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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]

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[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.

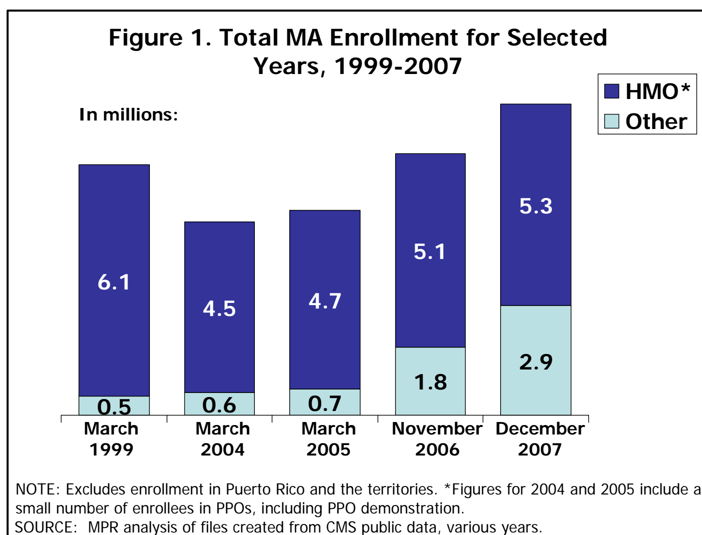
[9] Before 2006, CMS issued quarterly releases of what it termed "MA eligible beneficiaries by county." When CMS resumed releasing MA data in November 2006 after a hiatus, the new files did not provide this information. In December 2006, CMS released a different file with seemingly similar estimates.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

Figure 1. Total MA Enrollment for Selected Years, 1999-2007



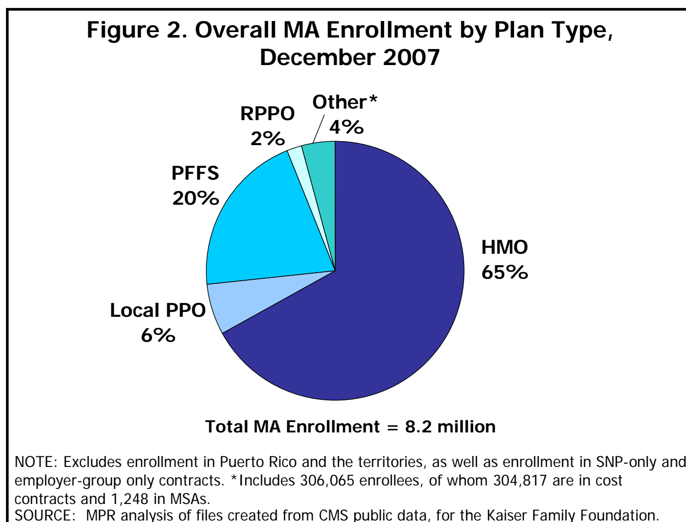
NOTE: Excludes enrollment in Puerto Rico and the territories. *Figures for 2004 and 2005 include a small number of enrollees in PPOs, including PPO demonstration.
SOURCE: MPR analysis of files created from CMS public data, various years.

(continued)
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

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[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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(continued)
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

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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

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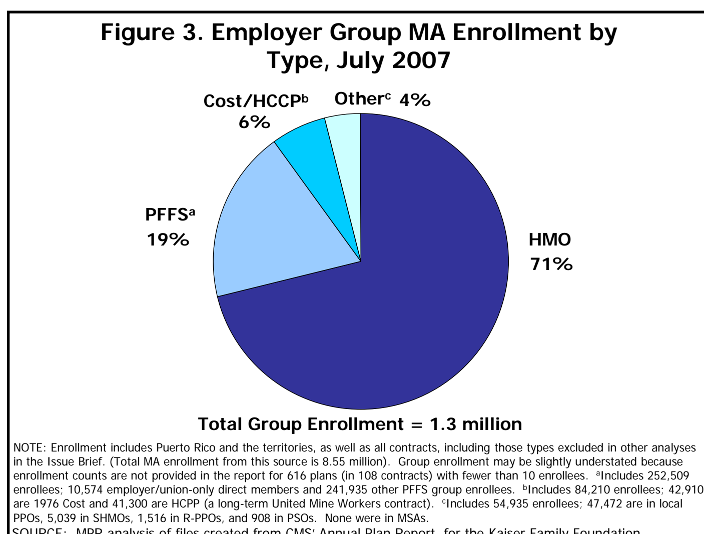
(continued)
Health Plan (PA), Secure Horizons (NC), and Security Health Plan of Wisconsin.

in HMOs (71 percent) or cost/HCPP 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).

Figure 3. Employer Group MA Enrollment by Type, July 2007



NOTE: Enrollment includes Puerto Rico and the territories, as well as all contracts, including those types excluded in other analyses in the Issue Brief. (Total MA enrollment from this source is 8.55 million). Group enrollment may be slightly understated because enrollment counts are not provided in the report for 616 plans (in 108 contracts) with fewer than 10 enrollees. [a]Includes 252,509 enrollees; 10,574 employer/union-only direct members and 241,935 other PFFS group enrollees. [b]Includes 84,210 enrollees; 42,910 are 1976 Cost and 41,300 are HCPP (a long-term United Mine Workers contract). [c]Includes 54,935 enrollees; 47,472 are in local PPOs, 5,039 in SHMOs, 1,516 in R-PPOs, and 908 in PSOs. None were in MSAs.
SOURCE: MPR analysis of files created from CMS' Annual Plan Report, for the Kaiser Family Foundation.

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

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(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.

REFERENCES

Biles, Brian, Lauren Hersch Nichols, Barbara S. Cooper, Emily Adrion, and Stuart Guterman "The Cost of Privatization: Extra Payments to Medicare Advantage Plans: Updated and Revised" New York: The Commonwealth Fund, November 30, 2006. (2008 update forthcoming)

Casey, Michelle, Astrid Knott, and Ira Moscovice. "Medicare Minus Choice: The Impact of HMO Withdrawals on Rural Medicare Beneficiaries." *Health Affairs*, vol. 21, no. 3, May/June 2002, pp. 192-199.

Congressional Budget Office. "Medicare Advantage: Private Health Plans in Medicare" Washington DC, June 28, 2007.

Draper, Debra, Marsha Gold, and John McCoy. "The Role of National Firms in Medicare+Choice." Washington, DC: Kaiser Family Foundation, June 2002.

General Accountability Office. "Medicare Advantage: Higher Spending Relative to Medicare Fee-for-Service May not Ensure Lower Out-of-Pocket Costs for Beneficiaries" Statement by James Cosgrove, Acting Director Health Care, GAO 08-522T, February 28, 2008.

Gold, Marsha. "Private Plans in Medicare: A 2007 Update." Washington, DC: Kaiser Family Foundation, March 2007a.

Gold, Marsha. "Medicare Advantage in 2006-2007: What Congress Intended?" *Health Affairs*, vol. 26, no. 4, May 2007b, pp. W445-W555.

Gold, Marsha. "The Growth of Private Plans in Medicare 2006." Washington, DC: Kaiser Family Foundation, March 2006a.

Gold, Marsha. "The Landscape of Private Plans in Medicare 2006." Washington, DC: Kaiser Family Foundation, 2006b.

Gold, Marsha. "Private Plans in Medicare: Another Look." *Health Affairs*, vol. 24, no. 5, September/October 2005, pp. 1302-1310.

Gold, Marsha "Medicare+Choice: An Interim Report Card." *Health Affairs*, vol. 20, no. 4, July/August 2001,

Gold, Marsha and Timothy Lake, "Medicare+Choice in California: Lessons and Insights" Washington, DC: Kaiser Family Foundation, September 2002.

Henry J. Kaiser Foundation/Hewitt. "Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt Survey on Retiree Health Benefits" Washington DC: Kaiser Family Foundation, December 2006.

Medicare Payment Advisory Commission. Report to Congress: Medicare Payment Policy Washington, DC: MedPAC, March 2008.

Medicare Payment Advisory Commission. "Report to Congress: Medicare Payment Policy." Washington, DC: MedPAC, March 2007.

Medicare Payment Advisory Commission. "Report to Congress: Medicare in Rural Areas." Washington, DC: MedPAC, June 2001.

Merlis, Mark. "The Value of Extra Benefits Offered by Medicare Advantage Plans in 2006" Washington DC: Kaiser Family Foundation, January 2008.

Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund "2008 Annual Report" Washington DC: 2008.

Verdier, James, Marsha Gold, and Sarah Davis. "Do We Know if Medicare Advantage Special Needs Plans are Special?" Washington, DC: Kaiser Family Foundation, January 2008.

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.

[a] This 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

		Plan Type				
	Any MA Contract	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	PFFS	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.

[a]Total 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.

[b]The 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.

[c]Of 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.

[d]Blues 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.

[a] For 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.
[b] Includes 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

	All Beneficiaries			Urban Beneficiaries			Rural Beneficiaries		
Percent of Beneficiaries with availability of:	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

		Local CCP							
State	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 CCP: Local HMO	Local CCP: 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

		Type of CCP	
State	Any 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 1st 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 1st 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*)

[a] This 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.
[b] This firm is a non-Blues brand affiliate of BCBS of South Carolina.
[c] This firm had a merger pending with UnitedHealthcare in 2008 (announced 2007), which could explain the reduced 2008 availability.
[d] CMS 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

	All Counties				Urban Counties				Rural Counties			
	October 2006		December 2007		October 2006		December 2007		October 2006		December 2007	
Contract Type	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
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
HMO	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
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
Cost	313,357	0.7	304,817	0.7	257,535	0.7	250,080	0.7	55,721	0.6	54,687	0.6
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
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
MSA	0	0.0	1,248	0.0	0	0.0	946	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)	RPPO	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)	RPPO	01/01/2006	911
	Humana enrollment			**60,415**
HIP of New York	H3330 (3)	HMO/HMOPOS	07/01/1987	60,268
	HIP of NY enrollment			**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	HCPP – 1833 Cost	02/01/1974	41,300
	United Mine Workers enrollment			**41,300**
Rochester Area HMO	H3305 (2)	HMO/HMOPOS	11/01/1985	35,533
	H3346 (2)	Local PPO	09/01/2005	39
	Rochester HMO enrollment			**35,572**
Coventry	H2663 (5)	HMO/HMOPOS	11/01/1995	4,035
	H3959 (2)	HMO/HMOPOS	01/01/1996	7,787
	H2672 (2)	HMO/HMOPOS	05/01/1999	1,535
	H5509 (2)	Local PPO	01/01/2006	632
	H5517 (1)	Local PPO	01/01/2006	5,282
	H5522 (1)	Local PPO	01/01/2006	2,354
	H0846 1)	PFFS	01/01/2007	8,399
	H5227 (1)	PFFS	01/01/2007	5,007
	Coventry enrollment			**35,031**
Independence Blue Cross	H3952 (2)	HMO/HMOPOS	01/01/1993	17,307
	H3156 (2)	HMO/HMOPOS	10/01/1995	985
	H3909 (2)	Local PPO	01/01/2002	4,506
	Independence enrollment			**22,798**
Group Health Cooperative	H5050 (2)	HMO/HMOPOS	01/01/1989	22,402
	Group Health enrollment			**22,402**
Wellpoint	H0564 (1)	HMO/HMOPOS	06/01/1993	962
	H3655 (2)	HMO/HMOPOS	10/01/1994	7,279
	H3370 (1)	HMO/HMOPOS	07/01/1996	4,593
	H1849 (1)	HMO/HMOPOS	01/01/1998	1,413
	H0540 (1)	PFFS	04/01/2003	233
	H5419 (1)	PFFS	02/01/2005	639
	R5941 (2)	RPPO	01/01/2006	266
	H1689 (2)	PFFS	01/01/2007	2,636
	H5304 (1)	PFFS	01/01/2007	193
	Wellpoint enrollment			**18,214**
Excellus, Inc.	H3351 (4)	HMO/HMOPOS	01/01/1990	13,904
	H3356 (1)	1876 Cost	01/01/1993	512
	H3335 (10)	Local PPO	07/01/2004	2,345
	Excellus enrollment			**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	Enrollment 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 BCBS	E5941		12, 13		
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 Avantra	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 MedicareComplete 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

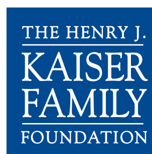
PERCENTAGE OF BENEFICIARIES WITH AVAILABILITY OF MEDICARE ADVANTAGE PLANS, BY STATE AND PLAN TYPE FOR URBAN COUNTIES, 2008

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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