan (WI), Independent Health (NY), Medicare Blue (NC), Excelleus Blue (NY), Partners Medical Choice (NC), Preferred Care Gold (NY), UPMC

have been enrolled in through the employer plan when working. In such circumstances, employers negotiated with plans already offered through the group, usually by “wrapping” supplemental benefits around a “bare bones” MA plan (Kaiser/Hewitt 2006). Such choices then would be offered along with any other stand-alone plans the employer was offering retirees.

Employers historically have been hesitant to push MA enrollment aggressively among their retirees, at least in part because of fear of the instability of MA offerings and their absence in some areas of the country. Doing business with Medicare also often was challenging because it involved additional administrative steps to adapt MA requirements to the group market. However, over time CMS has made it easier for employers to contract with MA plans for group enrollment, and the MMA introduced changes, such as the Part D drug benefit and higher MA plan payment rates, which increased the incentive for employers to consider integrating their own retiree benefits with an MA plan (or plans), particularly when doing so might reduce an employer’s costs. Below we review what is known about employer group enrollment under MA contracts in 2007.

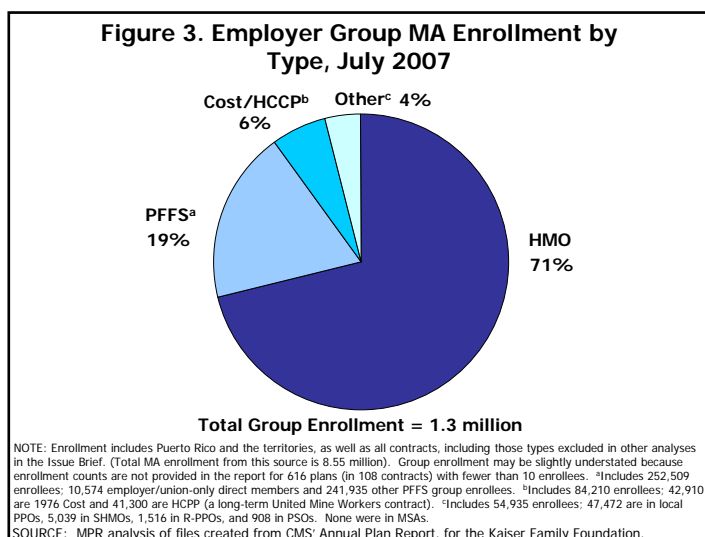
Employer Group Enrollment in 2007. The CMS Annual Plan Report from July 2007 shows that 1.33 million (or 15.6 percent) of the 8.55 million total MA enrollees nationwide are in group plans. While data do not show when beneficiaries originally enrolled, the enrollment patterns suggest that, in 2007, group MA enrollment mostly reflects long-standing arrangements. Fifty percent of enrollees in group contracts were in those that began before 1990, and another 25 percent began between 1990 and 1999.

As in the overall MA market, group MA enrollment still shows the historical influence of HMOs in the program. About 1.0 of the 1.3 million Medicare MA group enrollees in 2007 were

(continued)

Health Plan (PA), Secure Horizons (NC), and Security Health Plan of Wisconsin.

in HMOs (71 percent) or cost/HCCP contracts (Figure 3). The group market has been influenced by MA enrollment in established prepaid group practices that long have sought to convert commercial members to Medicare HMO members upon becoming eligible for Medicare. Kaiser alone accounted for almost a quarter (or 375,000) of group enrollees in 2007; almost all of this presence was through contracts begun in 1987 or earlier (see Appendix Table A.2).



The 2007 data show signs of potential new sources of employer interest in MA, which probably is not yet reflected in the data from 2007. Slightly fewer than 1 in 5 group MA enrollees in mid-2007 (241,035) were in plans offered under PFFS contracts, most in plans offered by BCBS of Michigan (47 percent), Aetna (21 percent), and Humana (20 percent).¹⁸ This sector of group enrollment, like PFFS itself, is relatively new.

Potential Shifts in Employer Group Enrollment in MA due to Growth of PFFS. With their geographically bound service areas and closed provider networks, HMOs historically have been a voluntary option for group retirees, not the sole option (a total replacement product). That could change in the future with growth in the PFFS plan sector in MA. PFFS has the potential to be attractive to employers, particularly if they have broadly dispersed workforces and an interest in simplified offerings for their retirees. Employers have an increasing number of PFFS sponsors with which to negotiate. In contrast to the 11 firms contracting with Medicare to offer a

¹⁸ Coventry accounts for another 5.5 percent of group PFFS enrollment. While UHC-PacifiCare is the second largest group MA purchaser (128,527), only 5,628 of its 2007 group enrollees were in PFFS (versus HMO) contracts (and 182 were in R-PPOs).

PFFS plan in 2006, 27 firms had such a contract in 2007, and almost 50 do in 2008 (Table 10). Some PFFS sponsors have plans available across substantial areas of the country. For example, Universal America, Coventry and Humana plans are available to 97 percent, 84 percent, and 82 percent, respectively, of all Medicare beneficiaries nationwide. In 2007, 37 PFFS contracts (over 75 percent of the total) included at least one group plan. Group plans also were commonly in place across other contract types—with 50 percent (295 of the 589 MA contracts) of all contracts having at least one employer plan.¹⁹

DISCUSSION

Most Medicare beneficiaries remain in the traditional Medicare program, but an increasing number are enrolled in MA plans. Among those choosing a Medicare Part D plan of any type, one-third are enrolled in an MA plan, which is substantially higher than MA's share of the Medicare program overall. A disproportionate share of the new enrollment and expanded choice involves growth in PFFS and similar offerings, both by existing and new MA sponsors. While more beneficiaries have access to local CCPs, market penetration among these plans actually was higher in 1999 than 2007.

Under current policy, MA plan availability and enrollment is forecasted to grow (CBO 2007, Trustees 2008). MA plans can be attractive to Medicare beneficiaries, since Medicare policy generates higher payments for plan sponsors allowing sponsors to offset cost sharing for Medicare benefits and cover additional services that traditional Medicare does not offer (MedPAC 2007; Gold 2007a; Biles et al 2008; GAO 2008, Merlis 2008). Major firms in MA also dominate PDP offerings, so they have the potential to encourage transition of enrollees from stand-alone PDPs to more potentially profitable MA plans. For employers, rising health care

¹⁹ For privacy reasons, CMS does not release plan enrollment with fewer than 10 enrollees. However, the total enrollment in such plans from groups or other sources is small (no more than 6,160 enrollees in 108 contracts (616

costs, and the growing availability of nationwide PFFS plans, could shift more retirees currently in the group market into MA plans. A similar shift towards MA from traditional Medicare may be occurring with the growth of SNPs that serve dually eligible beneficiaries, most of whom previously were enrolled in traditional Medicare.

Current MA trends make it relevant to consider what policymakers intend for Medicare in the future. Historically, the program has provided a standard set of benefits to beneficiaries nationwide through a structure that has supported access to virtually all providers. Although traditional Medicare involves private intermediaries and carriers in paying providers and administering policies, overall, the program is centrally administered. Under MA, Medicare continues to exercise overall oversight on policy, but it delegates substantial authority to private firms to configure the benefits they offer, determine provider access, and develop structures and processes to improve quality and care management. MA also provides beneficiaries with diverse plan choices regarding how they receive Medicare benefits. Under the current MA payment structure, beneficiaries in different parts of the country have access to plans in which benefits and cost sharing vary substantially. This differs from the traditional Medicare program, which varies the amount it pays providers geographically, but provides standardized benefits across the country.

It goes beyond the scope of this paper to consider all of the relevant issues as policymakers consider how Medicare should be structured in the future. The analysis in this paper is most relevant to a greater understanding of the kinds of private plan choices that the market will support. One rationale for MA is that its focus on networks and decentralization would encourage greater innovation and more localized structures better suited to managing care than is

(continued)
plans of any type).

available from a centralized Medicare model. However, the facts on the ground suggest that this outcome has not yet been realized.

Currently, a disproportionate share of the growth in MA plan offerings appears to reflect industry response to higher payments, the ease of establishing PFFS plans involving no networks, and the ability to piggyback on existing administrative structures used to market Medigap and other insurance products. It is possible that some of the PFFS enrollment eventually could migrate to more managed MA options. Lack of traction among regional PPOs suggests that any such migration would most likely be to local plans, as long as that option remains. However, the growth in local CCP availability contrasts with the relatively stagnant state of current CCP enrollment and the limited national scope of offerings now available in the CCP market through most major MA firms. While this analysis does not address this aspect in detail, there is the possibility that the existence of the PFFS option itself is eroding the more managed segments of the MA market. Such erosion would run counter to the interest of some policymakers who support the expansion of Medicare enrollment in more coordinated care arrangements that are presumed to more effectively manage patient care at a lower cost to Medicare than traditional fee-for-service arrangements.

In sum, MA plans are offering expanded choice, and some of the ways in which this has occurred are potentially attractive to beneficiaries and some employers who offer group retiree coverage. The issue for policymakers is whether such expansion also holds long-term promise for Medicare's financial condition and overall stability. If it does not, policymakers soon may have limited ability to alter course since continued growth in Medicare Advantage plan enrollment will generate entrenched interests and shifts in money flow that could be hard to reverse.

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TABLE 1
 MEDICARE ADVANTAGE PENETRATION IN RURAL VS. URBAN COUNTIES
 1999-2007 (Selected Years)

| | 1999 | 2003 | 2007 |
|------------------------|-------|-------|-------|
| All Counties | | | |
| Any MA Contract | 16.8% | 12.2% | 18.8% |
| Local CCP ^a | 15.5 | 10.8 | 13.3 |
| PFFS | -- | 0.0 | 3.8 |
| Urban | | | |
| Any MA Contract | 20.5 | 15.1 | 21.5 |
| Local CCP ^a | 19.0 | 13.7 | 16.3 |
| PFFS | -- | -- | 3.3 |
| Rural | | | |
| Any MA Contract | 3.1 | 2.0 | 9.8 |
| Local CCP ^a | 2.4 | 1.3 | 2.8 |
| PFFS | -- | 0.1 | 5.7 |

Source: MPR analysis of CMS Public Data, for the Kaiser Family Foundation (1999-2003 estimates from Kaiser Family Foundation Medicare Health and Prescription Drug Plan Tracker).

Note: 2007 estimates are for December and exclude SNP-only contracts.

^aThis refers to plans offered under a local coordinated care contract. Such contracts include local health maintenance organizations (HMOs), preferred provider organizations (PPOs), and provider sponsored organizations (PSOs).

TABLE 2

TRENDS IN MA MARKET SHARE, HISTORICALLY DOMINANT NATIONAL FIRMS AND AFFILIATES,
1999-2007

| | Number of MA Enrollees | | | Percent of MA Market Share | | |
|-----------------------------|------------------------|-----------|-----------|----------------------------|------|------|
| | 1999 | 2005 | 2007 | 1999 | 2005 | 2007 |
| All Plans | 6,190,371 | 5,671,480 | 8,768,530 | 100% | 100% | 100% |
| Historically Dominant Firms | 4,646,030 | 3,694,698 | 5,111,312 | 75.1 | 65.1 | 58.3 |
| Aetna | 685,193 | 101,906 | 183,676 | 11.1 | 1.8 | 2.1 |
| BCBS Affiliates | 961,557 | 976,046 | 1,295,199 | 15.5 | 17.2 | 14.8 |
| Cigna | 189,841 | 56,825 | 55,876 | 3.1 | 1.0 | 0.6 |
| Health Net | 262,795 | 197,495 | 235,338 | 4.2 | 3.5 | 2.7 |
| Humana | 475,560 | 437,254 | 1,078,439 | 7.7 | 7.7 | 12.3 |
| Kaiser Permanente | 644,884 | 873,224 | 880,807 | 10.4 | 15.4 | 10.0 |
| Pacificare ^a | 922,912 | 731,537 | **** | 14.9 | 12.9 | **** |
| UnitedHealthcare | 433,288 | 320,411 | 1,381,977 | 7.0 | 5.7 | 15.8 |

Source: MPR analysis of CMS data for the Kaiser Family Foundation. 2007 estimates are based on a file created from the State-County-Contract file for December 2007. 1999 estimates come from Draper et al. 2002. 2004 estimates come from Gold 2006b.

^a Pacificare was acquired by UnitedHealthcare in 2006, and their Medicare products were consolidated.

TABLE 3

PERCENTAGE OF BENEFICIARIES IN THE U.S. WITH MEDICARE ADVANTAGE PLAN TYPES
AVAILABLE FROM SELECTED LARGE SPONSORS, 2008

| | Any MA Contract | Plan Type | | | | |
|-----------------------|--------------------|--------------|--------------|-----------------|------|-----|
| | | Local HMO | Local PPO | Regional PPO | PFFS | MSA |
| Aetna | 42% | 21% | 16% | 5% | 25% | 0% |
| BCBS | 76% | 33% | 33% | 23% | 39% | 34% |
| Wellpoint Affiliates | 30% | 13% | 7% | 18% | 17% | 33% |
| Other | 50% | 25% | 27% | 4% | 23% | 5% |
| Cigna | 17% | <1% | <1% | 0% | 17% | 0% |
| Coventry | 84% | 5% | 3% | 0% | 84% | 6% |
| Health Net | 30% | 13% | 1% | 2% | 21% | 0% |
| Humana | 82% | 8% | 15% | 59% | 82% | 0% |
| Kaiser | 14% ^a | 11% | 0% | 0% | 0% | 0% |
| Sterling | 76% | 0% | 0% | 0% | 76% | 0% |
| UnitedHealthcare | 60% | 29% | 5% | 13% | 35% | 0% |
| Universal America | 97% | 2% | 0% | 0% | 97% | 0% |
| Well Care | 67% | 18% | 0% | 0% | 57% | 0% |
| Wellpoint (non-Blues) | 70% | 0% | 0% | 0% | 48% | 63% |

Source: MPR analysis for the Kaiser Family Foundation of a file created from CMS's Landscape File for 2007 and other sources.

Note: Includes all firms or BCBS affiliates with MA products available to 10 percent or more beneficiaries.

TABLE 4

MEDICARE PDP AND MA ENROLLMENT WITHIN NATIONAL PDPS AND SELECTED BROAD-BASED
MA FIRMS AND AFFILIATES, DECEMBER 2007

| | PDP and MA Contracts | All PDP Contracts | All MA ^a Contracts | MA as Percent of Total |
|--------------------------------------------|-------------------------|-------------------|----------------------------------|---------------------------|
| All Enrollees | 26,007,638 | 17,239,108 | 8,768,530 | 34% |
| Selected Firms | | | | |
| Aetna | 493,569 | 309,893 | 183,676 | 37% |
| BC/BS Affiliate | 1,295,199 | 0 ^a | 1,295,199 | 100% |
| Cigna | 375,897 | 320,021 | 55,876 | 15% |
| Coventry (Advantra Rx) | 982,572 | 722,046 | 260,526 | 27% |
| Envision Rx Plus | 15,149 | 15,149 | 0 | 0% |
| Express Scripts ^b | 9,560 | 9,560 | 0 | 0% |
| Health Net | 603,459 | 368,121 | 235,338 | 39% |
| Health Spring (PDP is HealthQuest) | 265,203 | 139,212 | 126,091 | 48% |
| Humana | 4,537,342 | 3,458,903 | 1,078,439 | 24% |
| Kaiser | 880,807 | 0 | 880,807 | 100% |
| Medco Health Solutions | 0 | 0 | 0 | 0% |
| NMHC Systems ^b | 30,366 | 30,366 | 0 | 0% |
| Rx American (Long's Drug Store) | 249,433 | 249,433 | 0 | 0% |
| Silverscript (Caremark/CVS) | 361,484 | 361,484 | 0 | 0% |
| Sterling ^c | 131,543 | 43,164 | 88,379 | 67% |
| Torchmark Corporation (United American) | 166,451 | 166,451 | 0 | 0 |
| UnitedHealthcare | 6,078,776 | 4,696,799 | 1,381,977 | 23% |
| Universal American ^d | 1,251,742 | 1,163,745 | 87,997 | 7% |
| WellCare | 1,137,779 | 982,559 | 155,220 | 14% |
| Wellpoint (non-Blues) | 1,352,277 | 1,229,532 | 122,845 | 9% |

Source: MPR analysis of files created from CMS monthly reports and other public sources, for the Kaiser Family Foundation.

^a Blue Cross Blue Shield does not offer a national PDP. However individual firms may offer PDPs in regions. Enrollment in these is not shown.

^b This firm has withdrawn as a PDP sponsor in 2008.

^c This firm will offer a national PDP in 2008. (Sterling offered products in most regions in 2007).

^d This firm will offer a national PDP in 2008. In spring 2007, Universal American acquired Member Health. Enrollment reported for 2007 reflects experience doing business as Member Health.

TABLE 5

MEDICARE ADVANTAGE ENROLLMENT IN MA PLAN TYPES BY SELECTED FIRMS AND AFFILIATES,
DECEMBER 2007

| | All MA ^a Contracts | MA Plan Type | | | | |
|----------------------------------------------------------------|----------------------------------|------------------|-----------|------------------|-----------|-------|
| | | Local HMO | Local PPO | Regional PPO | FFFS | MSA |
| All Enrollees | 8,768,530 | 5,772,656 | 511,012 | 226,2522 | 1,648,065 | 1,248 |
| Enrollees in Selected Firms | 5,826,279 | 3,678,161 | 388,958 | 144,825 | 1,423,830 | 1,248 |
| Enrollees in Selected Firms as Percent of All Enrollees | 66% | 64% ^b | 76% | 74% ^c | 86% | 100% |
| Aetna | 183,676 | 115,526 | 21,350 | 1,078 | 45,722 | -- |
| BC/BS | 1,295,199 | 764,922 | 190,344 | 55,189 | 201,764 | 122 |
| Wellpoint Affiliates ^d | 85,729 | 32,160 | 2,793 | 36,651 | 14,003 | 122 |
| Highmark/Independence | 406,171 | 336,427 | 69,744 | -- | -- | -- |
| Other | 803,299 | 396,325 | 117,807 | 18,538 | 187,761 | 0 |
| Cigna | 55,876 | 55,628 | 248 | -- | -- | -- |
| Coventry | 260,526 | 73,099 | 28,020 | -- | 159,407 | -- |
| Health Net | 235,338 | 198,159 | 411 | 3,337 | 13,765 | -- |
| Humana | 1,078,439 | 394,624 | 30,487 | 37,862 | 611,956 | -- |
| Kaiser | 880,807 | 815,425 | -- | -- | -- | -- |
| Sterling | 88,379 | -- | -- | -- | 88,091 | -- |
| UnitedHealthcare | 1,381,977 | 1,150,202 | 79,828 | 47,359 | 87,331 | -- |
| Universal American | 87,997 | 1,376 | 38,270 | -- | 48,055 | -- |
| WellCare | 155,220 | 109,200 | -- | -- | 46,020 | -- |
| Wellpoint (non-Blues) ^d | 122,845 | -- | -- | -- | 121,719 | 1,126 |

Source: MPR analysis of files created for Kaiser Family Foundation from CMS monthly reports and other public sources.

Note: Excludes data from Puerto Rico and the territories. Includes firms or BCBS affiliates available to 10 percent or more of beneficiaries nationally.

^aTotal includes enrollment in Cost, PACE, HCCP, and "other" contracts, as well as the indicated subgroups shown in the table. In December 2007, there were a total of 146,821 enrollees in cost contracts, 113 in PACE contracts, 3510 in HCCP, and 19,762 in "other" contracts.

^bThe remainder of HMO enrollment is in a variety of plans, including a number of historically prepaid group practices. Large HMOs include HIP (125,000 enrollees with its recent acquisitions), Tufts (71,000), Group Health Cooperative (57,000), Health Alliance Plan (69,000), Fallon (31,000), and Group Health MN (25,000). A newer firm, Bravo, has 49,000 enrollees.

^cOf the remainder of enrollment in R-PPOs, 78,306 is in Care Improvement Plus, a firm entering the market in 2007. Its enrollment grew from 5,839 in March 2007 to 78,306 in December 2007. Enrollment tends to be mainly in plans serving the SNP population. UnitedHealthcare also offers SNPs through its R-PPOs.

^dBlues and non-Blues branded Wellpoint MA products have a total enrollment of 208,574 when combined.

TABLE 6

AVAILABILITY OF MEDICARE ADVANTAGE PLANS, BY CONTRACT AND COUNTY TYPE, 2005-2008

| Percentage of Beneficiaries with Availability of | All Counties | | | | Urban Counties | | | | Rural Counties | | | |
|-----------------------------------------------------|--------------|------|------|------|----------------|------|------|------|----------------|------|------|------|
| | 2005 | 2006 | 2007 | 2008 | 2005 | 2006 | 2007 | 2008 | 2005 | 2006 | 2007 | 2008 |
| Any Contract ^a | 91 | 97 | 98 | 99 | 96 | 100 | 100 | 100 | 78 | 93 | 94 | 100 |
| Any Local Coordinated Care Plan | 64 | 77 | 79 | 84 | 78 | 89 | 91 | 93 | 18 | 38 | 42 | 55 |
| Local HMO | 62 | 70 | 74 | 79 | 76 | 84 | 87 | 90 | 15 | 25 | 33 | 43 |
| Local PPO or PSO ^b | 38 | 62 | 60 | 63 | 47 | 74 | 71 | 72 | 8 | 24 | 24 | 32 |
| Cost Contract | 23 | 9 | 13 | 9 | 27 | 10 | 14 | 9 | 9 | 8 | 7 | 8 |
| PFFS | 41 | 78 | 97 | 99 | 38 | 76 | 100 | 100 | 51 | 91 | 94 | 100 |
| Regional PPO ^b | 0 | 86 | 86 | 87 | 0 | 88 | 88 | 88 | 0 | 84 | 84 | 89 |
| MSA | 0 | 0 | 70 | 99 | 0 | 0 | 73 | 100 | 0 | 0 | 66 | 100 |

Source: MPR analysis of CMS data for the Kaiser Family Foundation. MPR analysis of publicly available CMS data from Geographic Services Area Report (March 2005) from the Medicare Personal Plan Finder (November 2005 and October 2006 release) and Landscape file (2008).

Note: Excludes employer-only contracts and contracts that offer SNP-only plans because they are not available to all beneficiaries.

^aFor 2005 and 2007, figures also include available HCPP, PACE, and "other" (largely demonstration contracts). Data were not available in 2006 for these three contract types. In 2008, PACE is excluded.

^bIncludes PPO demonstration in 2005. (The demonstration was discontinued in 2006, with many contracts converting to regular local PPOs.)

TABLE 7
 NUMBER OF MEDICARE ADVANTAGE CCP AND PFFS CONTRACTS AVAILABLE TO BENEFICIARIES, BY COUNTY TYPE, 2008

| Percent of Beneficiaries with availability of: | All Beneficiaries | | | Urban Beneficiaries | | | Rural Beneficiaries | | |
|------------------------------------------------|-------------------|----------------|------|---------------------|----------------|------|---------------------|----------------|------|
| | CCP | Local CCP Only | PFFS | CCP | Local CCP Only | PFFS | CCP | Local CCP Only | PFFS |
| No contracts of type | 3.2 | 16.5 | 1.8 | 1.7 | 7.8 | 1.0 | 3.9 | 45.5 | 0.0 |
| 1 contract | 0.6 | 11.6 | 0.0 | 0.2 | 7.8 | 0.0 | 2.0 | 26.2 | 0.7 |
| 2 contracts | 10.5 | 7.6 | 1.0 | 4.9 | 6.7 | 1.3 | 32.0 | 11.4 | 0.2 |
| 3-5 contracts | 30.9 | 27.7 | 15.6 | 26.0 | 31.6 | 16.1 | 50.7 | 14.6 | 14.4 |
| 6 or more contracts | 54.8 | 36.6 | 81.5 | 67.2 | 46.4 | 81.5 | 11.3 | 2.3 | 85.5 |

Source: MPR analysis for the Kaiser Family Foundation of a file created from CMS's Landscape File for 2007 and other sources.

Note: CCP refers to plans offered under a local coordinated care contract. Such contracts include local health maintenance organizations (HMOs), preferred provider organizations (PPOs), and provider sponsored organizations (PSOs).

TABLE 8

PERCENTAGE OF BENEFICIARIES WITH AVAILABILITY OF MEDICARE ADVANTAGE PLANS,
BY STATE AND PLAN TYPE, 2008

| State | Local CCP | | | | | | | | |
|----------------------|--------------|-----------|-----------|-----------|-----------|------------|----------|-----------|-----------|
| | Any Contract | Any CCP | Local HMO | Local PPO | R-PPO | PFFS | Cost | MSA | Other |
| All States | 99 | 84 | 79 | 63 | 87 | 100 | 9 | 99 | 26 |
| Alabama | 100 | 100 | 58 | 100 | 100 | 100 | 0 | 100 | 13 |
| Alaska | 83 | 0 | 0 | 0 | 0 | 83 | 0 | 83 | 0 |
| Arizona | 100 | 92 | 92 | 86 | 100 | 100 | 0 | 100 | 0 |
| Arkansas | 100 | 80 | 76 | 51 | 100 | 100 | 0 | 100 | 0 |
| California | 100 | 93 | 93 | 8 | 100 | 100 | 0 | 100 | 29 |
| Colorado | 100 | 81 | 81 | 62 | 0 | 100 | 100 | 100 | 2 |
| Connecticut | 100 | 100 | 100 | 81 | 0 | 100 | 0 | 100 | 92 |
| Delaware | 100 | 54 | 54 | 0 | 100 | 100 | 0 | 100 | 0 |
| District of Columbia | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 0 |
| Florida | 100 | 97 | 97 | 81 | 100 | 100 | 0 | 100 | 0 |
| Georgia | 100 | 54 | 52 | 45 | 100 | 100 | 0 | 100 | 0 |
| Hawaii | 100 | 100 | 100 | 72 | 100 | 100 | 100 | 100 | 0 |
| Idaho | 100 | 87 | 83 | 78 | 0 | 100 | 9 | 100 | 0 |
| Illinois | 100 | 90 | 77 | 88 | 100 | 100 | 0 | 100 | 19 |
| Indiana | 100 | 55 | 44 | 39 | 100 | 100 | 33 | 100 | 0 |
| Iowa | 100 | 78 | 78 | 47 | 100 | 100 | 7 | 100 | 0 |
| Kansas | 100 | 47 | 41 | 39 | 100 | 100 | 0 | 100 | 14 |
| Kentucky | 100 | 39 | 36 | 39 | 100 | 100 | 0 | 100 | 0 |
| Louisiana | 100 | 89 | 89 | 24 | 100 | 100 | 0 | 100 | 0 |
| Maine | 100 | 79 | 79 | 56 | 0 | 100 | 0 | 100 | 0 |
| Maryland | 100 | 84 | 84 | 84 | 100 | 100 | 83 | 100 | 44 |
| Massachusetts | 100 | 97 | 97 | 97 | 0 | 100 | 0 | 100 | 97 |
| Michigan | 100 | 84 | 84 | 57 | 100 | 100 | 0 | 100 | 30 |
| Minnesota | 100 | 100 | 100 | 0 | 100 | 100 | 100 | 100 | 45 |
| Mississippi | 100 | 61 | 61 | 0 | 100 | 100 | 0 | 100 | 0 |
| Missouri | 100 | 71 | 68 | 67 | 100 | 100 | 0 | 100 | 0 |
| Montana | 100 | 74 | 23 | 71 | 100 | 100 | 0 | 100 | 0 |
| Nebraska | 100 | 33 | 33 | 31 | 100 | 100 | 0 | 100 | 0 |
| Nevada | 100 | 100 | 89 | 100 | 100 | 100 | 0 | 100 | 0 |
| New Hampshire | 100 | 0 | 0 | 0 | 0 | 100 | 0 | 100 | 0 |

Table 8 (continued)

| State | Any Contract | Local CCP | | | | | | | |
|----------------|--------------|-----------|-----------|-----------|-------|------|------|-----|-------|
| | | Any CCP | Local HMO | Local PPO | R-PPO | PFFS | Cost | MSA | Other |
| New Jersey | 100 | 100 | 100 | 87 | 100 | 100 | 0 | 100 | 13 |
| New Mexico | 100 | 100 | 68 | 100 | 0 | 100 | 0 | 100 | 0 |
| New York | 100 | 100 | 95 | 100 | 100 | 100 | 6 | 100 | 100 |
| North Carolina | 100 | 67 | 67 | 56 | 100 | 100 | 0 | 100 | 0 |
| North Dakota | 100 | 0 | 0 | 0 | 100 | 100 | 37 | 100 | 0 |
| Ohio | 100 | 100 | 100 | 90 | 100 | 100 | 25 | 100 | 0 |
| Oklahoma | 100 | 68 | 62 | 63 | 100 | 100 | 0 | 100 | 0 |
| Oregon | 100 | 100 | 93 | 100 | 0 | 100 | 7 | 100 | 0 |
| Pennsylvania | 100 | 100 | 96 | 100 | 100 | 100 | 0 | 100 | 100 |
| Rhode Island | 100 | 100 | 100 | 0 | 0 | 100 | 0 | 100 | 81 |
| South Carolina | 100 | 61 | 32 | 58 | 100 | 100 | 0 | 100 | 0 |
| South Dakota | 100 | 2 | 0 | 2 | 100 | 100 | 34 | 100 | 0 |
| Tennessee | 100 | 88 | 88 | 56 | 100 | 100 | 0 | 100 | 22 |
| Texas | 100 | 80 | 79 | 55 | 100 | 100 | 11 | 100 | 51 |
| Utah | 100 | 92 | 92 | 89 | 0 | 100 | 0 | 100 | 0 |
| Vermont | 100 | 0 | 0 | 0 | 0 | 100 | 0 | 100 | 0 |
| Virginia | 100 | 72 | 36 | 63 | 100 | 100 | 16 | 100 | 7 |
| Washington | 100 | 99 | 94 | 91 | 0 | 100 | 0 | 100 | 0 |
| West Virginia | 100 | 100 | 35 | 100 | 100 | 100 | 0 | 100 | 0 |
| Wisconsin | 100 | 83 | 78 | 52 | 100 | 100 | 18 | 100 | 0 |
| Wyoming | 100 | 3 | 3 | 0 | 100 | 100 | 3 | 100 | 0 |

Source: MPR analysis for the Kaiser Family Foundation of a file created from CMS's Landscape File for 2007 and other sources.

Note: CCP refers to plans offered under a local coordinated care contract. Such contracts include local health maintenance organizations (HMOs), preferred provider organizations (PPOs) and provider sponsored organizations (PSOs).

TABLE 9

PERCENTAGE OF BENEFICIARIES WITH AVAILABILITY OF MEDICARE ADVANTAGE PLANS,
BY STATE AND PLAN TYPE FOR RURAL COUNTIES, 2008

| State | Any CCP | Type of CCP | |
|----------------------|-----------|-------------|-----------|
| | | Local HMO | Local PPO |
| All States | 55 | 43 | 32 |
| Alabama | 100 | 41 | 100 |
| Alaska | 0 | 0 | 0 |
| Arizona | 65 | 65 | 37 |
| Arkansas | 64 | 64 | 16 |
| California | 19 | 19 | 0 |
| Colorado | 17 | 17 | 0 |
| Connecticut | 100 | 100 | 64 |
| Delaware | NA | NA | NA |
| District of Columbia | NA | NA | NA |
| Florida | 62 | 62 | 31 |
| Georgia | 15 | 7 | 9 |
| Hawaii | 100 | 100 | 0 |
| Idaho | 69 | 59 | 46 |
| Illinois | 67 | 23 | 62 |
| Indiana | 15 | 11 | 8 |
| Iowa | 61 | 61 | 18 |
| Kansas | 5 | 0 | 5 |
| Kentucky | 9 | 7 | 9 |
| Louisiana | 64 | 64 | 0 |
| Maine | 54 | 54 | 21 |
| Maryland | 0 | 0 | 0 |
| Massachusetts | 0 | 0 | 0 |
| Michigan | 43 | 43 | 4 |
| Minnesota | 100 | 100 | 0 |
| Mississippi | 42 | 42 | 0 |
| Missouri | 29 | 28 | 25 |
| Montana | 61 | 22 | 57 |
| Nebraska | 3 | 3 | 0 |
| Nevada | 100 | 47 | 100 |
| New Hampshire | 0 | 0 | 0 |

Table 9 (continued)

| State | Any CCP | Type of CCP | |
|----------------|---------|-------------|-----------|
| | | Local HMO | Local PPO |
| New Jersey | NA | NA | NA |
| New Mexico | 100 | 20 | 100 |
| New York | 100 | 66 | 100 |
| North Carolina | 39 | 39 | 31 |
| North Dakota | 0 | 0 | 0 |
| Ohio | 100 | 100 | 66 |
| Oklahoma | 32 | 23 | 24 |
| Oregon | 100 | 76 | 100 |
| Pennsylvania | 100 | 81 | 100 |
| Rhode Island | NA | NA | NA |
| South Carolina | 18 | 4 | 14 |
| South Dakota | 0 | 0 | 0 |
| Tennessee | 64 | 64 | 26 |
| Texas | 43 | 41 | 5 |
| Utah | 48 | 48 | 34 |
| Vermont | 0 | 0 | 0 |
| Virginia | 57 | 28 | 29 |
| Washington | 91 | 68 | 56 |
| West Virginia | 100 | 35 | 100 |
| Wisconsin | 81 | 70 | 24 |
| Wyoming | 4 | 4 | 0 |

Source: MPR analysis for the Kaiser Family Foundation of a file created from CMS's Landscape File for 2007 and other sources.

Note: CCP refers to plans offered under a local coordinated care contract. Such contracts include local health maintenance organizations (HMOs), preferred provider organizations (PPOs) and provider sponsored organizations (PSOs).

NA = Not Applicable, No rural counties.

TABLE 10

PFFS CONTRACTS BY FIRM AND NUMBER OF COUNTIES COVERED BY THE CONTRACT, 2006-2008

| Firm Name/Contract Number | Number of Counties | | |
|--------------------------------------------|--------------------|-------|-------|
| | 2006 | 2007 | 2008 |
| Humana | | | |
| H1407 (Humana) | 1 | 1 | 0 |
| H1804 (Humana) | 2,731 | 2,908 | 2,912 |
| H1906 (Humana, Louisiana) | 64 | 64 | 64 |
| H5657 (Humana, New York) | 0 | 51 | 51 |
| H4008 (Humana Insurance Co PR) | 0 | 0 | 78 |
| UnitedHealthcare | | | |
| H2408 (Secure Horizons) | 277 | 300 | 423 |
| H4720 (Secure Horizons) | 0 | 1 | 32 |
| H5435 (Secure Horizons-Medicare Direct) | 1,557 | 1,481 | 1,483 |
| Sterling | | | |
| H5006 Option I | 1,268 | 2,773 | 2,827 |
| H5602 Partners Pennsylvania | 1 | 0 | 0 |
| H5839 Partners Montana | 2 | 2 | 2 |
| Wellpoint | | | |
| H5419 Blue Cross of CA | 5 | 5 | 61 |
| H0540 UniCare Life and Health ^a | 636 | 1,181 | 1,866 |
| H1689 BCBS of Wisconsin | 0 | 145 | 229 |
| H5308 5304 Empire BCBS | 0 | 1 | 8 |
| H9452 BCBS Anthem | 0 | 0 | 10 |
| H2613 BCBS of Missouri | 13 | 85 | 85 |
| Other BCBS Affiliates | | | |
| H2319 BCBS of Michigan | 83 | 83 | 83 |
| H4205 BCBS of South Carolina | 22 | 22 | 46 |
| H5884 BCBS of Tennessee | 95 | 95 | 95 |
| H5849 Arkansas BC MediPak Advantage | 0 | 75 | 75 |
| H5862 BC of Idaho Health Services | 0 | 44 | 44 |
| H1643 Highmark (Pennsylvania) | 0 | 0 | 55 |
| H9793 Highmark (Pennsylvania) | 0 | 0 | 62 |
| H2648 Traditional Blue Medicare PFFS | 0 | 0 | 18 |
| H3011 BCBS of Massachusetts | 0 | 0 | 14 |
| H3518 BCBS of Florida | 0 | 0 | 67 |
| Wellcare | | | |
| H1340 Wellcare | 0 | 451 | 988 |
| H4577 Wellcare | 0 | 292 | 550 |
| H6499 Wellcare | 0 | 50 | 52 |
| Medica | | | |
| H2409 Health Plans of Wisconsin | 13 | 13 | 3 |
| H2410 Health Plans | 91 | 91 | 91 |
| Heritage Health Systems/Universal | | | |
| H3333 Today's Option | 89 | 277 | 294 |
| H5421 Today's Option | 366 | 2,318 | 2,657 |
| H7357 Today's Options Powered by CCRx | 0 | 0 | 2,129 |

Table 10 (continued)

| Firm Name/Contract Number | Number of Counties | | |
|----------------------------------------------------------------------------|--------------------|-------|-------|
| | 2006 | 2007 | 2008 |
| Coventry | | | |
| H0846 Advantra Freedom | 0 | 2,275 | 2,687 |
| H5227 Advantra Freedom | 0 | 35 | 1,936 |
| H5952 Advantra Freedom | 0 | 52 | 52 |
| HealthNet | | | |
| H5721 Health Net | 0 | 48 | 48 |
| H5996 Health Net | 0 | 146 | 457 |
| Cigna | | | |
| H2762 Medicare Access | 0 | 0 | 398 |
| H5179 Cigna Health of Arizona | 0 | 0 | 12 |
| Aetna Medicare | | | |
| H5736 Aetna Medicare | 0 | 69 | 343 |
| BRAVO | | | |
| H6421 Bravo Health | 0 | 5 | 97 |
| H7406 Bravo Health | 0 | 0 | 15 |
| Other Companies | | | |
| H4204 Instil Health Insurance Company ^b | 83 | 205 | 205 |
| H5812 Geisinger Health Plan Gold Choice | 8 | 14 | 29 |
| H5909 MediSun PFFS | 1 | 1 | 1 |
| H1254 UPMC Health Plan | 0 | 21 | 21 |
| H1850 Windsor Medicare Extra | 0 | 95 | 95 |
| H4449 Sierra Optima ^c | 0 | 2,232 | 97 |
| H5485 Prime Time Health Plan | 0 | 7 | 6 |
| H5820 Any, Any, Any Plan (Universal Health Care) ^d | 0 | 651 | 7 |
| H6499 Harvard Pilgrim HealthCare | 0 | 5 | 97 |
| H8201 Metropolitan Health Plan | 0 | 22 | 22 |
| H9519 Independent Health (Buffalo) | 0 | 62 | 62 |
| H0097 Select Advantage | 0 | 0 | 5 |
| H0747 Educators Mutual Insurance Association | 0 | 0 | 29 |
| H0979 America's 1 st Choice Insurance Company of North Carolina | 0 | 0 | 59 |
| H6110 Network Health Insurance Corporation PFFS | 0 | 0 | 13 |
| H6206 First Care Advantage | 0 | 0 | 11 |
| H6356 Mercy Health Plans | 0 | 0 | 161 |
| H6621 Health Plan Secure Freedom | 0 | 0 | 143 |
| H7845 Health Markets Care Assured | 0 | 0 | 651 |
| H7981 MCS ClassiCare | 0 | 0 | 78 |
| H8606 Preferred Medicare | 0 | 0 | 78 |
| H8836 Mennonite Mutual Aide Association (Team Care Advantage) | 0 | 0 | 1,376 |
| H9720 America's 1 st Choice Health Plans Inc. | 0 | 0 | 25 |
| H9931 Health Partners Liberty Medicare | 0 | 0 | 97 |
| H3057 Tufts Health Plan | 0 | 0 | 14 |
| H4729 GHI Private FFS (HIP Owner) | 0 | 0 | 62 |
| H6504 Connecticut Insurance Company (HIP Owner) | 0 | 0 | 8 |

Source: MPR analysis of files created from the 2008 and 2007 CMS Personal Plan Finder and the 2008 Landscape File. MPR analysis of CMS data for the Kaiser Family Foundation.

Note: If "0" counties is indicated, there was no effective contract that year.

Table 10 (*continued*)

^aThis contract was under BCBS of Wisconsin in 2006, and was taken over by UniCare in 2007. It appears that some counties were transferred to UniCare products, and others remained part of the BCBS of Wisconsin product line in 2007.

^bThis firm is a non-Blues brand affiliate of BCBS of South Carolina.

^cThis firm had a merger pending with UnitedHealthcare in 2008 (announced 2007), which could explain the reduced 2008 availability.

^dCMS has suspended new enrollment in this plan. Ultimate availability in 2008 is not known.

APPENDIX TABLE A.1
 MEDICARE ADVANTAGE ENROLLMENT AND PENETRATION, BY TYPE OF CONTRACT AND COUNTY, 2006-2007

| Contract Type | All Counties | | | | | | Urban Counties | | | | | | Rural Counties | | | | | | | | | | | | |
|---------------|--------------|-------------|-----------|---------------|-----------|-------------|----------------|-------------|-----------|---------------|-----------|-------------|----------------|-------------|-----------|---------------|-----------|------|-----------|------|---------|-----|---------|-----|--|
| | October 2006 | | | December 2007 | | | October 2006 | | | December 2007 | | | October 2006 | | | December 2007 | | | | | | | | | |
| | Enrollees | Penetration | Enrollees | Penetration | Enrollees | Penetration | Enrollees | Penetration | Enrollees | Penetration | Enrollees | Penetration | Enrollees | Penetration | Enrollees | Penetration | | | | | | | | | |
| Any Contract | 6,943,277 | 16.0 | 8,160,517 | 18.8 | 6,348,679 | 18.8 | 7,260,606 | 21.5 | 592,938 | 6.5 | 899,135 | 9.8 | 5,096,481 | 11.7 | 5,340,026 | 12.2 | 4,901,043 | 14.5 | 5,117,764 | 15.1 | 193,905 | 2.1 | 221,579 | 2.4 | |
| Any CCP | 5,473,910 | 12.6 | 5,791,342 | 13.3 | 5,253,721 | 15.5 | 5,532,338 | 16.3 | 218,656 | 2.4 | 258,309 | 2.8 | 377,429 | 0.9 | 451,316 | 1.0 | 352,678 | 1.0 | 414,574 | 1.2 | 24,751 | 0.3 | 36,730 | 0.4 | |
| HMO | | | | | | | | | | | | | | | | | | | | | | | | | |
| PPO/POS | 377,429 | 0.9 | 451,316 | 1.0 | 352,678 | 1.0 | 414,574 | 1.2 | 24,751 | 0.3 | 36,730 | 0.4 | 313,357 | 0.7 | 304,817 | 0.7 | 257,535 | 0.7 | 250,080 | 0.7 | 55,721 | 0.6 | 54,687 | 0.6 | |
| Cost | | | | | | | | | | | | | | | | | | | | | | | | | |
| PFFS | 610,009 | 1.9 | 1,647,849 | 3.8 | 542,283 | 1.6 | 1,131,312 | 3.3 | 267,700 | 2.9 | 516,506 | 5.7 | 610,009 | 1.9 | 1,647,849 | 3.8 | 542,283 | 1.6 | 1,131,312 | 3.3 | 267,700 | 2.9 | 516,506 | 5.7 | |
| Regional PPO | 87,008 | 0.2 | 147,946 | 0.3 | 73,046 | 0.2 | 121,732 | 0.4 | 13,962 | 0.2 | 26,214 | 0.3 | 87,008 | 0.2 | 147,946 | 0.3 | 73,046 | 0.2 | 121,732 | 0.4 | 13,962 | 0.2 | 26,214 | 0.3 | |
| MSA | 0 | 0.0 | 1,248 | 0.0 | 0 | 0.0 | 946 | 0.0 | 0 | 0.0 | 302 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 302 | 0.0 | |

Source: MPR analysis for KFF of files created from CMS's State-County -Contract file. Beneficiary counts for penetration use December 2005 data, the latest CMS has published using a definition consistent with historical practice.

Note: CCP refers to plans offered under a local coordinated care contract. Such contracts include local health maintenance organizations (HMOs), preferred provider organizations (PPOs) and provider sponsored organizations (PSOs).

APPENDIX TABLE A.2

EMPLOYER-ONLY ENROLLMENT SUMMARY, MA ONLY

| | |
|-------------------------------------------------------|------------------|
| Employer-Only Enrollment, by Plan Type | |
| HMO/HMOPOS | 939,682 |
| PFFS | 241,935 |
| Local PPO | 47,472 |
| 1876 Cost | 42,910 |
| HCPP – 1833 Cost | 41,300 |
| Employer/Union Only Direct Contract PFFS | 10,574 |
| SHMO | 5,039 |
| RPPO | 1,516 |
| PSO (State License) | 908 |
| MSA | 0 |
| MSA Demonstration | 0 |
| PSO (Federal Waiver) | 0 |
| Total | 1,331,336 |
| Employer Enrollment, by Contract Start Date | |
| Before 1990 | 661,566 |
| 1990-1999 | 333,250 |
| 2000 or sooner | 336,520 |
| All Years | 1,331,336 |
| Top 15 Companies, by Employer-Only Enrollment | |
| Kaiser | 374,672 |
| UHC-Pacificare | 128,527 |
| BCBS of Michigan | 115,815 |
| Aetna | 77,292 |
| Humana | 60,415 |
| HIP of NY | 60,268 |
| Highmark | 56,180 |
| Health Net | 42,857 |
| United Mine Workers | 41,300 |
| Rochester Area HMO | 35,572 |
| Coventry | 35,031 |
| Independence Blue Cross | 22,798 |
| Group Health Coop | 22,402 |
| Wellpoint | 18,214 |
| Excellus, Inc. | 16,761 |
| Employer-Only Enrollment among BCBS Affiliates | |
| BCBS of Michigan | 115,815 |
| Independence | 22,798 |
| Wellpoint | 18,214 |
| Horizon BS of NJ | 7,837 |
| Capital Blue Cross | 5,902 |
| BCBS of Massachusetts | 5,157 |
| BCBS of Florida | 4,327 |
| BS of Puerto Rico | 2,941 |
| BCBS of Rhode Island | 1,523 |
| BCBS of Tennessee | 30 |
| BCBS of Idaho Health Services | 22 |

Source: MPR analysis for the Kaiser Family Foundation of the CMS Annual Plan Report, July 2007.

APPENDIX TABLE A.2b

TOP 15 COMPANIES, BY EMPLOYER-ONLY ENROLLMENT, PLAN TYPE,
AND CONTRACT EFFECTIVE DATE

| Company | Contract Number (number of plans with enrollment in contract) | Plan Type | Contract Effective Date | Total Enrollment |
|----------------------------------|---------------------------------------------------------------------|------------|-------------------------|---------------------|
| Kaiser Permanente | H9003 (2) | HMO/HMOPOS | 04/01/1980 | 25,854 |
| | H0630 (4) | HMO/HMOPOS | 01/01/1986 | 20,212 |
| | H1230 (3) | HMO/HMOPOS | 05/01/1986 | 13,288 |
| | H6360 (1) | 1876 Cost | 01/01/1987 | 3,947 |
| | H0524 (8) | HMO/HMOPOS | 08/01/1987 | 291,032 |
| | H2150 (1) | 1876 Cost | 01/01/1991 | 15,487 |
| | H1170 (2) | HMO/HMOPOS | 01/01/1997 | 4,852 |
| Kaiser enrollment | | | | 374,672 |
| UHC-Pacificare | H9011 (1) | HMO/HMOPOS | 10/01/1982 | 1,146 |
| | H0543 (4) | HMO/HMOPOS | 06/01/1985 | 46,006 |
| | H3805 (3) | HMO/HMOPOS | 01/01/1986 | 1,415 |
| | H0303 (3) | HMO/HMOPOS | 04/01/1986 | 24,600 |
| | H0609 (2) | HMO/HMOPOS | 07/01/1986 | 9,873 |
| | H5005 (2) | HMO/HMOPOS | 03/01/1987 | 4,609 |
| | H4102 (1) | HMO/HMOPOS | 03/01/1987 | 3,614 |
| | H4590 (2) | HMO/HMOPOS | 11/01/1987 | 4,119 |
| | H3749 (2) | HMO/HMOPOS | 01/01/1991 | 2,636 |
| | H3107 (1) | HMO/HMOPOS | 10/01/1991 | 302 |
| | H3307 (1) | HMO/HMOPOS | 10/01/1991 | 402 |
| | H2654 (4) | HMO/HMOPOS | 10/01/1992 | 8,437 |
| | H2949 (3) | HMO/HMOPOS | 10/01/1992 | 1,359 |
| | H0151 (1) | HMO/HMOPOS | 02/01/1995 | 593 |
| | H5253 (1) | HMO/HMOPOS | 08/01/1995 | 2,471 |
| | H1080 (1) | HMO/HMOPOS | 01/01/1996 | 295 |
| | H3659 (1) | HMO/HMOPOS | 05/01/1996 | 3,278 |
| | H3456 (1) | HMO/HMOPOS | 06/01/1997 | 1,475 |
| | H4456 (2) | HMO/HMOPOS | 07/01/1997 | 5,992 |
| | H2803 (1) | HMO/HMOPOS | 04/01/2003 | 84 |
| | H0316 (1) | HMO/HMOPOS | 09/01/2004 | 11 |
| | H2408 (1) | PFFS | 09/01/2004 | 1,162 |
| | H5435 (3) | PFFS | 09/01/2005 | 4,466 |
| R5287 (1) | RPPO | 01/01/2006 | 23 | |
| R5342 (1) | RPPO | 01/01/2006 | 159 | |
| UHC-Pacificare enrollment | | | | 128,527 |
| BCBS of Michigan | H2319 (2) | PFFS | 07/01/2005 | 113,229 |
| | H5883 (3) | HMO/HMOPOS | 01/01/2006 | 2,586 |
| BCBS of MI enrollment | | | | 115,815 |

Table A.2b (continued)

| Company | Contract Number (number of plans with enrollment in contract) | Plan Type | Contract Effective Date | Total Enrollment | |
|------------------------------|---------------------------------------------------------------------|------------------------------------------|-------------------------|---------------------|-------------------------|
| Aetna Inc. | H3931 (2) | HMO/HMOPOS | 11/01/1985 | 9,815 | |
| | H0523 (2) | HMO/HMOPOS | 05/01/1986 | 936 | |
| | H3312 (2) | HMO/HMOPOS | 10/01/1986 | 4,029 | |
| | H3152 (2) | HMO/HMOPOS | 09/01/1993 | 8,121 | |
| | H5414 (1) | HMO/HMOPOS | 01/01/2005 | 421 | |
| | H2112 (1) | HMO/HMOPOS | 02/01/2005 | 184 | |
| | H0318 (1) | HMO/HMOPOS | 07/01/2005 | 103 | |
| | H1109 (1) | HMO/HMOPOS | 07/01/2005 | 261 | |
| | H3623 (1) | HMO/HMOPOS | 07/01/2005 | 31 | |
| | H4910 (1) | HMO/HMOPOS | 07/01/2005 | 11 | |
| | H1110 (1) | Local PPO | 08/01/2005 | 56 | |
| | H4523 (1) | HMO/HMOPOS | 08/01/2005 | 725 | |
| | H4524 (1) | Local PPO | 08/01/2005 | 117 | |
| | H5437 (1) | Local PPO | 08/01/2005 | 179 | |
| | H5510 (1) | Local PPO | 01/01/2006 | 688 | |
| | H5512 (1) | Local PPO | 01/01/2006 | 717 | |
| | H5521 (1) | Local PPO | 01/01/2006 | 988 | |
| | H5531 (1) | Local PPO | 01/01/2006 | 112 | |
| | H5736 (2) | PFFS | 01/01/2006 | 49,711 | |
| R5595 (1) | RPPPO | 01/01/2006 | 19 | | |
| H5793 (1) | HMO/HMOPOS | 01/01/2007 | 68 | | |
| Aetna enrollment | | | | 77,292 | |
| Humana | H1406 (2) | HMO/HMOPOS | 07/01/1985 | 1,799 | |
| | H1036 (3) | HMO/HMOPOS | 02/01/1986 | 4,570 | |
| | H0307 (1) | HMO/HMOPOS | 04/01/1988 | 28 | |
| | H2649 (1) | HMO/HMOPOS | 01/01/1990 | 1,766 | |
| | H1951 (1) | HMO/HMOPOS | 06/01/1994 | 2,454 | |
| | H1804 (2) | PFFS | 01/01/2003 | 48,670 | |
| | H1716 (1) | Local PPO | 01/01/2005 | 25 | |
| | H5415 (1) | Local PPO | 01/01/2005 | 48 | |
| | H1906 (1) | PFFS | 05/01/2005 | 103 | |
| | H5683 (1) | PFFS | 01/01/2006 | 41 | |
| | H5826 (8) | RPPPO | 01/01/2006 | 911 | |
| | Humana enrollment | | | | 60,415 |
| | HIP of New York | H3330 (3) HIP of NY enrollment | HMO/HMOPOS | 07/01/1987 | 60,268 60,268 |
| Highmark | H3957 (2) | HMO/HMOPOS | 03/01/1995 | 43,185 | |
| | H3916 (2) | Local PPO | 05/01/2003 | 11,627 | |
| | H5106 (1) | Local PPO | 07/01/2005 | 1,368 | |
| Highmark enrollment | | | | 56,180 | |
| Health Net | H0351 (1) | HMO/HMOPOS | 03/01/1992 | 1,038 | |
| | H0562 (4) | HMO/HMOPOS | 10/01/1992 | 36,984 | |
| | H3366 (1) | HMO/HMOPOS | 03/01/1996 | 99 | |
| | H0755 (2) | HMO/HMOPOS | 12/01/1996 | 4,528 | |
| | H5721 (1) | PFFS | 01/01/2007 | 11 | |
| | H5996 (1) | PFFS | 01/01/2007 | 197 | |
| Health Net enrollment | | | | 42,857 | |

Table A.2b (continued)

| Company | Contract Number (number of plans with enrollment in contract) | Plan Type | Contract Effective Date | Total Enrollment |
|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| United Mine Workers | 90091 United Mine Workers enrollment | HCPP – 1833 Cost | 02/01/1974 | 41,300 41,300 |
| Rochester Area HMO | H3305 (2) H3346 (2) Rochester HMO enrollment | HMO/HMOPOS Local PPO | 11/01/1985 09/01/2005 | 35,533 39 35,572 |
| Coventry | H2663 (5) H3959 (2) H2672 (2) H5509 (2) H5517 (1) H5522 (1) H0846 (1) H5227 (1) Coventry enrollment | HMO/HMOPOS HMO/HMOPOS HMO/HMOPOS Local PPO Local PPO Local PPO PFFS PFFS | 11/01/1995 01/01/1996 05/01/1999 01/01/2006 01/01/2006 01/01/2006 01/01/2007 01/01/2007 | 4,035 7,787 1,535 632 5,282 2,354 8,399 5,007 35,031 |
| Independence Blue Cross | H3952 (2) H3156 (2) H3909 (2) Independence enrollment | HMO/HMOPOS HMO/HMOPOS Local PPO | 01/01/1993 10/01/1995 01/01/2002 | 17,307 985 4,506 22,798 |
| Group Health Cooperative | H5050 (2) Group Health enrollment | HMO/HMOPOS | 01/01/1989 | 22,402 22,402 |
| Wellpoint | H0564 (1) H3655 (2) H3370 (1) H1849 (1) H0540 (1) H5419 (1) R5941 (2) H1689 (2) H5304 (1) Wellpoint enrollment | HMO/HMOPOS HMO/HMOPOS HMO/HMOPOS HMO/HMOPOS PFFS PFFS RPPO PFFS PFFS | 06/01/1993 10/01/1994 07/01/1996 01/01/1998 04/01/2003 02/01/2005 01/01/2006 01/01/2007 01/01/2007 | 962 7,279 4,593 1,413 233 639 266 2,636 193 18,214 |
| Excellus, Inc. | H3351 (4) H3356 (1) H3335 (10) Excellus enrollment | HMO/HMOPOS 1876 Cost Local PPO | 01/01/1990 01/01/1993 07/01/2004 | 13,904 512 2,345 16,761 |

Source: MPR analysis for the Kaiser Family Foundation of CMS Annual Report, July 2007.

APPENDIX TABLE A.3

MSA CONTRACTS BY COMPANY, 2008

| Company | Contract Number | Number of Counties | |
|-----------------------------|-----------------|--------------------|------|
| | | 2007 | 2008 |
| WellPoint - UniCare | H7289 | 2118 | 2186 |
| BCBS – WellPoint (Anthem) | H2745 | 0 | 826 |
| BCBS – WellPoint (Anthem) | H5011 | 0 | 8 |
| BCBS – WellPoint (BC of CA) | H5769 | 58 | 58 |
| BCBS – WellPoint (Anthem) | H7791 | 0 | 17 |
| BCBS – WellPoint (Anthem) | H9956 | 0 | 10 |
| BCBS – WellPoint (Empire) | H3417 | 0 | 28 |
| Coventry | H7206 | 0 | 80 |
| Other (Geisinger) | H8468 | 0 | 16 |

Source: MPR analysis for the Kaiser Family Foundation of a file created from CMS's Landscape File for 2007 and other sources.

APPENDIX TABLE A.4

REGIONAL PPO CONTRACTS BY FIRM AND REGIONS COVERED, 2008^a

| Firm | Contract | Number of Regions | Region Number ^a | Enrollment | |
|-------------------------|----------|-------------------|----------------------------|---------------|---------------|
| | | | | November 2006 | December 2007 |
| Aetna | R5595 | 2 | 4, 5 | 785 | 1,078 |
| Humana | R5826 | 14 | 6-18, 21 | 29,706 | 37,862 |
| UnitedHealthcare | | 3 | | 33,651 | 47,359 |
| | R5342 | | 3 | | |
| | R5287 | | 9 | | |
| | R3175 | | 25 | | |
| WellPoint | | 3 | | 0 | 36,651 |
| WellPoint – BC of CA | R9943 | | 24 | | |
| WellPoint/Anthem | E5941 | | 12, 13 | | |
| BCBS | | | | | |
| Other | | 4 | | | |
| Instil Health Insurance | R5553 | | 8 | Unknown | Unknown |
| Wellmark BCBS Iowa | R5566 | | 19 | Unknown | Unknown |
| Health Net | R5863 | | 21 | 1,474 | 3,337 |
| Sierra ^b | R5674 | | 22 | Unknown | 2,067 |

Source: MPR analysis for the Kaiser Family Foundation of a file created from CMS's Landscape File for 2007 and other sources.

Note: Excludes SNP-only contracts.

^a There are 26 Medicare Advantage regions comprising one or more states in which R-PPOs may be offered. In 2008, R-PPOs are available in 21 regions, a constant from 2006 when R-PPOs were first offered. Four regions have two R-PPOs.

^b UnitedHealthcare has pending acquisition of Sierra. The Secure Horizons Medicare business is to be purchased from United by Humana (AM Best, February 26, 2008).

APPENDIX TABLE A.5

HMO CONTRACTS IN RURAL COUNTIES BY FIRM, 2008

| State | Contract Number | Organization Name | 2006 | 2007 | 2008 | July 2007 Contract Enrollment in Rural Counties |
|-------|-----------------|---------------------------------------------------|------|------|------|-------------------------------------------------|
| AL | H0150 | HealthSpring of Alabama, Inc. | 22 | 15 | 8 | 5,989 |
| AL | H0151 | Secure Horizons | 0 | 2 | 0 | 2,597 |
| AL | H0151 | Secure Horizons by UnitedHealthcare | 0 | 0 | 2 | 2,597 |
| AL | H0151 | UnitedHealthcare of Alabama, Inc. | 2 | 0 | 0 | 2,597 |
| AL | H0154 | Viva Medicare Plus | 4 | 4 | 4 | 604 |
| AR | H5700 | Arkansas Community Care, Inc. | 2 | 15 | 23 | 1,267 |
| AR | H5698 | Windsor Medicare Extra | 0 | 3 | 16 | 148 |
| AR | H5189 | Unison Advantage | 0 | 0 | 1 | 0 |
| AZ | H0351 | HealthNet of Arizona, Inc. | 1 | 2 | 2 | 2,219 |
| AZ | H0320 | Desert Canyon Community Care | 1 | 1 | 1 | 1,892 |
| AZ | H0316 | Secure Horizons | 0 | 3 | 0 | 1,885 |
| AZ | H0316 | Secure Horizons by UnitedHealthcare | 0 | 0 | 3 | 1,885 |
| AZ | H0316 | UnitedHealthcare of Arizona, Inc. | 3 | 0 | 0 | 1,885 |
| CA | H0524 | Kaiser Permanente | 2 | 2 | 2 | 4,011 |
| CA | H0543 | Secure Horizons Medicare Advantage Plan | 1 | 1 | 0 | 954 |
| CA | H0543 | Secure Horizons by UnitedHealthcare | 0 | 0 | 1 | 954 |
| CO | H0609 | AARP MedicareComplete Provided by Secure Horizons | 0 | 0 | 1 | 167 |
| CO | H0609 | Secure Horizons Medicare Advantage Plan | 1 | 1 | 0 | 167 |
| CO | H0624 | UnitedHealthcare Insurance Company | 0 | 1 | 0 | 13 |
| CO | H0621 | Colorado Access | 0 | 0 | 6 | 0 |
| CT | H0755 | HealthNet of Connecticut | 2 | 2 | 2 | 1,486 |
| CT | H5793 | Aetna Medicare | 0 | 0 | 1 | 0 |
| CT | H3528 | ConnecticutCare, Inc. | 0 | 0 | 2 | 0 |
| FL | H1035 | Florida Health Care Plan, Inc. | 1 | 1 | 1 | 3,013 |
| FL | H1036 | Humana Medical Plan, Inc. | 1 | 3 | 3 | 2,870 |
| FL | H5426 | Advantagecare | 1 | 0 | 3 | 694 |
| FL | H5402 | Quality Health Plans | 0 | 0 | 7 | 409 |
| FL | H1034 | America's Health Choice | 0 | 1 | 0 | 381 |
| FL | H1034 | America's Health Choice Medical Plans, Inc. | 1 | 0 | 0 | 381 |
| FL | H5427 | Freedom Health, Inc. | 0 | 1 | 2 | 337 |
| FL | H5404 | Universal Health Care, Inc. | 5 | 7 | 7 | 71 |
| FL | H1032 | Wellcare | 0 | 0 | 9 | 40 |
| FL | H5431 | HealthSun Health Plans, Inc. | 0 | 1 | 0 | 14 |
| FL | H5696 | Physicians United Plan | 0 | 1 | 1 | 13 |

Table A.5 (continued)

| State | Contract Number | Organization Name | 2006 | 2007 | 2008 | July 2007 Contract Enrollment in Rural Counties |
|-------|-----------------|---------------------------------------------------|------|------|------|-------------------------------------------------|
| FL | H5594 | Optimum Healthcare, Inc. | 0 | 1 | 1 | 0 |
| FL | H5402 | Quality Health Plans, Inc. | 1 | 2 | 0 | 0 |
| GA | H5578 | Southeast Community Care | 0 | 1 | 10 | 0 |
| GA | H5422 | Blue Cross Blue Shield Healthcare Plan of Georgia | 1 | 1 | 1 | 0 |
| HI | H1230 | Kaiser Foundation Health Plan, Inc. (Hawaii) | 2 | 2 | 2 | 5,729 |
| HI | H5969 | AlohaCare | 3 | 4 | 4 | 136 |
| IA | H4456 | John Deere Health Plan, Inc. | 31 | 0 | 0 | 166 |
| IA | H4456 | Secure Horizons by UnitedHealthcare | 0 | 0 | 36 | 166 |
| IA | H4456 | UnitedHealthcare Plan of the River Valley, Inc. | 0 | 36 | 0 | 166 |
| IA | H2803 | Secure Horizons | 0 | 3 | 0 | 112 |
| IA | H2803 | Secure Horizons by UnitedHealthcare | 0 | 0 | 3 | 112 |
| IA | H2803 | UnitedHealthcare Insurance Company | 3 | 0 | 0 | 112 |
| IA | H1609 | Coventry Health Care of Iowa, Inc. | 0 | 5 | 12 | 86 |
| ID | H1350 | Blue Cross of Idaho | 5 | 0 | 0 | 1,196 |
| ID | H1350 | Blue Cross of Idaho Health Services, Inc. | 0 | 13 | 13 | 0 |
| IL | H1463 | Health Alliance Medical Plans | 3 | 4 | 4 | 901 |
| IL | H1468 | OSF Care Advantage | 2 | 2 | 2 | 466 |
| IL | H4456 | John Deere Health Plan, Inc. | 5 | 0 | 0 | 138 |
| IL | H4456 | Secure Horizons by UnitedHealthcare | 0 | 0 | 8 | 138 |
| IL | H4456 | UnitedHealthcare Plan of the River Valley, Inc. | 0 | 8 | 0 | 138 |
| IL | H2667 | Mercy Health Plans of Missouri, Inc. | 0 | 0 | 1 | 87 |
| IL | H1416 | Wellcare | 0 | 0 | 1 | 0 |
| IL | H2667 | Mercy Health Plans, Inc. | 1 | 1 | 0 | 0 |
| IN | H3044 | Wellborn HMO Senior Advantage | 0 | 0 | 4 | 0 |
| IN | H1657 | Wellcare | 0 | 0 | 1 | 0 |
| KY | H1849 | Anthem Blue Cross and Blue Shield | 2 | 2 | 2 | 30 |
| LA | H1951 | Humana Health Benefit Plan of Louisiana, Inc. | 1 | 3 | 3 | 1,672 |
| LA | H1961 | Peoples Health | 0 | 3 | 3 | 627 |
| LA | H5576 | Vantage Health Plan, Inc. | 0 | 5 | 12 | 108 |
| LA | H1903 | Wellcare | 0 | 1 | 4 | 25 |
| LA | H7179 | Arcadian Community Care | 0 | 0 | 17 | 0 |
| ME | H5591 | Martin's Point Generations Advantage | 0 | 2 | 4 | 47 |
| ME | H5619 | Northeast Community Care | 0 | 0 | 1 | 0 |
| MI | H2320 | PriorityMedicare | 1 | 11 | 14 | 799 |
| MI | H5883 | Blue Care Network | 1 | 5 | 5 | 264 |
| MI | H2354 | HealthPlus of Michigan | 1 | 1 | 1 | 130 |
| MI | H3653 | Paramount Elite | 0 | 0 | 1 | 0 |

Table A.5 (continued)

| State | Contract Number | Organization Name | 2006 | 2007 | 2008 | July 2007 Contract Enrollment in Rural Counties |
|-------|-----------------|---------------------------------------------------|------|------|------|-------------------------------------------------|
| MI | H4971 | Secure Horizons by UnitedHealthcare | 0 | 0 | 1 | 0 |
| MN | H2459 | UCare | 0 | 0 | 66 | 2,103 |
| MN | H2459 | UCare Minnesota | 44 | 57 | 0 | 2,103 |
| MN | H5750 | North Star Advantage/North Star Advantage Plan | 1 | 0 | 0 | 0 |
| MN | H9005 | HealthPartners | 2 | 2 | 0 | 0 |
| MN | H9005 | HealthPartners Classic Plan | 0 | 0 | 2 | 0 |
| MO | H2667 | Mercy Health Plans of Missouri, Inc. | 0 | 0 | 10 | 2,762 |
| MO | H2654 | Secure Horizons | 0 | 8 | 0 | 1,944 |
| MO | H2654 | Secure Horizons by UnitedHealthcare | 0 | 0 | 10 | 1,944 |
| MO | H2654 | UnitedHealthcare of the Midwest, Inc. | 7 | 0 | 0 | 1,944 |
| MO | H2663 | Group Health Plan, Inc. | 0 | 0 | 1 | 44 |
| MO | H9466 | Anthem Blue Cross and Blue Shield | 0 | 0 | 5 | 0 |
| MO | H2649 | Humana Health Plan, Inc. | 0 | 0 | 2 | 0 |
| MO | H2667 | Mercy Health Plans, Inc. | 10 | 10 | 0 | 0 |
| MS | H5698 | Windsor Medicare Extra | 0 | 2 | 21 | 177 |
| MS | H4407 | HealthSpring, Inc. | 1 | 1 | 2 | 0 |
| MT | H0427 | Clear Choice Health Plans | 0 | 0 | 3 | 0 |
| MT | H3864 | Clear Choice Health Plans | 0 | 2 | 0 | 0 |
| NC | H3449 | Blue Medicare HMO | 0 | 0 | 14 | 9,933 |
| NC | H3449 | Partners Medicare Choice | 0 | 9 | 0 | 9,933 |
| NC | H3456 | Secure Horizons | 0 | 6 | 0 | 5,431 |
| NC | H3456 | Secure Horizons by UnitedHealthcare | 0 | 0 | 6 | 5,431 |
| NC | H3456 | UnitedHealthcare of North Carolina, Inc. | 6 | 0 | 0 | 5,431 |
| NC | H2899 | Southeast Community Care | 0 | 0 | 5 | 0 |
| NC | H3404 | Partners National Health Plans - NC, Inc. | 8 | 0 | 0 | 0 |
| NE | H2803 | Secure Horizons | 0 | 2 | 0 | 107 |
| NE | H2803 | Secure Horizons by UnitedHealthcare | 0 | 0 | 2 | 107 |
| NE | H2803 | UnitedHealthcare Insurance Company | 2 | 0 | 0 | 107 |
| NM | H3204 | Presbyterian Senior Care | 2 | 2 | 2 | 181 |
| NM | H9082 | Molina Healthcare of New Mexico, Inc. | 0 | 0 | 2 | 0 |
| NM | H3059 | Physicians Health Choice of New Mexico | 0 | 0 | 1 | 0 |
| NV | H2961 | Senior Dimensions | 1 | 0 | 1 | 4,101 |
| NV | H2949 | AARP MedicareComplete Provided by Secure Horizons | 0 | 0 | 1 | 489 |
| NV | H2949 | Secure Horizons Medicare Advantage Plan | 1 | 1 | 0 | 489 |
| NV | H2931 | Senior Dimensions | 4 | 4 | 4 | 482 |
| NY | H3362 | Independent Health | 5 | 5 | 5 | 5,935 |
| NY | H3351 | Excellus Health Plan, Inc. | 7 | 7 | 7 | 5,502 |

Table A.5 (continued)

| State | Contract Number | Organization Name | 2006 | 2007 | 2008 | July 2007 Contract Enrollment in Rural Counties |
|-------|-----------------|---------------------------------------------------|------|------|------|-------------------------------------------------|
| NY | H3305 | Preferred Care Gold | 4 | 4 | 5 | 5,401 |
| NY | H3384 | Healthnow New York, Inc. | 9 | 0 | 0 | 4,430 |
| NY | H3361 | Wellcare | 2 | 2 | 2 | 306 |
| NY | H3379 | Secure Horizons | 0 | 4 | 0 | 291 |
| NY | H3379 | UnitedHealthcare of New York, Inc. | 4 | 0 | 0 | 291 |
| NY | H3328 | Fidelis | 0 | 3 | 0 | 135 |
| NY | H3328 | New York State Catholic Health Plan, Inc. | 1 | 0 | 0 | 135 |
| NY | H9859 | MVP Gold | 0 | 1 | 5 | 104 |
| NY | H3388 | CDPHP Medicare Choice | 0 | 1 | 1 | 87 |
| NY | H3370 | Empire Blue Cross Blue Shield HMO | 0 | 1 | 1 | 45 |
| NY | H3312 | Aetna Medicare | 0 | 1 | 1 | 0 |
| NY | H3327 | Touchstone Health | 0 | 0 | 2 | 0 |
| NY | H3384 | Senior Blue | 0 | 9 | 9 | 0 |
| NY | H3328 | Fidelis Care | 0 | 0 | 3 | 0 |
| OH | H3664 | Primetime Health Plan | 3 | 3 | 3 | 3,749 |
| OH | H3655 | Anthem Blue Cross and Blue Shield | 18 | 18 | 18 | 2,503 |
| OH | H3668 | MediGold | 2 | 3 | 3 | 1,166 |
| OH | H3672 | Hometown Health Plan | 3 | 0 | 0 | 1,066 |
| OH | H3672 | The Health Plan | 0 | 3 | 6 | 1,066 |
| OH | H5151 | The Health Plan | 4 | 4 | 5 | 560 |
| OH | H3660 | SummaCare | 1 | 1 | 1 | 79 |
| OH | H9313 | Advantage Plans from Medical Mutual of Ohio | 0 | 7 | 45 | 0 |
| OK | H3749 | Secure Horizons Medicare Advantage Plan | 2 | 2 | 0 | 271 |
| OK | H3749 | Secure Horizons by UnitedHealthcare | 0 | 0 | 2 | 271 |
| OK | H3706 | Generations Healthcare | 1 | 7 | 3 | 225 |
| OK | H3755 | CommunityCare HMO, Inc. | 1 | 0 | 0 | 167 |
| OK | H5700 | Arkansas Community Care, Inc. | 0 | 3 | 0 | 70 |
| OK | H4125 | Arcadian Health Plan | 0 | 0 | 5 | 0 |
| OK | H3755 | CommunityCare Senior Health Plan | 0 | 1 | 1 | 0 |
| OR | H3864 | Clear Choice Health Plans | 9 | 9 | 9 | 3,414 |
| OR | H3814 | Atrio Health Plans | 3 | 0 | 0 | 3,163 |
| OR | H3811 | Samaritan Advantage Health Plan | 2 | 2 | 2 | 2,269 |
| OR | H3810 | CareResource | 2 | 2 | 2 | 1,603 |
| OR | H3805 | AARP MedicareComplete Provided by Secure Horizons | 0 | 0 | 1 | 1,409 |
| OR | H3805 | Secure Horizons Medicare Advantage Plan | 1 | 1 | 0 | 1,409 |
| OR | H9003 | Kaiser Foundation Health Plan of the NW | 1 | 1 | 1 | 669 |
| OR | H3818 | Family Care Health Plans, Inc. | 2 | 3 | 1 | 566 |

Table A.5 (continued)

| State | Contract Number | Organization Name | 2006 | 2007 | 2008 | July 2007 Contract Enrollment in Rural Counties |
|-------|-----------------|----------------------------------------------------|------|------|------|-------------------------------------------------|
| OR | H9103 | Kaiser Foundation Health Plan of the NW | 1 | 0 | 1 | 28 |
| OR | H3814 | Atrio Myadvantage | 0 | 3 | 3 | 0 |
| PA | H3954 | Geisinger Gold | 0 | 0 | 14 | 20,589 |
| PA | H3957 | Keystone Health Plan West, Inc. | 6 | 6 | 6 | 18,462 |
| PA | H3907 | UPMC Health Plan | 6 | 9 | 14 | 6,804 |
| PA | H3959 | HealthAmerica Avantara | 2 | 2 | 2 | 3,355 |
| PA | H3962 | Keystone Health Plan Central, Inc. | 8 | 8 | 8 | 2,193 |
| PA | H3920 | Unison Advantage | 0 | 8 | 8 | 1,388 |
| PA | H3931 | Aetna Medicare | 0 | 2 | 2 | 124 |
| PA | H3954 | Geisinger Health Plan Gold | 12 | 14 | 0 | 0 |
| PA | H3920 | Unison Health Plan | 8 | 0 | 0 | 0 |
| SC | H5783 | Southeast Community Care | 0 | 1 | 2 | 33 |
| SC | H5578 | Southeast Community Care | 0 | 3 | 0 | 0 |
| TN | H4461 | Cariten Senior Health | 12 | 13 | 13 | 11,742 |
| TN | H4456 | John Deere Health Plan, Inc. | 9 | 0 | 0 | 3,602 |
| TN | H4456 | Secure Horizons by UnitedHealthcare | 0 | 0 | 13 | 3,602 |
| TN | H4456 | UnitedHealthcare Plan of the River Valley, Inc. | 0 | 13 | 0 | 3,602 |
| TN | H4454 | HealthSpring | 7 | 7 | 10 | 3,222 |
| TN | H5698 | Windsor Medicare Extra | 0 | 3 | 19 | 100 |
| TN | H4406 | AARP Medicare Complete Provided by Secure Horizons | 0 | 0 | 1 | 90 |
| TN | H4406 | Secure Horizons | 0 | 1 | 0 | 90 |
| TN | H4406 | UnitedHealthcare of Tennessee, Inc. | 1 | 0 | 0 | 90 |
| TN | H5998 | Unison Advantage | 0 | 0 | 4 | 0 |
| TX | H4513 | Texas HealthSpring | 6 | 11 | 11 | 1,725 |
| TX | H4529 | Texas Community Care | 0 | 17 | 17 | 1,192 |
| TX | H4510 | Humana Health Plan of Texas, Inc. | 0 | 2 | 3 | 387 |
| TX | H4525 | FirstCare Advantage | 7 | 7 | 7 | 302 |
| TX | H4521 | Valley Baptist Health Plan, Inc. | 1 | 0 | 0 | 115 |
| TX | H5700 | Arkansas Community Care, Inc. | 0 | 3 | 3 | 108 |
| TX | H4527 | Physicians Health Choice | 0 | 0 | 2 | 0 |
| TX | H4521 | Valley Baptist Health Plans | 0 | 1 | 1 | 0 |
| UT | H4604 | Secure Horizons | 0 | 2 | 0 | 113 |
| UT | H4604 | Secure Horizons by UnitedHealthcare | 0 | 0 | 2 | 113 |
| UT | H4604 | UnitedHealthcare of Utah, Inc. | 2 | 0 | 0 | 113 |
| UT | H8649 | Altius Advantra | 0 | 0 | 6 | 0 |
| UT | H5628 | Molina Healthcare of Utah | 0 | 0 | 1 | 0 |
| VA | H4456 | John Deere Health Plan, Inc. | 6 | 0 | 0 | 2,215 |
| VA | H4456 | Secure Horizons by UnitedHealthcare | 0 | 0 | 11 | 2,215 |

Table A.5 (continued)

| State | Contract Number | Organization Name | 2006 | 2007 | 2008 | July 2007 Contract Enrollment in Rural Counties |
|-------|-----------------|-------------------------------------------------|------|------|------|-------------------------------------------------|
| VA | H4456 | UnitedHealthcare Plan of the River Valley, Inc. | 0 | 11 | 0 | 2,215 |
| WA | H5050 | Group Health Cooperative | 5 | 5 | 5 | 4,624 |
| WA | H5005 | Secure Horizons Medicare Advantage Plan | 2 | 2 | 0 | 790 |
| WA | H5005 | Secure Horizons by UnitedHealthcare | 0 | 0 | 2 | 790 |
| WA | H9003 | Kaiser Foundation Health Plan of the NW | 2 | 2 | 2 | 370 |
| WA | H5826 | Community HealthFirst Medicare Advantage Plan | 0 | 12 | 12 | 208 |
| WI | H5211 | Security Health Plans of Wisconsin, Inc. | 25 | 28 | 28 | 9,398 |
| WI | H5262 | Gundersen Lutheran Health Plan, Inc. | 10 | 10 | 10 | 5,685 |
| WI | H5253 | Secure Horizons | 0 | 8 | 0 | 203 |
| WI | H5253 | Secure Horizons by UnitedHealthcare | 0 | 0 | 7 | 203 |
| WI | H5253 | UnitedHealthcare of Wisconsin, Inc. | 8 | 0 | 0 | 203 |
| WI | H4270 | UCare | 0 | 0 | 17 | 0 |
| WV | H5151 | The Health Plan | 12 | 12 | 15 | 700 |
| WY | H0806 | Altius Advantra | 0 | 0 | 1 | 0 |

Source: MPR analysis for the Kaiser Family Foundation of a file created from CMS's Landscape File for 2007 and other sources.

APPENDIX TABLE A.6

PERCENTAGE OF BENEFICIARIES WITH AVAILABILITY OF MEDICARE ADVANTAGE PLANS,
BY STATE AND PLAN TYPE FOR URBAN COUNTIES, 2008

| State | Any Contract | Any CCP | Local HMO | Local PPO | R-PPO | PFFS | Cost | MSA | Other |
|----------------------|--------------|-----------|-----------|-----------|-----------|------------|----------|------------|-----------|
| All States | 100 | 93 | 90 | 72 | 88 | 100 | 9 | 100 | 31 |
| Alabama | 100 | 100 | 67 | 100 | 100 | 100 | 0 | 100 | 0 |
| Alaska | 83 | 0 | 0 | 0 | 0 | 100 | 0 | 100 | 0 |
| Arizona | 100 | 97 | 97 | 94 | 100 | 100 | 0 | 100 | 0 |
| Arkansas | 100 | 94 | 87 | 84 | 100 | 100 | 0 | 100 | 0 |
| California | 100 | 96 | 96 | 9 | 100 | 100 | 100 | 100 | 30 |
| Colorado | 100 | 95 | 95 | 75 | 0 | 100 | 100 | 100 | 2 |
| Connecticut | 100 | 100 | 100 | 83 | 0 | 100 | 0 | 100 | 92 |
| Delaware | 100 | 77 | 77 | 0 | 100 | 100 | 0 | 100 | 0 |
| District of Columbia | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 0 |
| Florida | 100 | 100 | 100 | 85 | 100 | 100 | 0 | 100 | 0 |
| Georgia | 100 | 70 | 69 | 58 | 100 | 100 | 0 | 100 | 0 |
| Hawaii | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 0 |
| Idaho | 100 | 99 | 99 | 99 | 0 | 100 | 3 | 100 | 0 |
| Illinois | 100 | 95 | 90 | 93 | 100 | 100 | 0 | 100 | 20 |
| Indiana | 100 | 68 | 55 | 50 | 100 | 100 | 40 | 100 | 0 |
| Iowa | 100 | 98 | 98 | 79 | 100 | 100 | 8 | 100 | 0 |
| Kansas | 100 | 80 | 73 | 67 | 100 | 100 | 0 | 100 | 25 |
| Kentucky | 100 | 70 | 64 | 70 | 100 | 100 | 0 | 100 | 0 |
| Louisiana | 100 | 99 | 99 | 35 | 100 | 100 | 0 | 100 | 0 |
| Maine | 100 | 100 | 100 | 85 | 0 | 100 | 0 | 100 | 0 |
| Maryland | 100 | 91 | 91 | 91 | 100 | 100 | 89 | 100 | 47 |
| Massachusetts | 100 | 97 | 97 | 97 | 0 | 100 | 0 | 100 | 97 |
| Michigan | 100 | 97 | 96 | 71 | 100 | 100 | 0 | 100 | 39 |
| Minnesota | 100 | 100 | 100 | 0 | 100 | 100 | 100 | 100 | 69 |
| Mississippi | 100 | 93 | 93 | 0 | 100 | 100 | 0 | 100 | 0 |
| Missouri | 100 | 91 | 87 | 87 | 100 | 100 | 0 | 100 | 0 |
| Montana | 100 | 100 | 26 | 100 | 100 | 100 | 0 | 100 | 0 |
| Nebraska | 100 | 68 | 68 | 68 | 100 | 100 | 0 | 100 | 0 |
| Nevada | 100 | 100 | 96 | 100 | 100 | 100 | 0 | 100 | 0 |
| New Hampshire | 100 | 0 | 0 | 0 | 0 | 100 | 0 | 100 | 0 |
| New Jersey | 100 | 100 | 100 | 82 | 100 | 100 | 0 | 100 | 13 |

Table A.6 (continued)

| State | Any Contract | Any CCP | Local HMO | Local PPO | R-PPO | PFFS | Cost | MSA | Other |
|----------------|--------------|---------|-----------|-----------|-------|------|------|-----|-------|
| New Mexico | 100 | 100 | 100 | 100 | 0 | 100 | 0 | 100 | 0 |
| New York | 100 | 100 | 98 | 100 | 100 | 100 | 6 | 100 | 100 |
| North Carolina | 100 | 83 | 83 | 70 | 100 | 100 | 0 | 100 | 0 |
| North Dakota | 100 | 0 | 0 | 0 | 100 | 100 | 59 | 100 | 0 |
| Ohio | 100 | 100 | 100 | 97 | 100 | 100 | 32 | 100 | 0 |
| Oklahoma | 100 | 95 | 92 | 93 | 100 | 100 | 0 | 100 | 0 |
| Oregon | 100 | 100 | 100 | 100 | 0 | 100 | 0 | 100 | 0 |
| Pennsylvania | 100 | 100 | 100 | 100 | 100 | 100 | 0 | 100 | 100 |
| Rhode Island | 100 | 100 | 100 | 0 | 0 | 100 | 0 | 100 | 81 |
| South Carolina | 100 | 78 | 43 | 75 | 100 | 100 | 0 | 100 | 0 |
| South Dakota | 100 | 5 | 0 | 5 | 100 | 100 | 52 | 100 | 0 |
| Tennessee | 100 | 100 | 100 | 71 | 100 | 100 | 0 | 100 | 25 |
| Texas | 100 | 89 | 89 | 68 | 100 | 100 | 10 | 100 | 62 |
| Utah | 100 | 99 | 99 | 99 | 0 | 100 | 0 | 100 | 0 |
| Vermont | 100 | 0 | 0 | 0 | 0 | 100 | 0 | 100 | 0 |
| Virginia | 100 | 76 | 39 | 73 | 100 | 100 | 21 | 100 | 10 |
| Washington | 100 | 100 | 99 | 98 | 0 | 100 | 0 | 100 | 0 |
| West Virginia | 100 | 100 | 35 | 100 | 100 | 100 | 0 | 100 | 0 |
| Wisconsin | 100 | 84 | 81 | 65 | 100 | 100 | 18 | 100 | 0 |
| Wyoming | 100 | 0 | 0 | 0 | 100 | 100 | 54 | 100 | 0 |

Source: MPR analysis for the Kaiser Family Foundation of a file created from CMS's Landscape File for 2007 and other sources.



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