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MEDICARE

# Strategies for Simplifying the Medicare Advantage Market

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# Strategies for Simplifying the Medicare Advantage Market

By

Marsha Gold[1]

## EXECUTIVE SUMMARY

In 2009, Medicare offers beneficiaries the option to enroll at least seven different types of Medicare Advantage (MA) plans: Health Maintenance Organizations (HMOs), Provider Sponsored Organizations (PSOs), local Preferred Provider Organizations (PPOs), regional PPOs, Private Fee-For-Service Plans (PFFS), Medical Savings Accounts (MSAs), and Special Needs Plans (SNPs). In terms of the quantity, in 2009, half of all Medicare beneficiaries have at least 41 plan choices (excluding SNPs available only to qualifying subgroups) not including an extensive array of Medicare stand-alone prescription drugs also offered.

Nationwide, 283 distinct firms have some form of MA or other prepaid comprehensive contract with Medicare. But while many firms participate in the MA market, offering multiple products, often within the same community, enrollment is heavily concentrated in a few firms, both nationally and in local markets. This situation makes it more likely that the MA choices offered beneficiaries can be streamlined without extensive disruption for current enrollees.

Existing research suggests that simplification may have advantages for beneficiaries. Traditional microeconomic theory holds that choice is good for markets and beneficiaries. The theory posits that market competition is a driving force for innovation and efficiency; such competition provides benefits by having many competitors, none of whom dominates. Broad choice also makes it easier for beneficiaries to find options that best meet their individual medical needs, economic circumstances, and personal preferences. There are downsides to choice and competition, however. With more choice, there is less ability to achieve economies of scale, either within firms or overall in Medicare, and potentially more chances for competitors to "game" the system through product design. Such outcomes would make it harder to achieve overall goals of the Medicare program. Further, emerging empirical research in the areas of psychology and behavioral economics shows that, while consumers say they prefer having many choices, they do not necessarily respond well to such multiple options.

This Issue Brief considers the case for simplifying beneficiary plan choices in the Medicare Advantage program and analyzes implications of potential options on plan availability and current enrollees. The analysis is based on plans offered in the individual market to all beneficiaries.

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## Options for Simplification

The first set of options would require a minimum enrollment for Medicare Advantage plans offered to beneficiaries, and the second set would limit the types of Medicare Advantage plans that would be offered. The analysis assesses the effects of these options on plan availability and beneficiaries.

**Minimum Enrollments and Related Policies.** Because current MA enrollment is highly concentrated by plan and firm, there are some relatively simple ways in which CMS could streamline the number of choices provided to beneficiaries while limiting the effects on current enrollees (see Table ES-1).

- ***Options 1 and 2: Eliminate Small or Duplicative Plans as Recommended in the 2010 CMS Call Letter.*** Eliminating plans with 10 or fewer enrollees, and limiting the number of MA-PDs per contract per MSA, would remove more than a third of all individual non-SNP plans (963) but affect relatively small numbers of enrollees and leave beneficiaries with an average of 33 choices each (versus the current mean of 43).
- ***Options 3 and 4: Go Further In Eliminating Low-Enrollment Plans*.** Raising the minimum plan enrollment threshold to 100 would approximately double the number of plans eliminated with very little impact on current enrollees, since few are in plans with 11–99 enrollees. Applying this enrollment threshold at the contract level, rather than the plan level, would affect few additional enrollees but lower the administrative burden on CMS.
- ***Options 5 and 6: Require Firms to Reach a Minimum Market Threshold.*** Requiring that firms in urban areas reach a minimum enrollment of 1,500, or 5 percent market share, in each MSA in which they operate would reduce the number of plans offered by more than half but affect fewer than 10 percent of current enrollees, and leave beneficiaries with an average of 22 plans available to them (15, if all of the previously discussed options also were enacted).

**Streamline Authorized Plan Types.** Another approach would be to reduce the number of Medicare Advantage plan types offered under the Medicare Advantage program – eliminating plan types that do not appear to be necessary. Such actions would not necessarily reduce the number of plans offered because firms offering them could decide to replace them with plans under remaining contract types. However, their elimination would reduce the number of distinctions beneficiaries have to make, thus reducing the complexity of choice. (The analysis for these options assumes that the eliminated plans would leave the Medicare Advantage market and not be replaced with other types of plans; it thus reflects the upper bound for the option's effects.)

- ***Option 7: Eliminate PSOs.*** Eliminating the provider-sponsored option (PSO) would have little effect on the number of plans offered even if all PSOs available in 2009 withdrew from Medicare Advantage and did not convert to either Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs). While initiated to encourage providers to offer plans outside the usual state

licensure requirements, there are only seven PSOs nationwide in 2009, and structurally they seem fairly similar to current HMOs and PPOs.

- ***Option 8: Eliminate Regional PPOs (RPPOs).*** Originally intended as a vehicle to expand choice in rural areas, regional PPO plans are available to more than 90 percent of beneficiaries, but have relatively low enrollment. Firms have indicated that these plans have difficulty competing against local coordinated care plans, with payments and benefits established on a county-by-county basis. PFFS plans, combined with selected local coordinated care plan offerings, have evolved to fulfill the role originally intended for RPPOs. The rationale for keeping two types of plans for this purpose may no longer exist, assuming that Congress keeps current network PFFS requirements, as authorized by the Medicare Improvements for Patients and Providers Act of 2008 [MIPPA].

- ***Option 9: Require Network PFFS Plans to Become Coordinated Care Contracts.*** In 2011, PFFS plans in most areas of the country will be required to form networks (except in counties with two or fewer other kinds of plans). The utility of separate network-based PFFS authority may be obsolete to the extent they are expected to be like coordinated care plans and could be authorized under that authority. The analysis makes the assumption that those PFFS plans subject to the network requirement would withdraw from the Medicare Advantage market and not be replaced with new plans of different types because their sponsors already had such plans approved or because they did not choose to offer them..

**Standardize Plan Features.** In addition to these steps, MA also could be simplified through standardization of benefits so that beneficiaries do not have to analyze as many distinctions. This could involve standardized service areas, benefits, and labels, as well as more consistent requirements under Part D for PFFS and coordinated care plans. While these options do not change the number of plan choices, they could increase the quality and clarity and make it easier for beneficiaries to choose. These actions might build on CMS's ongoing efforts to make plan labeling more consistent and clarify out of pocket costs for beneficiaries (see 2010 Call Letter).

## CONCLUSIONS

Medicare Advantage has evolved into a program that gives beneficiaries many and more complex choices than virtually all other public or private health insurance programs (KFF/HRET 2008). Despite the proliferation of choice, diverse plan options, and many competitors, enrollment is concentrated disproportionately among a limited number of firms, contracts, and plans. Our analysis shows that eliminating low-enrollment plans, as CMS has proposed, would affect a relatively small number of beneficiaries. Even with these changes (Options 1 and 2), beneficiaries could continue to have many plan choices available, raising a more basic question for policymakers is whether the MA program warrants a more fundamental redesign to better serve its beneficiaries in the long term.

**Table ES.1. Estimated Effects of Policy Options to Simplify Medicare Advantage Choices for Beneficiaries on Plan Availability and Enrollees, based on 2009 Enrollment (excluding group plans and SNPs)**

| Option | Number of Plans Affected | Number of Plans Unaffected | Number of Enrollees Affected | Percent of Medicare Advantage Enrollees Affected | Number of Plans Available per Beneficiary | |
|---|---|---|---|---|---|---|
| | | | | | Mean | Median |
| **Current Program 2009** | -- | 2,735 | -- | -- | 43 | 41 |
| **CMS Call Letter 2010 Changes** | | | | | | |
| 1. Require plans to have minimum number of enrollees – more than 10 | 461 | 2,274 | 291,065[a] | 3.9% | 37 | 35 |
| 2. Limit contracts to no more than two MA-PDs per MSA | 639 | 2,096 | 315,741 | 4.3% | 38 | 37 |
| *Combined Effect of #1 and #2* | 963 | 1,772 | 606,806 | 8.2% | 33 | 32 |
| **Other Options to Eliminate Low-Enrollment Plans** | | | | | | |
| 3. Require plans to have minimum number of enrollees – 100 or more | 923 | 1,812 | 311,377 | 4.2% | 32 | 31 |
| 4. Require at least 100 enrollees per contract | 184 | 2,551 | 1,649 | 0.0% | 40 | 39 |
| 5. Contract with firms that have a minimum of 1,500 individual enrollees *nationwide* | 109 | 2,626 | 20,312 | 0.3% | 42 | 40 |
| 6. In urban areas, allow firms to contract only if they have at least 5 percent market share or more than 1,500 enrollees | 1,556 | 1,179 | 654,229 | 8.8% | 22 | 22 |
| *Combined Effect of Options #3-6* | 1,912 | 823 | 962,867 | 13.0% | 17 | 17 |
| *Combined Effect of Options #1-6* | 2,054 | 681 | 1,247,996 | 16.9% | 15 | 15 |
| **Other Options to Streamline Plan Types[a]** | | | | | 15 | 15 |
| 7. Eliminate PSOs | 7 | 2,728 | 12,876 | 0.2% | 43 | 41 |
| 8. Eliminate RPPOs | 51 | 2,684 | 291,643 | 3.9% | 41 | 40 |
| 9. Require Network PFFS to Become Coordinated Care Contracts | 688 | 2,040 | 1,514,050 | 20.5% | 19 | 15 |
| *Combined Effect of Options 7-9* | 746 | 2,047 | 1,818,569 | 24.9% | 16 | 13 |
| *Combined Effect of All Options* | 2,094 | 641 | 2,539,223 | 34.3% | 8 | 7 |

Source: MPR analysis for the Kaiser Family Foundation (KFF) using CMS's county-contract-plan file for March 2009

Note: In March 2009, there were 7,106,326 enrollees reported as in plans serving the individual market (excluding SNPs). Since CMS does not report enrollment for plans with 10 or fewer enrollees; the number of enrollees cited as affected by cutting such plans is an estimate based on the difference between the total numbers of individual non-SNP MA enrollees nationally in March 2009 (7,397,421) and the cumulative number of such enrollees in reported plans (7,106,356).

[a] If these changes were made, some firms might substitute alternative contracts in some areas, adding to the total number of plans. Option #9 shows all current PFFS plans affected by network requirements already in place because of MIPPA.

# Strategies for Simplifying the Medicare Advantage Market

## INTRODUCTION

In this Issue Brief, we analyze diverse options for simplifying choice in the Medicare Advantage (MA) program. The brief responds to concerns expressed by the Centers for Medicare & Medicaid Services (CMS) and others that the large number of choices currently provided to Medicare beneficiaries may be detrimental to effective choice and generate other problems for the Medicare program and industry (e.g., discriminatory practices, financial instability among small-volume offerors, and reduced economies of scale for MA firms). CMS's 2010 MA Call Letter encourages one option for simplifying choice for Medicare beneficiaries—eliminating plans offered under contracts that have very few enrollees or that are virtually indistinguishable from others offered to beneficiaries under the same contract.[2] The issue of simplification and how to achieve it warrants broader consideration, however.

Our core analysis is organized in two parts. The first, which is largely theoretical, synthesizes the arguments for and against simplification as reflected in the literature on consumer choice and competition theory. The second, which is empirically based, first examines the current structure of MA choice in 2009 as defined by MA sponsors, contracts, and plans, and then analyzes the effect of specific options for simplifying the market. We conclude by summarizing the implications of our analysis for MA policy.

## PART I: THEORETICAL UNDERPINNINGS

### *THE ORIGINS OF MA COMPLEXITY*

Medicare, at its inception, was designed as a program that delivered benefits through a single public plan, but over time, has evolved into a much more complex program. Today, the plan choices available to Medicare beneficiaries are numerous and diverse. In 1982, Congress for the first time gave beneficiaries the option to enroll in private plans by authorizing enrollment in Medicare HMOs (effective in 1985). In 1997, Congress broadened the authorized private plan options to include other forms of coordinated care, particularly Preferred Provider Organizations (PPOs), Provider Sponsored Organizations (PSOs) as well as private fee-for-service option (PFFS) and a time-limited demonstration of Medical Savings Accounts (MSAs). The Medicare Modernization Act of 2003 (MMA) further expanded the types of MA plans, authorizing new regional PPO and special needs (SNP) plans, redesigned MSAs, and enhanced federal MA payments to stabilize the existing market and encourage firms to participate (Gold 2006). Today, most Medicare beneficiaries have a choice of at least five different *types* of Medicare Advantage plans, not to mention stand-alone prescription drug plans

[2] CMS 2009. The provisions cited are discussed on pp. 11–12 of the Call Letter.

(PDPs). In terms of the *number* of choices, on average Medicare beneficiaries in 2009 can choose from among 43 Medicare Advantage plans; they also have at least 45 prescription drug plans (Hargrave et al. 2009).

The evolution of the Medicare marketplace raises fundamental questions about whether the number and diversity of options is well-suited to meet the needs of the beneficiary population. Those who want to stay with traditional Medicare for Parts A and B but want the prescription drug benefit (Part D) need to choose a freestanding prescription drug plan (PDP). In 2009, there were 16 nationwide sponsors of such plans, with other firms offering products in one or more regions (aggregations of one or more states) so that all beneficiaries now have at least 45 PDPs from which to choose (KFF 2008). The alternative is to choose an MA plan that integrates coverage for Parts A and B (with a so-called "Part C" plan), along with Part D and selected supplemental benefits. In most instances, beneficiaries also can now select between MA plans that incorporate a prescription drug benefit (MA-PD) and those that do not (MA-only).

## *THE VALUE OF CHOICE FROM THE CONSUMER PERSPECTIVE*

Traditional microeconomic theory holds that choice maximizes utility and allows other important goals to be achieved by promoting competition and allowing people's diverse preferences to be matched in the marketplace. Such a theory suggests that more choice is better. The conviction that social welfare is enhanced by the provision and exercise of choice strongly influences public policy in the United States (Botti and Iyengar 2006).

Research emerging from psychology and behavioral economics confirms that consumers say they want choice but also that they experience problems in handling it. When consumers are confronted with *many* choices, they are less likely to make a decision than when they have few (Iyengar and Lepper 2000). When they do make a choice, those with many choices express more dissatisfaction and regret. Consumers have cognitive difficulty in distinguishing between multiple choices and, counter to traditional theory, often do not know their preferences in advance. Because decisions made in this context also generate negative emotions, some argue that consumers would be better off by narrowing the choice set and emphasizing only high-value choices (Botti and Iyengar 2006).

For the past several years, researchers have examined how these considerations on choice apply to health insurance, particularly among the elderly, who have been provided with an increased array of choices through the MMA.[3] "Bounded rationality" (a term defined by Herbert Simon) exists, say Hanoch and Rice (2006), because people have "restricted information-processing capabilities, inexpert computational abilities, incomplete knowledge of the world, and limited time for making decisions." Such dynamics are particularly relevant for the elderly because of the increased risk of

[3] See especially Hanoch and Rice (2006).

cognitive impairment among the elderly and the mechanisms they use to compensate for changes in cognitive function.

Research has shown that such processes influence the choice of health insurance among Medicare beneficiaries. Beneficiaries were more satisfied after Medigap standardization simplified the types of choices available to them to supplement their Medicare benefits (Fox et al. 2003; McCormack et al. 1996). In the 2004–2005 period, most beneficiaries did not choose a drug discount card, despite being offered numerous options, because they did not understand the choices and had difficulty in accessing information (KFF 2004). Increasing the choice set in Medicare private plans from 1–2 to 3–4 increased the probability of enrolling, but further expansion in choice resulted in no greater willingness to enroll and, in many cases, less (Elbel and Schlesinger 2009a). In a nationally representative experiment conducted among those ages 65 and over, individuals provided with structured choices between a designated health plan and alternatives did not respond in predicted ways (Elbel and Schlesinger 2009b). Rather, they showed "status quo" bias and were swayed by the way options were ordered. They also experienced increased difficulty with eight or more options, a fact the authors attribute both to preference uncertainty and cognitive overload. The findings persisted even when choice was reconfigured to create "dominated options," in which one option dominates the others presented. Likewise, early analysis of prescription drug plan choice under the MMA shows that, contrary to expectations, beneficiaries do not necessarily choose plans that could yield lower out-of-pocket costs (Gruber 2009).

In sum, while consumers express interest in choice and economists view choice as enhancing value, the empirical evidence shows that individuals faced with a large number of alternatives often avoid choice or choose options that may be inconsistent with their preferences, and afterward feel negative about the experience. There is thus strong empirical support for policymakers to consider ways of streamlining and improving the number and quality of available MA options.

*CHOICE WITHIN A COMPETITIVE MARKET FRAMEWORK*

Choice also is positively regarded because of its role in competitive markets; economic theory holds the role of choice as central to the drive toward innovation and efficiency. As White (2007) summarizes:

> *Markets should maximize value because as suppliers pursue profit and investment in creating capacity in pursuit of profit, they will be disciplined by customers' shopping. The need to offer lower prices than the competition's should encourage efficiency, and the drive to satisfy customers should encourage the creation of a diversity of products to match different individual utilities.*

Few believe that current health care markets function optimally. Rather, the debate centers on whether markets ultimately can perform optimally, and whether they should—that is, the debate revolves around the relative merits of making markets work by removing regulatory barriers to competition versus regulating markets more or even replacing them, at least in part, to achieve public policy goals (Nichols et al. 2004; Butler

2004; Cogan et al. 2005; Marmor and Bradshaw 2006). Policymakers differ in their perspectives on these issues; the Republican Party generally favors competition, encouraging it with MA and the design of Part D through the MMA. Democrats tend to have more reservations; with the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), they sought to constrain competition (Iglehart 2004, 2008). Such ideological disagreements cannot be resolved empirically.

Beyond ideology, choice has important operational implications for markets and program administration. Antitrust theory is built around the concept that a sufficient number of firms need to participate in a market to support competition. Restrictions on choice that adversely affect competition thus raise concerns. But such restrictions also have potential positive effects. With a limited workforce for program administration, CMS may be able to do a better job of overseeing the industry with fewer participants and fewer plans to be approved or monitored. Limiting firm offerings also could mean they may be less able to structure benefits so as to attract more "profitable" (usually healthier) enrollees—however firms may define such enrollees based on the methods in place to set payment rates and then adjust for risk. Fewer sponsors also could result in larger enrollments, possibly leading to economies of scale, reduced administrative costs, and lower financial risk of firm failure.

The effect of program change on competition historically has been a political as well as administrative issue, to the extent that such arguments are used by industry to oppose unwelcome regulatory changes. Such arguments were made about standardizing Medigap benefits, although analysts have found mostly positive effects from standardization—but also no evidence of cost savings (Fox et al. 2004; Rice et al. 1997).

Even though the interpretation of whether reduced choice is positive or negative tends to be controversial, it is important to consider how simplification of the market might affect the number of firms participating, market concentration, and the ability of regulators to monitor offerings.

## PART II: EMPIRICAL ANALYSIS

Our analysis of the current MA market and how it would be affected by various options for simplification is based on analysis of public data on 2009 MA offerings and enrollment. While we focus mainly on options possible under CMS's current authority, we include some options that appear to require new legislation (see Appendix, Methods and Data Sources.)

### *CURRENT MA INDUSTRY STRUCTURE AND CONCENTRATION*

The MA market today can be perceived either as extremely competitive or not very competitive at all, depending upon how competition is defined. This variance stems in large part from the fact that many firms participate in this market—and there are many plans available to each beneficiary—but enrollment is concentrated in plans offered by relatively few firms.

Nationwide, 283 distinct parent organizations (referred to in this brief as "firms") have some form of contract to sponsor an MA or other prepaid group plan. Ninety-nine percent of beneficiaries have a choice of plans from at least five firms, and 75 percent from 10 firms or more (Table 1). There are fewer firms sponsoring products that require the formation of networks (such as HMOs and PPOs). When we examine only local coordinated care plans, we find fewer beneficiaries with choices available from five firms or more, but 65 percent can choose from at least three firms (see Table 1 and Appendix Table A.1). Rural beneficiaries have fewer choices, reflecting the well-known difficulties of establishing coordinated care and provider networks in these areas.[4]

**Table 1. Percentage of Beneficiaries by Number of Firms Competing for the MA Business in 2009**

| | Percent of Beneficiaries | | | | |
|---|---|---|---|---|---|
| Locally Competing Firms | Any Contract Type | MA Contracts Only | CCPs Only | Local CCPs Only[a] | Local CCPs Only (excluding SNPs) |
| Under 5 | 1% | 1% | 45% | 51% | 58%[a] |
| 5–9 | 24 | 30 | 38 | 32 | 24 |
| 10–15 | 53 | 54 | 11 | 11 | 12 |
| 16+ | 22 | 16 | 6 | 6 | 5 |

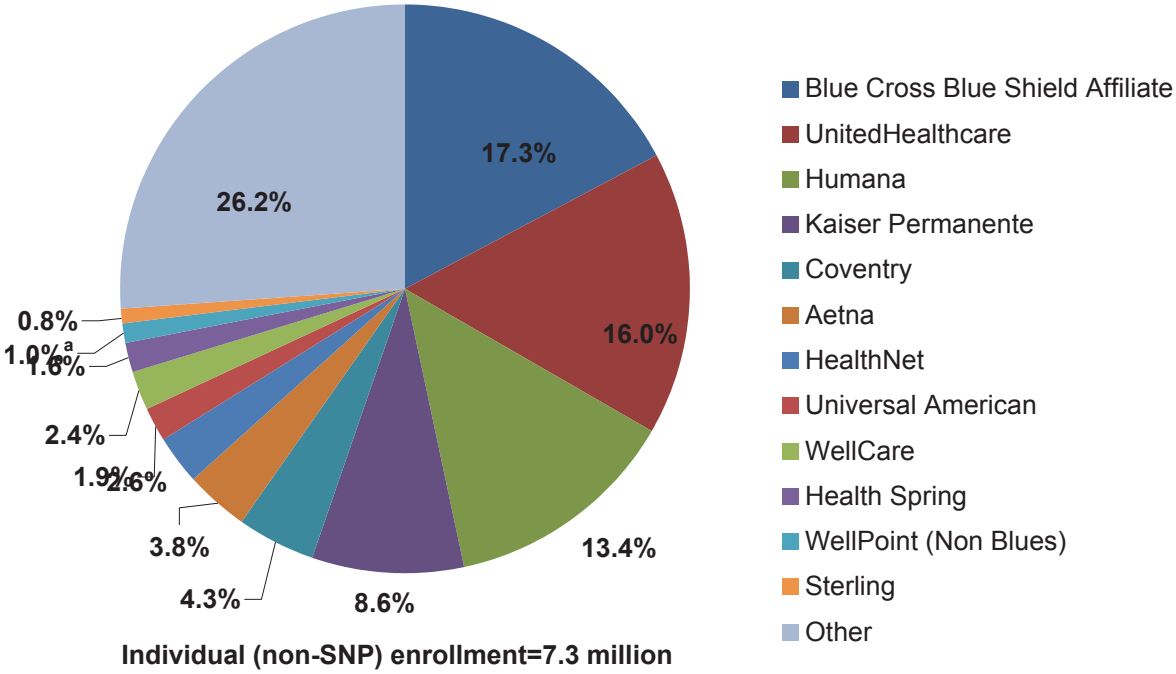
Source: MPR analysis of CMS data from the Contract-County file for March 2009. Excludes sponsors offering group-only products.

[a]Includes 12 percent with no choice, 12 percent with one sponsor only, 11 percent with two choices, and 24 percent with three to four choices.

While many firms participate in the individual MA market, national enrollment tends to be concentrated in a small number of firms (Figure 1). One in three individual enrollees is in a plan sponsored by either UnitedHealthcare (18 percent) or Humana (15 percent). These and nine other national firms account for more than half of all enrollment. Another 16 percent of enrollees are with firms that are independently owned but BCBS affiliated.

[4] While 98 percent of rural beneficiaries have 5 or more sponsor choices for any MA or similar prepaid plan, few have that many choices of coordinated care plans. When SNPs are excluded, 38 percent of beneficiaries have no local CCP choice, 30 percent can choose from one sponsor only, 17 percent from two, and 15 percent have choices among three or more (data not presented). When regional PPOs are considered, 97 percent of rural beneficiaries have some choice (up from 62 percent without PPOs)—33 percent can choose from one sponsor, 35 percent from two, and 30 percent from among three or more (data not presented).

**Figure 1. Distribution of Individual MA Enrollment by Firm or Affiliate, 2009**




Source: MPR analysis of CMS's Contract-County file for March 2009

Note: Excludes group and SNP enrollees; only enrollees in plans authorized under MA are included (excludes cost, HCPP, PACE and demonstration plans).

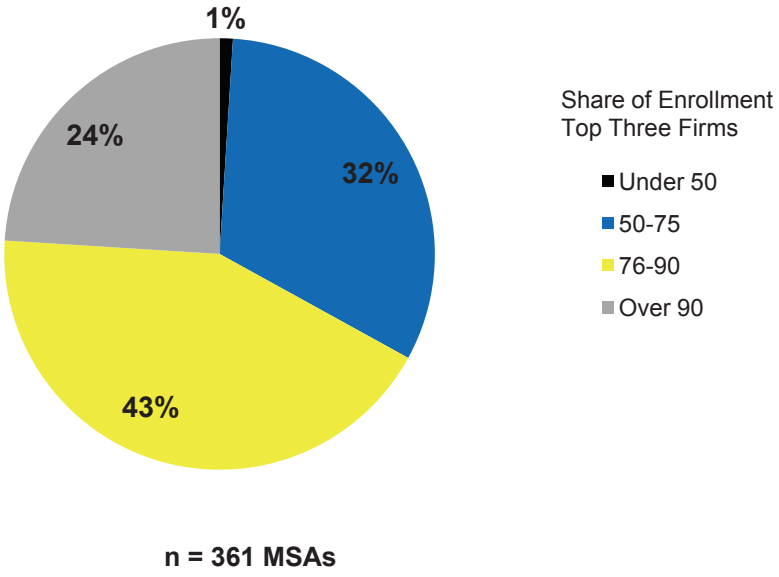
[a]WellPoint has 4 percent market share including the firm's BC-BS affiliates. (BC-BS has 14.3 percent without WellPoint enrollees.)

Despite the large number of firms, competition in most markets tends to be limited to a smaller number of dominant firms. In almost two-thirds of the MSAs, the three firms in the MSA with the highest enrollment account for more than 75 percent of all enrollment in that area (Figure 2). The most common metric used by regulators to assess the adequacy of competition is the Herfindahl-Hirschman Index (HHI), which serves as the foundation for federal antitrust merger guidelines.[5] Looking at the health insurance industry generally,[6] the HHI is above 1,800 (a marker of concentration) in all but 15 of the largest 100 markets (Appendix Table A-2). The same is true in all but 36 of the 361 MSAs (see Appendix Table A.3).

[5] This index is constructed by summing the squares of the market share of individual competitors in the market to assess their "concentration." The HHI is used as a screen for assessing proposed mergers. Markets with an HHI above 1,800 are viewed as "highly concentrated." See Hyman and Kovacic (2004).

[6] Robinson (2004) argues that, as a result of consolidation, competition actually is limited. However, others challenge his use of states to define markets and point out that the HHI is better suited for screening than for diagnosing market competition (Hyman and Kovacic 2004).

**Figure 2. Distribution of MSAs by Percent Enrollment in Top 3 Firms, 2009**




**n = 361 MSAs**

Source: MPR analysis of CMS data, 2009.

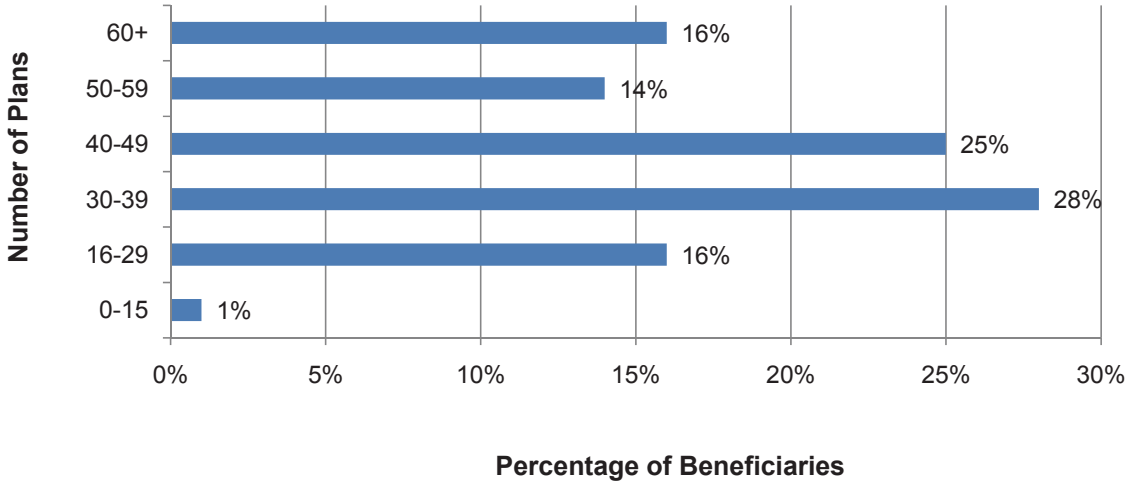
Note: The top three firms are selected separately in each MSA.

While these findings do not mean that competition is absent, they do indicate that a few firms are likely to define the terms of competition. That is, in most urban markets, a few firms dominate and competition is mainly among these firms or between them and the traditional Medicare program. Because of this circumstance, it may be possible to reduce the number of choices without having a major effect on market competition.

**Choices Available to Beneficiaries in 2009.** While some aspects of the Medicare market are national in scope, competition tends to be local; firms compete for business in different communities with an array of products they believe will be both attractive to beneficiaries and financially feasible, given current MA payment structures. With the exception of regional PPOs, service areas under a contract are set by county and benefits are tailored to payment rates that also vary on a county basis.

At the local market level, beneficiaries have many available choices. Excluding groups and SNP plans, there were 2,735 plans offered under MA in 2009. Virtually all beneficiaries had at least 16 plans available to them and almost two-thirds had 40 or more (see Figure 3 and Appendix Table A.4).

**Figure 3. Distribution of Beneficiaries by Number of Individual MA Plans Available, 2009**




Source: MPR analysis of CMS data.

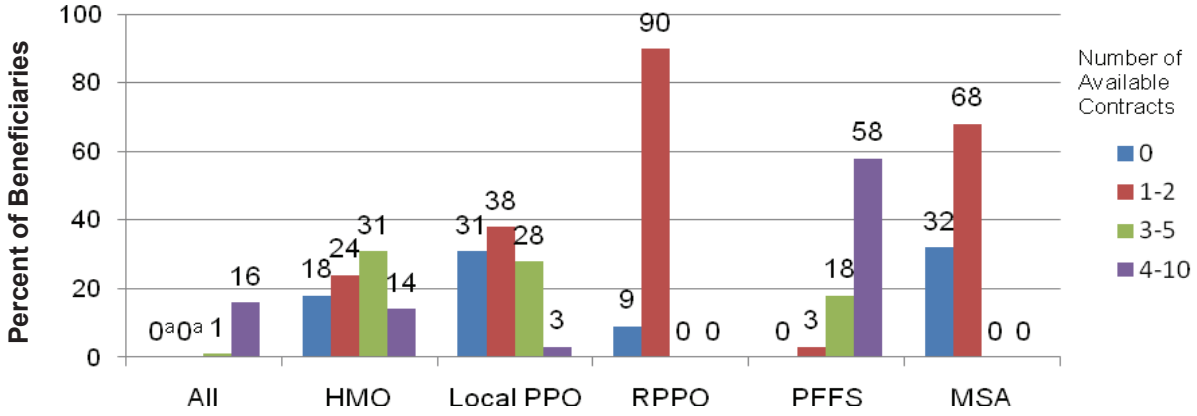
Note: Excludes SNP and group plans.

The extensiveness of choice in MA reflects a combination of (1) the types of plans authorized in MA; (2) the number of firms competing in markets to enroll individuals in these diverse products (i.e., the number of unique contracts for each plan type per market); and (3) the diversity of the number of benefit packages (i.e., the number of total plans available per market).

**Available Plan Types.** Most employers that offer health insurance offer their employees a limited choice of health plans, if they offer a choice at all. In contrast, Medicare offers beneficiaries at least seven MA plan types: HMO, PPO, PSO, Regional PPO, PSO, MSA, and PFFS, along with three non-MA options authorized separately (cost, HCPP, PACE) (see Table A-5). In contrast, 85 percent of firms offering health benefits (with 49 percent of covered workers) use a single plan type (KFF/HRET 2008). Our analysis shows that virtually all beneficiaries have at least one PFFS choice, 91 percent a regional PPO choice, 82 an HMO choice, 69 percent a local PPO (or PSO) choice, and 68 percent an MSA choice (Table A-6). As a result, two-thirds of beneficiaries are asked to choose from among at least one contract for each of five plan types, even on this streamlined basis. Some of the distinctions across these plans may be more relevant than others to beneficiaries. For example, the distinction between a PSO and other coordinated care plans (HMO or PPO) rests mainly in the sponsor and the likely regulatory situation. Each plan type, except the point-of-service HMO (HMO-POS), involves a separate CMS contract and separate approval of each plan offered in the contract's service area. Offering more plan types thus adds both to the complexity of beneficiaries' decision making and the administrative burden on CMS.

**Contracts.** Under MA, CMS contracts with firms to offer specific plan types in given geographical areas (Figure 4). In 2009, there were 538 MA contracts, although 92 percent of enrollees were in only one-third (178) of these (see Table A.6). CMS authorizes particular firms to offer products at the contract level, with the firms having to meet defined specified organizational, network, and other standards for the product and for the collection and reporting of certain data (e.g., CAHPS), which are mostly contract specific.

**Figure 4. Distribution of Beneficiaries by Number and Type of Contracts Available, 2009**




Source: MPR analysis of CMS data.

Note: Number of contracts excludes SNP and group-only contracts.

[a]<0.5 percent.

## *OPTIONS FOR SIMPLIFICATION*

In theory, it is possible to simplify choice within the MA market in two ways. First, limit the number of choices available to beneficiaries. Second, improve the clarity or quality of those choices through standardization. In practice, these two options are not entirely distinct and can be combined. We review here the effects of various options for simplifying the MA market, focusing first on those whose major effect is to limit the number of choices available, second on options that streamline the types of choices authorized, and finally on options to standardize the way choices are presented to better support beneficiaries considering choice. Table 2 summarizes the effect of the first two types of options on the number of plans available to beneficiaries and current enrollees.

**Table 2. Estimated Effects of Policy Options to Simplify Medicare Advantage Choices for Beneficiaries on Plan Availability and Enrollees, based on 2009 Enrollment (excluding group plans and SNPs)**

| Option | Number of Plans Affected | Number of Plans Unaffected | Number of Enrollees Affected | Percent of Medicare Advantage Enrollees Affected | Number of Plans Available per Beneficiary | |
|---|---|---|---|---|---|---|
| | | | | | Mean | Median |
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| **CMS Call Letter 2010 Changes** | | | | | | |
| 1. Require plans to have minimum number of enrollees – more than 10 | 461 | 2,274 | 291,065[a] | 3.9% | 37 | 35 |
| 2. Limit contracts to no more than two MA-PDs per MSA[b] | 639 | 2,096 | 315,741 | 4.3% | 38 | 37 |
| *Combined Effect of #1 and #2* | 963 | 1,772 | 606,806 | 8.2% | 33 | 32 |
| **Other Options to Eliminate Low-Enrollment Plans** | | | | | | |
| 3. Require plans to have minimum number of enrollees – 100 or more | 923 | 1,812 | 311,377 | 4.2% | 32 | 31 |
| 4. Require at least 100 enrollees per contract[c] | 184 | 2,551 | 1,649 | 0.0% | 40 | 39 |
| 5. Contract with firms that have a minimum of 1,500 individual enrollees *nationwide* | 109 | 2,626 | 20,312 | 0.3% | 42 | 40 |
| 6. In urban areas, allow firms to contract only if they have at least 5 percent market share or more than 1,500 enrollees | 1,556 | 1,179 | 654,229 | 8.8% | 22 | 22 |
| *Combined Effect of Options #3-6* | 1,912 | 823 | 962,867 | 13.0% | 17 | 17 |
| *Combined Effect of Options #1-6* | 2,054 | 681 | 1,247,996 | 16.9% | 15 | 15 |
| **Other Options to Streamline Plan Types**[d] | | | | | 15 | 15 |
| 7. Eliminate separate PSO authority | 7 | 2,728 | 12,876 | 0.2% | 43 | 41 |
| 8. Eliminate separate RPPO authority | 51 | 2,684 | 291,643 | 3.9% | 41 | 40 |
| 9. Require Network PFFS to Become Coordinated Care Contracts[e] | 688 | 2,040 | 1,514,050 | 20.5% | 19 | 15 |
| *Combined Effect of Options 6-9* | 746 | 2,047 | 1,818,569 | 24.9% | 16 | 13 |
| *Combined Effect of All Options* | 2,094 | 641 | 2,539,223 | 34.3% | 8 | 7 |

Source: MPR analysis for the Kaiser Family Foundation (KFF) using CMS's county-contract-plan file for March 2009

[a]In March 2009, there were 7,106,326 enrollees reported as in plans serving the individual market (excluding SNPs). Since CMS does not report enrollment for plans with 10 or fewer enrollees; the number of enrollees cited as affected by cutting such plans is an estimate based on the difference between the total numbers of individual non-SNP MA enrollees nationally in March 2009 (7,397,421) and the cumulative number of such enrollees in reported plans (7,106,356). This number also is added to the count of 21,046 enrollees in plans with enrollment of 11-99 option 3). Calculation of the percentage of MA enrollees affected by individual options uses the higher national number without exclusions.

[b]Assumes no more than two MA-PDs in an MSA per contract, with the reductions occurring in the lowest enrollment plans. The entire plan is dropped if 50 percent or more of plan enrollment is removed by the MSA restriction.

[c]CMS does not report enrollment for contracts with fewer than 10 enrollees. These figures show only the reported enrollment. At most, the excluded enrollment is equal to that estimated in Option 1 but probably is less.

[d]If these changes were made, some firms might substitute alternative contracts in some areas, adding to the total number of plans.

[e]Includes all PFFS plans affected by network requirements according to final CMS 2010 Call Letter. http://www.cms.hhs.gov/ManagedCareMarketing/Downloads/MIPPA_Imp_memo091208Final.pdf., accessed June 2, 2009

**Eliminate Certain Plans as Called for in the 2010 Call Letter.** In its 2010 MA Call Letter, CMS strongly urges firms to streamline their plan offerings by eliminating plans that have 10 or fewer enrollees and those that differ little in their design from similar plans offered to the same beneficiaries.[7]

In 2009, there were 461 individual MA, non-SNP plans with 10 or fewer enrollees. (See Figure 4, Table A.7, and Table A.8.) If these plans were eliminated, beneficiaries would have an average of 38 plan choices (versus 43 now). If firms were limited to no more than 2 MA-PDs in an MSA in each contract they held, 639 plans could be eliminated while still leaving an average of 38 plans per beneficiary. Together, these options would remove more than a third of all plans (963) but affect relatively small numbers of enrollees, while leaving beneficiaries with an average of 33 choices each.

*OTHER WAYS TO ELIMINATE LOW-ENROLLMENT PLANS*

Since CMS is considering minimum enrollment thresholds, there are other options it might want to consider.

**Minimum Plan Enrollment Threshold.** Raising the threshold of minimum enrollment to 100 would approximately double the number of plans eliminated while having very little impact on enrollees, since few people are in plans with 11–99 enrollees. Eliminating these plans would simplify beneficiary choice and reduce CMS administrative burden while leaving beneficiaries with an average of 40 choices.

**Minimum Contract Enrollment Threshold.** Another option is to calculate minimums on the basis of contracts rather than plans. Nationwide, 34 percent of contracts (53) have 100 or fewer enrollees, with about half having 10 or fewer (see Figure 5 and Table A-9). Because few if any beneficiaries have selected these contracts, there would be minimal losses to beneficiaries or the industry in eliminating them. Steps that lower the number of contracts reduce the need for review and lessen other demands on CMS. Fewer contracts also will generate fewer plans, which in turn will reduce the demands on CMS's actuarial staff to review bids and benefit packages and the burden of choice for beneficiaries.

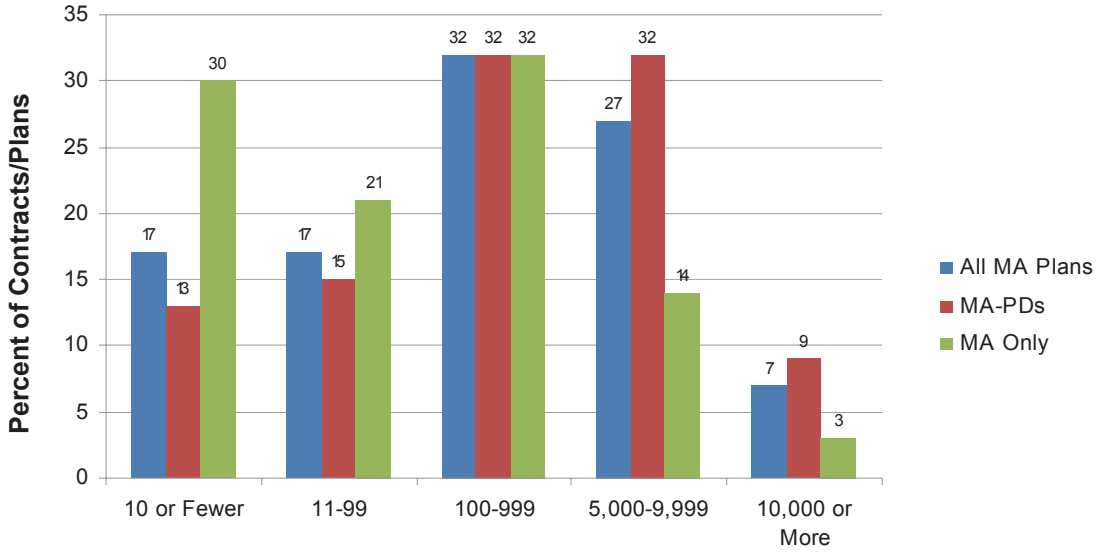
**Minimum Firm Enrollment Threshold.** CMS also could require competing firms to reach a minimum enrollment threshold to continue their participation. Under CMS regulation 42 CFR 422.514, organizations are required to achieve a minimum

[7] CMS has indicated that it will review carefully all plans that carry 10 or fewer enrollees over a three-year period or longer. CMS also has offered certain incentives to encourage integration—namely, an automatic transfer under certain circumstances of beneficiaries from one plan to another available from the same sponsor (e.g., similar benefits, premiums, or network requirements). Since enrollment tends to be concentrated in large firms, and these firms also tend to offer multiple products (contracts) with multiple benefit packages (plans), this could be feasible in many areas of the country.

enrollment of 5,000 (only 1,500 in rural areas or if it is a PSO). It is not clear whether the requirement applies at the firm or contract level. Eliminating any firm with a total enrollment of 1,500 across its contracts would eliminate 36 firms but would leave beneficiaries with almost the same number of plans on average (42 versus 43). The effect on choice is greater if minimums are applied at the local market level, at least in urban areas. Establishing a firm minimum of 1,500 enrollees, or 5 percent of enrollment to maintain the firm's presence in that market would eliminate 56 percent of plans (1,556) but affect fewer than 10 percent of current enrollees (0.6 million). Of all of the options considered so far, this one would go furthest in simplifying the market, although it also would affect more beneficiaries. However, on average, beneficiaries would still have a choice of 22 plans—or 15, if all of the above options were adopted. Rural beneficiaries would not be directly affected because the restriction is limited to urban areas.

Many purchasers limit the number of firms they use to provide health benefits plans through selective contracting so Medicare beneficiaries still will have substantially more choice than other payers offer even with the limitations just discussed. Because it is a public program, Medicare differs from private payers in being less likely, from a political point of view, to limit participation. However, Medicaid, which also is a state program, has limited the number of participating plans in some states (Kaye 2005). A program in which the plans bid competitively for the Medicare program, such as that mentioned in President Obama's proposed budget, could provide a vehicle for selecting among competing sponsors; Medicare's new reporting requirements might provide additional information to support such decision making (OMB 2009; CMS 2009a).

**Figure 5. Distribution of Plans by Type and Level of Enrollment, 2009**




Source: MPR analysis of CMS data.

Note: Excludes group and SNP-only contracts and like plans.

*REDUCE THE NUMBER OF PLAN TYPES OFFERED*

Another way to limit choice is to revisit the current broad-based authority for multiple types of plans. Such change already is underway, in part in response to changes introduced in MIPPA.

**Eliminate PSOs.** A relatively simple step would involve eliminating separate PSO authority under the assumption that it was not needed when HMO and PPO authority already exists.. PSOs were developed to encourage provider-based organizations to participate in MA by sidestepping certain state regulatory requirements for insurers. However, there are few distinct PSO contracts and in 2009, there are only seven PSO plans nationwide. Eliminating PSOs as a distinct contract type could make it easier for beneficiaries to focus on the real differences in their access to providers across coordinated care plans, rather than their regulatory situation—e.g., who is in the network, what out-of-network coverage is provided, and what services require referral.

**Eliminate RPPOs.** A third way to simplify the MA market is to eliminate the regional PPO option. Originally conceived as a way of encouraging coordinated care offerings on a more national basis, the regional PPO, with its larger service area and greater uniformity of benefits, largely has failed the marketplace test. Although RPPO options are available to more than 90 percent of beneficiaries nationwide (mainly because Humana offers them in 14 of the 26 regions), their enrollment remains small and lags behind that of local PPOs (328,000 versus 835,000 in individual plans in March 2009). Firms have told us that the regional PPO option typically is not viable in a market that establishes payment rates by county and also allows local plans to establish service areas and benefits by county, while requiring regional plans to offer standard products across broad regions (Gold 2008; Gold et al. 2008). Moreover, in some areas of the country, regional PPOs may be feasible only because CMS appears to have taken a less demanding stance in assessing network adequacy, particularly in certain rural areas. Regional PPOs appear to provide much more limited benefits than other plan types (Gold and Hudson 2009a, b).

The case for regional PPOs is largely one of access to MA in rural areas, but PFFS authority also is meeting that need and has been a more popular product in the marketplace. While one can debate the relevance of MA choice in markets where coordinated care lacks traction, it is harder to make the case for maintaining two separate options for achieving this goal. Eliminating the RPPO option would have relatively little effect on the number of plans available, at least nationwide; fewer than 300,000 enrollees would be affected. The key policy questions are (1) Do either PFFS or RPPO have an advantage over the other with respect to care management? (2) Is there is a net positive value in offering these alternatives to the regular program within Medicare in areas where local coordinated care plans are not able to make inroads? Among rural beneficiaries, 65 percent reside in areas with no local HMO option and 74 percent in areas with no local PPO or PSO option (data not presented). In urban areas, the comparable numbers are 27 percent and 33 percent.

**Require Network PFFS to Become Coordinated Care Contracts.** With MIPPA requiring PFFS plans to have networks (except in counties with two or fewer other plans), it is not clear how these plans and coordinated care options will differ in the future in locales subject to this requirement. Based on CMS information about affected counties, we estimate that 1.6 million PFFS enrollees are now in plans subject to this requirement; that is, 688 plans would have the majority of their enrollment subject to the requirement. If each of these plans withdrew from the market and did not substitute other offerings, the number of plans available to beneficiaries would decline from the current 43 to 18, with reductions concentrated in urban areas.

In reality, firms likely will respond in different ways to MIPPA, with some substituting other offerings and others withdrawing entirely. This market is highly concentrated, with 85 percent of PFFS enrollment nationwide in nine firms (Appendix Table A-10). Three of the nine dominant firms—Coventry, HealthNet, and WellCare—already have announced that they will withdraw from the PFFS market in 2010 in anticipation of the 2011 network requirements.[8] A fourth, the market leader Humana, began in 2009 to shift PFFS enrollment toward coordinated care products in response to MIPPA, with PFFS seen as a declining share of its market (Oppenheimer 2009). Other firms, such as Universal American, are building networks in key markets so that they can maintain or even expand MA enrollment. They are likely to apply to offer new PPOs in at least some of these areas and actively compete for the PFFS business being dropped by other companies, using a combination of network and non-network plans.

With MIPPA requiring networks for PFFS plans (unless there are few other alternatives available) and more consistent quality reporting across plan types, it is not clear whether there is or should be a distinction between network PFFS plans and coordinated care options. PFFS plans currently required to have networks could be required to contract as a coordinated care plan, eliminating potential beneficiary confusion over the difference between them and traditional Medicare, and simplifying the number of types of plans beneficiaries are asked to choose among.

### *STANDARDIZATION AS A MEANS OF SIMPLIFYING CHOICE*

The options discussed previously deal with simplifying the complexity of choice based on the large number of alternatives that beneficiaries are asked to consider. Enhanced choice also can be achieved by standardizing the plans offered, either as a complement to plan simplification or on its own. There are several ways of standardizing plan options so that beneficiaries do not have to make as many distinctions among them and CMS has less administrative burden. Some forms of standardization also could increase the quality of choices available to beneficiaries.

**Standardize Service Areas for Benefits.** Currently, firms can define plans in ways that vary benefit packages by county (except for regional PPOs). The rationale is that payment rates differ by county, which affects the financial feasibility of different benefit packages.

[8] There could be some exceptions to allow firms to keep group contracts in place..

Requiring standardized service areas that coincide with accepted geographical units (e.g., MSAs, rural areas within states) could make it easier to develop standardized materials and other forms of communication to support beneficiary choice at the local level. Larger areas also could reduce beneficiary complaints about unequal benefits when two counties with different sets of plan benefits are included in the same media market (such as New York City and Nassau/Suffolk Counties in New York).[9]

**Standardize Benefits.** Given what many view as the positive experience of standardizing Medigap benefits, there have been calls for a similar standardization of MA (O'Brien and Hoadley 2008; Fox et al. 1999). Because of the considerable diversity in today's MA benefit structures (Gold and Hudson 2009), such standardization could be challenging, particularly if the aim is to avoid disruption. However, CMS could use information contained in the bids about actuarial values to assign plans to tiers, based on their characteristics or the generosity of their benefits. CMS also could standardize individual benefits. In another analysis, we have shown that most MA plans simplify Medicare's benefit structure for Part A/Part B benefits (Gold and Hudson 2009b). Most plans eliminate Medicare's inpatient hospital day limits and shift cost sharing toward copayments and away from deductibles and coinsurance. CMS could require that practices already in place throughout most of the industry be adopted by all, so that beneficiaries would know better which benefits are available to them.

**Standardize Plan Labels.** Firms currently decide on the names of their plans, using them in unique ways that help to brand their products. In previous work, we have shown how the same names can be attached to different products within the same market and how that could result in confusion for beneficiaries (Gold 2009). CMS will begin to address this issue in 2010 by requiring that standardized plan type terminology be applied to the names of each plan (see Appendix A-5). However, while such labeling should clarify plan type, it will provide little guidance to beneficiaries seeking to assess the trade-offs between plans of the same type. In other markets, standardized benefits may be used to allow plans to be described as "gold," "silver," and "bronze." Such standardized labels will be more difficult to apply in MA as long as benefits remain unstandardized. Using the bid data however, CMS could enhance labeling to better support beneficiary choice. For example, when firms offer two plans in the same market, one could be labeled "basic" and the other "enhanced," based on their actuarial value. CMS also might apply bid data in other ways to enhance beneficiaries' understanding of the actuarial value of plans and the protection this provides against both anticipated and unanticipated large expenses.

**Standardize Rules Across Plan Types on Part D Offerings.** Increasingly, Congress is requiring that PFFS and coordinated care plans meet the same requirements. This standardization could be extended to rules about Part D offerings. Coordinated care plans are required to offer at least one MA-PD option; their enrollees who want Part D must purchase it from those plans. The MA-only option exists mainly to meet the preferences of enrollees who do not want Part D, either because they have other sources for these

[9] However, borders exist whenever any distinctions are made across areas, so the issue of unequal treatment would remain, although the geography would change and differences might become less noticeable.

benefits, or for other reasons. PFFS plans originally were exempted from the requirement to offer a prescription drug plan because their capacity to do this was unclear. However, most firms in the PFFS market offer MA-PDs along with their MA plans, and the largest PFFS sponsors offer a nationwide PDP. They should thus be positioned to provide an MA-PD.

Imposing a consistent Part D requirement would simplify choice for beneficiaries and also reduce the number of plans and the potential for gaming the system. PFFS plans account for 273 of the 700 MA-only plans offered (data not shown).[10] Some firms are much more likely to emphasize MA-only PFFS plans than others.[11] Standardizing rules across coordinated care plans and PFFS would level the playing field.

## CONCLUSIONS

MA today has evolved into a complex program that gives beneficiaries a greater number of and more complex choices than virtually all other insurance programs. Despite the proliferation of choice, diverse plan options, and many competitors, enrollment in MA still is concentrated disproportionately in a limited number of firms, contracts, and plans. The issue for policymakers is what purpose is served by providing such an extensive set of choices. This is particularly true when there is evidence of at least as many adverse as positive effects on beneficiary choice, decision quality, and satisfaction with those choices. Managing choice is administratively burdensome for government, increases the risk of the industry gaming and discrimination, and adds to firm and Medicare costs by limiting savings from economies of scale.

Our analysis shows that eliminating low-enrollment plans, as CMS has proposed, has some potential to simplify choice for beneficiaries. However, even if this occurs, the remaining MA market still would be very complicated. The types of contracts authorized in MA, and how their plans are presented to beneficiaries, drive the number contracts and plans to be reviewed. For this reason, actions that reduce contract types would better align Medicare with the structure of private plan choice and simplify decision making for beneficiaries. Standardizing the way plans are structured and presented to beneficiaries through standardized service areas, benefits, labels, and requirements could further increase the clarity and quality of choice for beneficiaries.

[10] Among MA-only PFFS plans, 36 percent have fewer than 10 enrollees and another 18 percent have between 11 and 99 enrollees.

[11] Among national firms, MA-PDs are least common for Wellcare (23 percent of 64 PFFS plans), HealthNet (32 percent of 62 PFFS plans), and Coventry (41 percent of 17 PFFS plans). In contrast, MA-PDs make up 99 percent of market leader Humana's 173 PFFS plans). MA-PD offerings typically have been attractive to sponsors because they simplify beneficiary choice and can generate attractive benefit plans, since sponsors can use savings resulting from Part A/B payment rates to offset the costs of prescription drugs, whereas freestanding PDPs cannot. Freestanding PDPs do benefit, however, from the ability to share risk with the government, whereas MA-PDs do not.

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# APPENDIX A

# METHODS AND ADDITIONAL TABLES

### Methods and Data Sources

This analysis focused on firms, the traditional unit of concern in monitoring a market's competitiveness for purposes of antitrust enforcement. Operationally, we defined what constitutes a firm using the CMS's data on "parent organization," with some adjustments for common parent ownership or affiliation (e.g., Blue Cross and Blue Shield members). We supplemented our descriptive analysis with calculations employing the traditional Herfindahl-Hirschman Index (HHI), defining markets on the basis of standardized Metropolitan Statistical Areas (MSAs), for economic purposes, and nationally, because MA policy is set at the federal level. Firms also are relevant units of study because some features of MA may be set at the firm level, such as their general preferences with respect to network construction, provider payment, product design, quality improvement, and electronic infrastructure.

Our analysis of the effects of various options for simplifying the MA market focused on the effects on choice for beneficiaries. Under the MMA, most MA choices are defined by aggregations of counties. For this reason, we examined the effects of options on choices available to beneficiaries based on their county of residence. In these analyses, we focused solely on options available to all beneficiaries in the individual market, excluding group and SNP plans. Group plans are not relevant because the choices offered beneficiaries are circumscribed by the group sponsor, usually the former employer of the retired beneficiary. Choice among SNPs is relevant, but we excluded it here because the SNP market is a specialized one, with plans available only to certain beneficiaries, and may warrant a separate analysis. (Most SNP enrollees currently are dually eligible for Medicare and Medicaid. The specialized nature of SNPs also means that most beneficiaries cannot enroll in them, so plan enrollments also tend to be smaller.)

Our analysis used publicly available CMS data for March 2009, drawn from a number of files but primarily from a combination of the MA Contract-Plan-State-County file and the downloadable file of information on plans used to support Medicare Options Compare. The former provides information on the parent organization for each contract and plan and enrollment in each of the counties within its service area. The latter allows disaggregation of plans by counties, which have uniform benefits.

The analysis is descriptive and cross-sectional and uses 2009 data to assess the effects of various policy options. Using 2009 data provides a picture of choice as it currently exists in the marketplace. By 2009, the MA market had stabilized after the major changes that came in 2006 with the implementation of Part D. The main limitation to the analysis is its static nature. However, modeling the long-term behavioral response by firms and beneficiaries to choice, although relevant, is complex and beyond the scope of this paper. This caveat is particularly relevant now, given potential changes in the market in 2010 and beyond as the industry responds to new requirements in MIPPA and reacts to potential payment reform in MA.

**Table A.1. Percentage of Beneficiaries by Number of Sponsors Offering MA Plans by Type, 2009 (excludes group-only contracts)**

| | | | Percentage of Beneficiaries | | Excludes SNP-Only Contracts | |
|---|---|---|---|---|---|---|
| Number of Sponsors with Plans Available | Any Contract | Any MA Contract | Any CCP | Any Local CCP | Any CCP | Any Local CCP |
| 0 | 0.2% | 0.2% | 1.1% | 10.5% | 1.1% | 11.5% |
| 1 | 0.0 | 0.0 | 6.2 | 10.9 | 10.0 | 12.3 |
| 2 | 0.0 | 0.2 | 14.0 | 9.0 | 15.3 | 10.8 |
| 3 | 0.2 | 0.1 | 13.3 | 10.6 | 15.3 | 15.0 |
| 4 | 0.4 | 0.9 | 10.5 | 9.8 | 12.7 | 8.8 |
| 5 | 1.1 | 1.7 | 15.7 | 13.0 | 12.5 | 8.2 |
| 6 | 2.5 | 4.7 | 8.4 | 7.4 | 6.3 | 7.4 |
| 7 | 6.1 | 5.1 | 5.4 | 6.4 | 6.6 | 4.9 |
| 8 | 6.1 | 8.2 | 4.8 | 2.7 | 2.4 | 1.7 |
| 9 | 8.6 | 10.5 | 3.8 | 2.9 | 3.4 | 3.3 |
| 10 | 11.7 | 10.8 | 2.2 | 2.5 | 1.1 | 1.3 |
| 11-15 | 41.4 | 41.8 | 8.8 | 8.4 | 9.5 | 9.3 |
| 16-20 | 12.0 | 8.9 | 4.6 | 4.6 | 3.8 | 3.8 |
| 20+ | 9.5 | 6.9 | 1.3 | 1.3 | 0.0 | 0.0 |

Source: MPR analysis of CMS's Contract-County file for March 2009.

Note: Unique sponsors are identified based on parent affiliation.

**Table A.2. Market Share Indicators of MA Market Concentration: HHI Based on All Enrollment, 2009, Top 100 MSAs Ordered by MSA Rank in Total Population**

| MSA Name | All Enrollees | |
|---|---|---|
| | Percentage of Enrollment in Top Three Firms[a] | HHI[b] |
| New York-Northern New Jersey-Long Island, NY-NJ-PA2 | 59.5% | 1,577 |
| Los Angeles-Long Beach-Santa Ana, CA | 70.2 | 2,031 |
| Chicago-Naperville-Joliet, IL-IN-WI | 74.4 | 2,754 |
| Philadelphia-Camden-Wilmington, PA-NJ-DE | 88.3 | 3,340 |
| Dallas-Fort Worth-Arlington, TX | 88.2 | 5,589 |
| Miami-Fort Lauderdale-Miami Beach, FL | 68.6 | 3,105 |
| Washington-Arlington-Alexandria, DC-VA-MD | 68.8 | 2,476 |
| Houston-Baytown-Sugar Land, TX | 67.4 | 1,821 |
| Detroit-Warren-Livonia, MI | 95.8 | 5,270 |
| Boston-Cambridge-Quincy, MA-NH | 81.3 | 3,321 |
| Atlanta-Sandy Springs-Marietta, GA | 62.3 | 1,510 |
| San Francisco-Oakland-Fremont, CA | 89.8 | 5,026 |
| Riverside-San Bernardino-Ontario, CA | 67.3 | 1,820 |
| Phoenix-Mesa-Scottsdale, AZ | 67.3 | 1,961 |
| Seattle-Tacoma-Bellevue, WA | 82.4 | 2,590 |
| Minneapolis-St. Paul-Bloomington, MN-WI | 75.6 | 2,723 |
| San Diego-Carlsbad-San Marcos, CA | 89.7 | 3,568 |
| St. Louis, MO-IL | 80.6 | 2,484 |
| Baltimore-Towson, MD | 78.3 | 2,439 |
| Pittsburgh, PA | 90.3 | 3,846 |
| Tampa-St. Petersburg-Clearwater, FL | 78.8 | 2,481 |
| Denver-Aurora, CO | 92.0 | 3,919 |
| Cleveland-Elyria-Mentor, OH | 72.6 | 2,378 |
| Cincinnati-Middletown, OH-KY-IN | 78.2 | 2,259 |
| Portland-Vancouver-Beaverton, OR-WA | 64.5 | 1,802 |
| Kansas City, MO-KS | 93.4 | 4,103 |
| Sacramento-Arden-Arcade-Roseville, CA | 91.3 | 4,336 |
| San Jose-Sunnyvale-Santa Clara, CA | 89.7 | 4,832 |
| San Antonio, TX | 90.2 | 4,063 |
| Orlando, FL | 79.3 | 2,590 |
| Columbus, OH | 76.6 | 2,450 |
| Providence-New Bedford-Fall River, RI-MA | 88.7 | 3,701 |
| Virginia Beach-Norfolk-Newport News, VA-NC | 69.9 | 2,481 |
| Indianapolis, IN | 51.5 | 1,345 |
| Milwaukee-Waukesha-West Allis, WI | 81.5 | 2,889 |
| Las Vegas-Paradise, NV | 95.5 | 4,730 |
| Charlotte-Gastonia-Concord, NC-SC | 77.7 | 2,135 |
| New Orleans-Metairie-Kenner, LA | 99.3 | 4,849 |

**Table A.2** *(continued)*

| MSA Name | All Enrollees | |
|---|---|---|
| | Percentage of Enrollment in Top Three Firms[a] | HHI[b] |
| Nashville-Davidson-Murfreesboro, TN | 87.1 | 5,136 |
| Austin-Round Rock, TX | 73.7 | 2,163 |
| Memphis, TN-MS-AR | 67.8 | 1,791 |
| Buffalo-Niagara Falls, NY | 93.3 | 3,212 |
| Louisville, KY-IN | 76.5 | 2,207 |
| Hartford-West Hartford-East Hartford, CT | 75.9 | 2,640 |
| Jacksonville, FL | 86.4 | 4,079 |
| Richmond, VA | 65.5 | 2,194 |
| Oklahoma City, OK | 88.1 | 3,244 |
| Birmingham-Hoover, AL | 82.1 | 2,589 |
| Rochester, NY | 96.6 | 5,388 |
| Salt Lake City, UT | 71.6 | 1,889 |
| Bridgeport-Stamford-Norwalk, CT | 88.5 | 6,064 |
| Honolulu, HI | 86.2 | 3,412 |
| Tulsa, OK | 80.9 | 4,095 |
| Dayton, OH | 80.8 | 2,560 |
| Tucson, AZ | 92.1 | 4,326 |
| Albany-Schenectady-Troy, NY | 79.9 | 2,961 |
| New Haven-Milford, CT | 85.0 | 4,167 |
| Fresno, CA | 82.2 | 3,211 |
| Raleigh-Cary, NC | 79.8 | 2,704 |
| Omaha-Council Bluffs, NE-IA | 86.6 | 4,266 |
| Oxnard-Thousand Oaks-Ventura, CA | 84.3 | 2,892 |
| Worcester, MA | 91.8 | 4,442 |
| Grand Rapids-Wyoming, MI | 86.4 | 4,188 |
| Allentown-Bethlehem-Easton, PA-NJ | 59.2 | 1,694 |
| Albuquerque, NM | 94.7 | 4,249 |
| Baton Rouge, LA | 94.1 | 4,888 |
| Akron, OH | 74.9 | 2,240 |
| Springfield, MA | 88.4 | 3,690 |
| El Paso, TX | 70.1 | 1,962 |
| Bakersfield, CA | 67.7 | 2,057 |
| Toledo, OH | 84.6 | 3,521 |
| Syracuse, NY | 71.7 | 1,985 |
| Columbia, SC | 61.1 | 1,744 |
| Greensboro-High Point, NC | 86.5 | 3,804 |
| Poughkeepsie-Newburgh-Middletown, NY | 61.7 | 1,588 |
| Knoxville, TN | 96.7 | 6,512 |
| Little Rock-North Little Rock, AR | 67.5 | 1,672 |
| Youngstown-Warren-Boardman, OH-PA | 70.4 | 2,258 |

**Table A.2** *(continued)*

| MSA Name | All Enrollees | |
|---|---|---|
| | Percentage of Enrollment in Top Three Firms[a] | HHI[b] |
| Sarasota-Bradenton-Venice, FL | 67.2 | 1,697 |
| Wichita, KS | 97.5 | 4,177 |
| McAllen-Edinburg-Pharr, TX | 88.6 | 2,998 |
| Stockton, CA | 80.5 | 3,820 |
| Scranton-Wilkes-Barre, PA | 73.6 | 2,392 |
| Greenville, SC | 50.0 | 1,461 |
| Charleston-North Charleston, SC | 51.5 | 1,292 |
| Colorado Springs, CO | 93.3 | 5,919 |
| Harrisburg-Carlisle, PA | 74.4 | 2,115 |
| Madison, WI | 68.4 | 1,955 |
| Augusta-Richmond County, GA-SC | 62.0 | 1,699 |
| Jackson, MS | 79.2 | 2,562 |
| Portland-South Portland, ME | 57.9 | 1,530 |
| Lakeland-Winter Haven, FL | 62.1 | 1,634 |
| Des Moines, IA | 84.6 | 2,546 |
| Chattanooga, TN-GA | 77.9 | 2,192 |
| Palm Bay-Melbourne-Titusville, FL | 89.3 | 5,090 |
| Lancaster, PA | 52.1 | 1,329 |
| Boise City-Nampa, ID | 85.4 | 3,786 |
| Santa Rosa-Petaluma, CA | 96.4 | 7,641 |
| Lansing-East Lansing, MI | 97.5 | 8,658 |
| Modesto, CA | 93.7 | 4,622 |

Source: MPR analysis of CMS data on enrollment by contract-plan-county, March 2009.

Note: Includes enrollment in all MA plans in the group and individual market (including SNPs).

[a]Based on the firms with the highest enrollment in that market, so the specific firms may differ across MSAs.

[b]The Herfindahl-Hirschman Index (HHI) is the standard index used in federal antitrust work. It is constructed by adding the squares of the market share of individual firms to assess the level of market concentration. Markets with an HHI above 1,800 are viewed as highly concentrated and subject to increased scouting. The maximum HHI is 10,000.

**Table A.3. Selected Indicators of MA Market Concentration: All MA Enrollees, 2009; All MSAs, Alphabetical by Name, 2009**

| MSA Name | Percentage of Enrollment in Top Three Firms[a] | HHI[b] | Percentage of National Enrollment |
|---|---|---|---|
| Abilene, TX | 75.1% | 2,658 | 0.023% |
| Akron, OH | 74.9 | 2,240 | 0.412 |
| Albany, GA | 73.1 | 1,977 | 0.028 |
| Albany-Schenectady-Troy, NY | 80.0 | 2,961 | 0.484 |
| Albuquerque, NM | 94.7 | 4,249 | 0.567 |
| Alexandria, LA | 65.6 | 2,035 | 0.024 |
| Allentown-Bethlehem-Easton, PA-NJ | 59.2 | 1,694 | 0.310 |
| Altoona, PA | 89.5 | 4,812 | 0.142 |
| Amarillo, TX | 88.2 | 3,858 | 0.033 |
| Ames, IA | 87.4 | 4,240 | 0.009 |
| Anchorage, AK | 90.8 | 3,863 | 0.003 |
| Anderson, IN | 73.9 | 2,253 | 0.027 |
| Anderson, SC | 53.6 | 1,593 | 0.079 |
| Ann Arbor, MI | 98.2 | 8,527 | 0.098 |
| Anniston-Oxford, AL | 97.5 | 7,419 | 0.025 |
| Appleton, WI | 82.5 | 2,590 | 0.152 |
| Asheville, NC | 74.8 | 2,306 | 0.167 |
| Athens-Clarke County, GA | 71.4 | 2,614 | 0.033 |
| Atlanta-Sandy Springs-Marietta, GA | 62.3 | 1,510 | 0.987 |
| Atlantic City, NJ | 94.4 | 6,227 | 0.043 |
| Auburn-Opelika, AL | 91.7 | 3,650 | 0.019 |
| Augusta-Richmond County, GA-SC | 62.0 | 1,699 | 0.141 |
| Austin-Round Rock, TX | 73.7 | 2,163 | 0.155 |
| Bakersfield, CA | 67.7 | 2,057 | 0.347 |
| Baltimore-Towson, MD | 78.3 | 2,439 | 0.293 |
| Bangor, ME | 76.0 | 2,298 | 0.032 |
| Barnstable Town, MA | 90.5 | 3,988 | 0.061 |
| Baton Rouge, LA | 94.1 | 4,888 | 0.367 |
| Battle Creek, MI | 98.3 | 4,331 | 0.059 |
| Bay City, MI | 97.8 | 8,149 | 0.035 |
| Beaumont-Port Arthur, TX | 90.8 | 4,248 | 0.133 |
| Bellingham, WA | 71.3 | 2,121 | 0.089 |
| Bend, OR | 93.5 | 7,355 | 0.102 |
| Billings, MT | 85.1 | 2,787 | 0.054 |
| Binghamton, NY | 74.6 | 2,339 | 0.108 |
| Birmingham-Hoover, AL | 82.1 | 2,589 | 0.760 |
| Bismarck, ND | 97.1 | 3,959 | 0.014 |
| Blacksburg-Christiansburg-Radford, VA | 90.0 | 5,062 | 0.030 |
| Bloomington, IN | 77.9 | 2,954 | 0.030 |
| Bloomington-Normal, IL | 92.9 | 4,121 | 0.034 |

**Table A.3** *(continued)*

| MSA Name | Percentage of Enrollment in Top Three Firms[a] | HHI[b] | Percentage of National Enrollment |
|---|---|---|---|
| Boise City-Nampa, ID | 85.4 | 3,786 | 0.330 |
| Boston-Cambridge-Quincy, MA-NH | 81.3 | 3,321 | 1.289 |
| Boulder, CO | 94.8 | 4,782 | 0.105 |
| Bowling Green, KY | 89.9 | 4,259 | 0.024 |
| Bremerton-Silverdale, WA | 84.3 | 4,304 | 0.064 |
| Bridgeport-Stamford-Norwalk, CT | 88.5 | 6,064 | 0.260 |
| Bristol, VA | 91.4 | 3,836 | 0.045 |
| Brownsville-Harlingen, TX | 89.4 | 4,390 | 0.079 |
| Brunswick, GA | 64.8 | 1,836 | 0.016 |
| Buffalo-Niagara Falls, NY | 93.3 | 3,212 | 1.189 |
| Burlington, NC | 76.9 | 3,020 | 0.111 |
| Burlington-South Burlington, VT | 81.0 | 2,314 | 0.006 |
| Canton-Massillon, OH | 73.8 | 3,092 | 0.339 |
| Cape Coral-Fort Myers, FL | 72.2 | 3,000 | 0.269 |
| Carson City, NV | 87.4 | 3,907 | 0.005 |
| Casper, WY | 100.0 | 8,546 | 0.003 |
| Cedar Rapids, IA | 85.0 | 3,555 | 0.097 |
| Champaign-Urbana, IL | 85.7 | 4,912 | 0.058 |
| Charleston, WV | 83.7 | 3,425 | 0.177 |
| Charleston-North Charleston, SC | 51.5 | 1,292 | 0.100 |
| Charlotte-Gastonia-Concord, NC-SC | 77.7 | 2,135 | 0.303 |
| Charlottesville, VA | 83.2 | 3,605 | 0.025 |
| Chattanooga, TN-GA | 77.9 | 2,192 | 0.165 |
| Cheyenne, WY | 97.9 | 4,426 | 0.011 |
| Chicago-Naperville-Joliet, IL-IN-WI | 74.4 | 2,754 | 0.984 |
| Chico, CA | 61.3 | 1,976 | 0.024 |
| Cincinnati-Middletown, OH-KY-IN | 78.2 | 2,259 | 0.913 |
| Clarksville, TN-KY | 74.0 | 2,211 | 0.040 |
| Cleveland, TN | 86.0 | 3,048 | 0.043 |
| Cleveland-Elyria-Mentor, OH | 72.6 | 2,378 | 0.973 |
| Coeur d'Alene, ID | 82.6 | 2,522 | 0.067 |
| College Station-Bryan, TX | 90.4 | 4,787 | 0.006 |
| Colorado Springs, CO | 93.3 | 5,919 | 0.173 |
| Columbia, MO | 78.1 | 2,353 | 0.013 |
| Columbia, SC | 61.1 | 1,744 | 0.167 |
| Columbus, GA-AL | 69.9 | 1,972 | 0.061 |
| Columbus, IN | 79.5 | 3,501 | 0.014 |
| Columbus, OH | 76.6 | 2,450 | 0.752 |
| Corpus Christi, TX | 94.8 | 3,929 | 0.236 |
| Corvallis, OR | 69.7 | 1,954 | 0.055 |
| Cumberland, MD-WV | 96.9 | 3,316 | 0.012 |
| Dallas-Fort Worth-Arlington, TX | 88.2 | 5,589 | 1.422 |
| Dalton, GA | 51.9 | 1,303 | 0.008 |
| Danville, IL | 93.7 | 5,397 | 0.042 |

**Table A.3** *(continued)*

| MSA Name | Percentage of Enrollment in Top Three Firms[a] | HHI[b] | Percentage of National Enrollment |
|---|---|---|---|
| Danville, VA | 68.7 | 2,011 | 0.053 |
| Davenport-Moline-Rock Island, IA-IL | 71.9 | 2,104 | 0.095 |
| Dayton, OH | 80.8 | 2,560 | 0.444 |
| Decatur, AL | 100.0 | 7,194 | 0.028 |
| Decatur, IL | 79.4 | 3,560 | 0.015 |
| Deltona-Daytona Beach-Ormond Beach, FL | 90.7 | 4,090 | 0.458 |
| Denver-Aurora, CO | 92.0 | 3,919 | 1.308 |
| Des Moines, IA | 84.6 | 2,546 | 0.107 |
| Detroit-Warren-Livonia, MI | 95.8 | 5,270 | 1.686 |
| Dothan, AL | 91.6 | 4,530 | 0.032 |
| Dover, DE | 82.6 | 2,428 | 0.010 |
| Dubuque, IA | 100.0 | 4,943 | 0.002 |
| Duluth, MN-WI | 74.2 | 2,269 | 0.116 |
| Durham, NC | 75.8 | 2,318 | 0.119 |
| Eau Claire, WI | 66.9 | 1,871 | 0.074 |
| El Centro, CA | 71.6 | 2,287 | 0.006 |
| El Paso, TX | 70.1 | 1,962 | 0.295 |
| Elizabethtown, KY | 82.3 | 3,191 | 0.022 |
| Elkhart-Goshen, IN | 79.6 | 2,300 | 0.050 |
| Elmira, NY | 91.8 | 4,467 | 0.038 |
| Erie, PA | 77.9 | 3,485 | 0.231 |
| Eugene-Springfield, OR | 70.6 | 2,157 | 0.297 |
| Evansville, IN-KY | 73.2 | 2,760 | 0.123 |
| Fairbanks, AK | n.a. | n.a. | n.a. |
| Fargo, ND-MN | 77.4 | 2,630 | 0.033 |
| Farmington, NM | 67.6 | 1,927 | 0.003 |
| Fayetteville, NC | 81.8 | 2,511 | 0.069 |
| Fayetteville-Springdale-Rogers, AR-MO | 63.5 | 1,722 | 0.135 |
| Flagstaff, AZ | 81.1 | 2,639 | 0.019 |
| Flint, MI | 94.7 | 5,522 | 0.172 |
| Florence, AL | 93.9 | 6,253 | 0.028 |
| Florence, SC | 83.0 | 2,916 | 0.018 |
| Fond du Lac, WI | 77.9 | 2,517 | 0.058 |
| Fort Collins-Loveland, CO | 79.4 | 2,669 | 0.095 |
| Fort Smith, AR-OK | 54.1 | 1,395 | 0.125 |
| Fort Walton Beach-Crestview-Destin, FL | 70.6 | 1,875 | 0.014 |
| Fort Wayne, IN | 61.0 | 1,711 | 0.231 |
| Fresno, CA | 82.2 | 3,211 | 0.311 |
| Gadsden, AL | 95.0 | 4,328 | 0.037 |
| Gainesville, FL | 80.0 | 2,610 | 0.022 |
| Gainesville, GA | 78.7 | 2,214 | 0.043 |
| Glens Falls, NY | 89.6 | 3,509 | 0.076 |
| Goldsboro, NC | 91.6 | 4,032 | 0.016 |

**Table A.3** *(continued)*

| MSA Name | Percentage of Enrollment in Top Three Firms[a] | HHI[b] | Percentage of National Enrollment |
|---|---|---|---|
| Grand Forks, ND-MN | 74.6 | 2,238 | 0.024 |
| Grand Junction, CO | 83.4 | 3,787 | 0.028 |
| Grand Rapids-Wyoming, MI | 86.4 | 4,188 | 0.462 |
| Great Falls, MT | 95.2 | 4,212 | 0.035 |
| Greeley, CO | 74.1 | 2,298 | 0.062 |
| Green Bay, WI | 73.1 | 2,383 | 0.160 |
| Greensboro-High Point, NC | 86.5 | 3,804 | 0.446 |
| Greenville, NC | 92.7 | 5,134 | 0.011 |
| Greenville, SC | 50.0 | 1,461 | 0.229 |
| Gulfport-Biloxi, MS | 87.6 | 2,890 | 0.029 |
| Hagerstown-Martinsburg, MD-WV | 77.6 | 2,392 | 0.034 |
| Hanford-Corcoran, CA | 77.0 | 2,735 | 0.015 |
| Harrisburg-Carlisle, PA | 74.4 | 2,115 | 0.363 |
| Harrisonburg, VA | 76.3 | 2,208 | 0.029 |
| Hartford-West Hartford-East Hartford, CT | 75.8 | 2,640 | 0.357 |
| Hattiesburg, MS | 96.0 | 5,193 | 0.017 |
| Hickory-Morganton-Lenoir, NC | 71.1 | 2,072 | 0.115 |
| Hinesville-Fort Stewart, GA | 52.5 | 1,335 | 0.006 |
| Holland-Grand Haven, MI | 89.0 | 3,935 | 0.189 |
| Honolulu, HI | 86.2 | 3,412 | 0.360 |
| Hot Springs, AR | 79.9 | 2,286 | 0.029 |
| Houma-Bayou Cane-Thibodaux, LA | 88.1 | 5,684 | 0.056 |
| Houston-Baytown-Sugar Land, TX | 67.4 | 1,821 | 1.457 |
| Huntington-Ashland, WV-KY-OH | 73.5 | 2,293 | 0.122 |
| Huntsville, AL | 86.3 | 3,297 | 0.071 |
| Idaho Falls, ID | 70.7 | 2,302 | 0.024 |
| Indianapolis, IN | 51.5 | 1,345 | 0.310 |
| Iowa City, IA | 73.2 | 2,644 | 0.019 |
| Ithaca, NY | 85.9 | 3,147 | 0.014 |
| Jackson, MI | 96.6 | 7,110 | 0.076 |
| Jackson, MS | 79.2 | 2,562 | 0.136 |
| Jackson, TN | 69.4 | 1,976 | 0.012 |
| Jacksonville, FL | 86.4 | 4,079 | 0.330 |
| Jacksonville, NC | 86.3 | 3,375 | 0.006 |
| Janesville, WI | 82.9 | 2,755 | 0.020 |
| Jefferson City, MO | 79.4 | 2,923 | 0.020 |
| Johnson City, TN | 90.0 | 3,612 | 0.121 |
| Johnstown, PA | 94.1 | 5,553 | 0.199 |
| Jonesboro, AR | 65.7 | 2,176 | 0.020 |
| Joplin, MO | 83.5 | 2,678 | 0.038 |
| Kalamazoo-Portage, MI | 94.9 | 5,522 | 0.148 |
| Kankakee-Bradley, IL | 87.2 | 2,660 | 0.005 |
| Kansas City, MO-KS | 93.4 | 4,103 | 0.708 |
| Kennewick-Richland-Pasco, WA | 83.7 | 3,510 | 0.047 |

**Table A.3** *(continued)*

| MSA Name | Percentage of Enrollment in Top Three Firms[a] | HHI[b] | Percentage of National Enrollment |
|---|---|---|---|
| Killeen-Temple-Fort Hood, TX | 68.7 | 2,093 | 0.010 |
| Kingsport-Bristol, TN-VA | 82.4 | 3,499 | 0.279 |
| Kingston, NY | 68.1 | 2,385 | 0.042 |
| Knoxville, TN | 96.7 | 6,512 | 0.415 |
| Kokomo, IN | 91.1 | 3,541 | 0.007 |
| La Crosse, WI-MN | 79.6 | 4,276 | 0.091 |
| Lafayette, IN | 93.0 | 4,404 | 0.034 |
| Lafayette, LA | 75.5 | 2,946 | 0.026 |
| Lake Charles, LA | 63.5 | 1,575 | 0.034 |
| Lakeland-Winter Haven, FL | 62.1 | 1,634 | 0.387 |
| Lancaster, PA | 52.1 | 1,329 | 0.276 |
| Lansing-East Lansing, MI | 97.5 | 8,658 | 0.239 |
| Laredo, TX | 74.0 | 2,222 | 0.014 |
| Las Cruces, NM | 80.9 | 2,573 | 0.056 |
| Las Vegas-Paradise, NV | 95.5 | 4,730 | 0.913 |
| Lawrence, KS | 98.0 | 4,348 | 0.008 |
| Lawton, OK | 95.1 | 5,763 | 0.013 |
| Lebanon, PA | 69.6 | 2,404 | 0.085 |
| Lewiston, ID-WA | 94.7 | 4,258 | 0.032 |
| Lewiston-Auburn, ME | 84.7 | 2,921 | 0.024 |
| Lexington-Fayette, KY | 85.3 | 5,009 | 0.131 |
| Lima, OH | 86.2 | 3,109 | 0.027 |
| Lincoln, NE | 76.3 | 2,234 | 0.036 |
| Little Rock-North Little Rock, AR | 67.5 | 1,672 | 0.110 |
| Logan, UT-ID | 70.1 | 1,940 | 0.044 |
| Longview, TX | 59.6 | 1,510 | 0.048 |
| Longview-Kelso, WA | 94.5 | 4,603 | 0.085 |
| Los Angeles-Long Beach-Santa Ana, CA | 70.2 | 2,031 | 6.276 |
| Louisville, KY-IN | 76.5 | 2,207 | 0.411 |
| Lubbock, TX | 81.3 | 2,415 | 0.041 |
| Lynchburg, VA | 70.6 | 2,071 | 0.083 |
| Macon, GA | 59.9 | 1,561 | 0.067 |
| Madera, CA | 85.0 | 4,376 | 0.064 |
| Madison, WI | 68.4 | 1,955 | 0.068 |
| Manchester-Nashua, NH | 81.3 | 3,315 | 0.051 |
| Mansfield, OH | 84.6 | 2,852 | 0.029 |
| McAllen-Edinburg-Pharr, TX | 88.6 | 2,998 | 0.076 |
| Medford, OR | 90.0 | 4,048 | 0.131 |
| Memphis, TN-MS-AR | 67.8 | 1,791 | 0.282 |
| Merced, CA | 62.1 | 1,694 | 0.016 |
| Miami-Fort Lauderdale-Miami Beach, FL | 68.6 | 3,105 | 4.073 |
| Michigan City-La Porte, IN | 79.1 | 2,449 | 0.011 |
| Midland, TX | 67.7 | 1,953 | 0.014 |

**Table A.3** *(continued)*

| MSA Name | Percentage of Enrollment in Top Three Firms[a] | HHI[b] | Percentage of National Enrollment |
|---|---|---|---|
| Milwaukee-Waukesha-West Allis, WI | 81.5 | 2,889 | 0.613 |
| Minneapolis-St. Paul-Bloomington, MN-WI | 75.6 | 2,723 | 1.276 |
| Missoula, MT | 93.6 | 3,488 | 0.031 |
| Mobile, AL | 98.0 | 3,406 | 0.268 |
| Modesto, CA | 93.7 | 4,622 | 0.282 |
| Monroe, LA | 81.7 | 2,827 | 0.032 |
| Monroe, MI | 85.6 | 3,724 | 0.055 |
| Montgomery, AL | 82.3 | 2,503 | 0.183 |
| Morgantown, WV | 95.8 | 6,888 | 0.035 |
| Morristown, TN | 98.4 | 4,429 | 0.078 |
| Mount Vernon-Anacortes, WA | 87.9 | 3,386 | 0.059 |
| Muncie, IN | 69.2 | 2,043 | 0.017 |
| Muskegon-Norton Shores, MI | 85.5 | 3,603 | 0.105 |
| Myrtle Beach-Conway-North Myrtle Beach, SC | 56.8 | 1,344 | 0.053 |
| Napa, CA | 95.9 | 7,615 | 0.086 |
| Naples-Marco Island, FL | 69.5 | 1,999 | 0.065 |
| Nashville-Davidson-Murfreesboro, TN | 87.1 | 5,136 | 0.617 |
| New Haven-Milford, CT | 85.0 | 4,167 | 0.300 |
| New Orleans-Metairie-Kenner, LA | 99.3 | 4,849 | 0.783 |
| New York-Northern New Jersey-Long Island, NY-NJ-PA | 59.5 | 1,577 | 6.364 |
| Niles-Benton Harbor, MI | 97.4 | 6,354 | 0.062 |
| Norwich-New London, CT | 94.4 | 5,127 | 0.042 |
| Ocala, FL | 68.9 | 2,003 | 0.221 |
| Ocean City, NJ | 91.2 | 4,895 | 0.026 |
| Odessa, TX | 78.1 | 2,353 | 0.014 |
| Ogden-Clearfield, UT | 70.5 | 1,828 | 0.172 |
| Oklahoma City, OK | 88.1 | 3,244 | 0.422 |
| Olympia, WA | 80.2 | 3,224 | 0.127 |
| Omaha-Council Bluffs, NE-IA | 86.6 | 4,266 | 0.198 |
| Orlando, FL | 79.3 | 2,590 | 0.783 |
| Oshkosh-Neenah, WI | 81.4 | 2,939 | 0.112 |
| Owensboro, KY | 93.8 | 5,528 | 0.021 |
| Oxnard-Thousand Oaks-Ventura, CA | 84.3 | 2,892 | 0.302 |
| Palm Bay-Melbourne-Titusville, FL | 89.3 | 5,090 | 0.366 |
| Panama City-Lynn Haven, FL | 77.3 | 2,544 | 0.015 |
| Parkersburg-Marietta, WV-OH | 88.6 | 3,649 | 0.048 |
| Pascagoula, MS | 72.4 | 2,213 | 0.026 |
| Pensacola-Ferry Pass-Brent, FL | 80.7 | 2,839 | 0.141 |
| Peoria, IL | 79.7 | 4,400 | 0.118 |
| Philadelphia-Camden-Wilmington, PA-NJ-DE | 88.3 | 3,340 | 3.252 |
| Phoenix-Mesa-Scottsdale, AZ | 67.3 | 1,961 | 2.473 |
| Pine Bluff, AR | 82.6 | 3,189 | 0.030 |
| Pittsburgh, PA | 90.3 | 3,846 | 3.185 |
| Pittsfield, MA | 62.5 | 1,755 | 0.002 |

**Table A.3** *(continued)*

| MSA Name | Percentage of Enrollment in Top Three Firms[a] | HHI[b] | Percentage of National Enrollment |
|---|---|---|---|
| Pocatello, ID | 79.1 | 2,207 | 0.035 |
| Port St. Lucie-Fort Pierce, FL | 72.0 | 2,227 | 0.195 |
| Portland-South Portland, ME | 57.9 | 1,530 | 0.105 |
| Portland-Vancouver-Beaverton, OR-WA | 64.5 | 1,802 | 1.596 |
| Poughkeepsie-Newburgh-Middletown, NY | 61.7 | 1,588 | 0.086 |
| Prescott, AZ | 73.0 | 2,236 | 0.115 |
| Providence-New Bedford-Fall River, RI-MA | 88.7 | 3,701 | 0.875 |
| Provo-Orem, UT | 74.1 | 1,961 | 0.152 |
| Pueblo, CO | 93.0 | 6,550 | 0.065 |
| Punta Gorda, FL | 80.1 | 2,958 | 0.100 |
| Racine, WI | 82.0 | 2,433 | 0.078 |
| Raleigh-Cary, NC | 79.8 | 2,704 | 0.208 |
| Rapid City, SD | 86.7 | 3,630 | 0.025 |
| Reading, PA | 63.4 | 1,854 | 0.239 |
| Redding, CA | 63.8 | 1,765 | 0.029 |
| Reno-Sparks, NV | 91.2 | 3,911 | 0.152 |
| Richmond, VA | 65.5 | 2,194 | 0.268 |
| Riverside-San Bernardino-Ontario, CA | 67.3 | 1,820 | 2.422 |
| Roanoke, VA | 66.4 | 1,833 | 0.090 |
| Rochester, MN | 79.7 | 2,380 | 0.061 |
| Rochester, NY | 96.6 | 5,388 | 1.076 |
| Rockford, IL | 85.9 | 2,824 | 0.133 |
| Rocky Mount, NC | 94.1 | 4,910 | 0.019 |
| Rome, GA | 70.1 | 1,981 | 0.012 |
| Sacramento-Arden-Arcade-Roseville, CA | 91.3 | 4,337 | 1.344 |
| Saginaw-Saginaw Township North, MI | 93.5 | 7,132 | 0.068 |
| Salem, OR | 66.0 | 1,917 | 0.365 |
| Salinas, CA | 82.3 | 2,981 | 0.013 |
| Salisbury, MD | 100.0 | 10,000 | 0.001 |
| Salt Lake City, UT | 71.6 | 1,889 | 0.387 |
| San Angelo, TX | 74.2 | 2,737 | 0.011 |
| San Antonio, TX | 90.2 | 4,066 | 0.848 |
| San Diego-Carlsbad-San Marcos, CA | 89.7 | 3,568 | 1.717 |
| San Francisco-Oakland-Fremont, CA | 89.8 | 5,026 | 2.572 |
| San Jose-Sunnyvale-Santa Clara, CA | 89.7 | 4,832 | 0.859 |
| San Luis Obispo-Paso Robles, CA | 93.2 | 4,617 | 0.061 |
| Sandusky, OH | 86.2 | 3,186 | 0.018 |
| Santa Barbara-Santa Maria-Goleta, CA | 84.2 | 3,100 | 0.137 |
| Santa Cruz-Watsonville, CA | 85.3 | 3,813 | 0.057 |
| Santa Fe, NM | 83.6 | 4,547 | 0.056 |
| Santa Rosa-Petaluma, CA | 96.4 | 7,641 | 0.285 |
| Sarasota-Bradenton-Venice, FL | 67.2 | 1,697 | 0.329 |
| Savannah, GA | 55.5 | 1,442 | 0.077 |

**Table A.3** *(continued)*

| MSA Name | Percentage of Enrollment in Top Three Firms[a] | HHI[b] | Percentage of National Enrollment |
|---|---|---|---|
| Scranton-Wilkes-Barre, PA | 73.6 | 2,392 | 0.307 |
| Seattle-Tacoma-Bellevue, WA | 82.4 | 2,590 | 1.174 |
| Sheboygan, WI | 79.1 | 2,490 | 0.058 |
| Sherman-Denison, TX | 68.1 | 2,614 | 0.014 |
| Shreveport-Bossier City, LA | 89.4 | 5,032 | 0.097 |
| Sioux City, IA-NE-SD | 83.8 | 3,172 | 0.050 |
| Sioux Falls, SD | 81.6 | 4,206 | 0.027 |
| South Bend-Mishawaka, IN-MI | 61.6 | 1,645 | 0.109 |
| Spartanburg, SC | 48.4 | 1,220 | 0.140 |
| Spokane, WA | 70.7 | 1,899 | 0.165 |
| Springfield, IL | 76.8 | 3,114 | 0.020 |
| Springfield, MA | 88.4 | 3,690 | 0.241 |
| Springfield, MO | 77.4 | 2,177 | 0.275 |
| Springfield, OH | 88.7 | 3,435 | 0.102 |
| St. Cloud, MN | 61.6 | 1,807 | 0.075 |
| St. George, UT | 79.3 | 3,003 | 0.070 |
| St. Joseph, MO-KS | 89.8 | 4,110 | 0.010 |
| St. Louis, MO-IL | 80.6 | 2,484 | 1.237 |
| State College, PA | 83.3 | 3,139 | 0.089 |
| Stockton, CA | 80.5 | 3,820 | 0.256 |
| Sumter, SC | 78.8 | 2,239 | 0.027 |
| Syracuse, NY | 71.7 | 1,985 | 0.218 |
| Tallahassee, FL | 88.6 | 5,410 | 0.143 |
| Tampa-St. Petersburg-Clearwater, FL | 78.8 | 2,481 | 2.144 |
| Terre Haute, IN | 92.9 | 3,519 | 0.011 |
| Texarkana, TX-Texarkana, AR | 74.3 | 2,468 | 0.027 |
| Toledo, OH | 84.6 | 3,521 | 0.294 |
| Topeka, KS | 92.5 | 3,993 | 0.012 |
| Trenton-Ewing, NJ | 96.7 | 3,515 | 0.071 |
| Tucson, AZ | 92.1 | 4,326 | 0.764 |
| Tulsa, OK | 80.9 | 4,095 | 0.486 |
| Tuscaloosa, AL | 96.1 | 5,323 | 0.055 |
| Tyler, TX | 56.2 | 1,395 | 0.038 |
| Utica-Rome, NY | 82.6 | 2,911 | 0.141 |
| Valdosta, GA | 73.9 | 2,063 | 0.009 |
| Vallejo-Fairfield, CA | 92.4 | 6,355 | 0.238 |
| Vero Beach, FL | 61.2 | 1,734 | 0.044 |
| Victoria, TX | 87.0 | 4,294 | 0.010 |
| Vineland-Millville-Bridgeton, NJ | 99.2 | 5,169 | 0.031 |
| Virginia Beach-Norfolk-Newport News, VA-NC | 69.9 | 2,481 | 0.283 |
| Visalia-Porterville, CA | 71.0 | 2,019 | 0.060 |
| Waco, TX | 76.1 | 2,287 | 0.036 |
| Warner Robins, GA | 62.9 | 1,930 | 0.012 |
| Washington-Arlington-Alexandria, DC-VA-MD | 68.8 | 2,476 | 0.387 |

**Table A.3** *(continued)*

| MSA Name | Percentage of Enrollment in Top Three Firms[a] | HHI[b] | Percentage of National Enrollment |
|---|---|---|---|
| Waterloo-Cedar Falls, IA | 90.9 | 3,650 | 0.042 |
| Wausau, WI | 91.9 | 4,700 | 0.082 |
| Weirton-Steubenville, WV-OH | 77.4 | 2,753 | 0.092 |
| Wenatchee, WA | 88.2 | 3,943 | 0.033 |
| Wheeling, WV-OH | 86.0 | 3,866 | 0.136 |
| Wichita Falls, TX | 74.9 | 2,150 | 0.007 |
| Wichita, KS | 97.5 | 4,177 | 0.118 |
| Williamsport, PA | 58.0 | 1,576 | 0.068 |
| Wilmington, NC | 82.6 | 3,984 | 0.062 |
| Winchester, VA-WV | 77.6 | 2,225 | 0.020 |
| Winston-Salem, NC | 94.2 | 4,267 | 0.386 |
| Worcester, MA | 91.8 | 4,442 | 0.499 |
| Yakima, WA | 57.0 | 1,646 | 0.059 |
| York-Hanover, PA | 62.7 | 1,612 | 0.210 |
| Youngstown-Warren-Boardman, OH-PA | 70.4 | 2,258 | 0.452 |
| Yuba City-Marysville, CA | 71.7 | 2,389 | 0.016 |
| Yuma, AZ | 78.6 | 3,884 | 0.044 |

Source: MPR analysis of CMS data on enrollment by contract-plan-county, March 2009.

Note: Includes enrollments all MA plans in the group and individual market (including SNPs).

n.a. = not applicable / no MA.

[a]The three firms chosen have the highest market share in that MSA and are not necessarily the same across markets.

[b]HHI is the standard index used in federal antitrust work. It is constructed by adding the squares of the market share of individual firms to assess the level of market concentration. Markets with an HHI above 1,800 are viewed as highly concentrated and subject to increased scouting. The maximum HHI is 10,000.

**Table A.4. Percentage of Beneficiaries by Number of MA Contracts Available by Type, 2009 (excludes group-only contracts)**

| | Percentage of Beneficiaries | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Number of Contracts Offered | Any Private Plan Contract | Any MA Contract | Any MA Except SNP-Only | HMO | Local PPO or POS[a] | PFFS | RPPO [a] | MSA |
| 0 | 0.2% | 0.2% | 0.2% | 17.6% | 31.2% | 0.2% | 9.1% | 31.9% |
| 1 | 0.0 | 0.0 | 0.0 | 13.4 | 21.9 | 1.0 | 74.1 | 64.3 |
| 2 | 0.0 | 0.1 | 0.2 | 11.0 | 16.1 | 2.0 | 16.8 | 3.9 |
| 3 | 0.1 | 0.1 | 0.0 | 14.0 | 13.0 | 4.5 | 0.0 | 0.0 |
| 4 | 0.1 | 0.2 | 0.2 | 10.3 | 10.7 | 7.5 | 0.0 | 0.0 |
| 5 | 0.4 | 0.6 | 1.0 | 7.3 | 4.5 | 5.9 | 0.0 | 0.0 |
| 6 | 0.9 | 1.3 | 1.5 | 6.3 | 1.6 | 3.5 | 0.0 | 0.0 |
| 7 | 1.2 | 1.6 | 2.1 | 3.4 | 0.7 | 6.1 | 0.0 | 0.0 |
| 8 | 1.5 | 1.8 | 2.3 | 2.3 | 0.4 | 14.7 | 0.0 | 0.0 |
| 9 | 2.6 | 3.0 | 4.5 | 1.1 | 0.0 | 14.8 | 0.0 | 0.0 |
| 10 | 3.5 | 4.8 | 5.5 | 0.9 | 0.0 | 13.5 | 0.0 | 0.0 |
| 11-15 | 29.7 | 29.9 | 31.5 | 6.8 | 0.0 | 26.2 | 0.0 | 0.0 |
| 16-20 | 21.6 | 21.5 | 22.7 | 4.3 | 0.0 | 0.0 | 0.0 | 0.0 |
| Over 20 | 38.1 | 35.0 | 28.4 | 1.3 | 0.0 | 0.0 | 0.0 | 0.0 |

Source: MPR analysis of CMS's Contract-County enrollment file.

[a]Excludes contracts of this type with SNP plans only. PFFS and MSAs cannot offer SNPs.

**Table A.5. CMS's Standardized Plan Type Terminology for Active HPMS Plans**

| Plan Type | Plan Name with Standardized Plan Type Label | Note on Availability/Authority |
|---|---|---|
| HMO | Plan name (HMO) | |
| PPO | Plan name (PPO) | |
| HMO-POS | Plan name (HMO-POS) | |
| ESRD II | Plan name (HMO-POS) | Specialized |
| PSO | Plan name (PSO) | |
| MSA | Plan name (MSA) | |
| MSA demo | Plan name (MSA) | |
| RFB PFFS | Plan name (PFFS) | Specialized |
| PFFS | Plan name (PFFS) | |
| 1876 cost | Plan name (cost) | Authorized separately from MA |
| 1833 cost | Plan name (cost) | Authorized separately from MA |
| PACE | Plan name (PACE) | Authorized separately from MA |
| PDP | Plan name (PDP) | Part D only |
| Regional PPO | Plan name (regional PPO) | |
| Employer PDP | Plan name (employer PDP) | Specialized, Part D only |
| Employer PFFS | Plan name (employer PFFS) | Specialized |
| RFB HMO | Plan name (HMO) | Specialized |
| RFB HMO-POS | Plan name (HMO-POS) | Specialized |
| RFB local PPO | Plan name (PPO) | Specialized |
| RFB PSO | Plan name (PSO) | Specialized |
| CCRC | Plan name (HMO-POS) | Specialized |

Source: CMS 2010 call letter, exhibit on pp. 90-91 (annotation added by MPR).

Note: HPMS refers to CMS's Health Plan Management System; RFB refers to religious fraternal benefit plans.

**Table A.6. Percentage of Beneficiaries by Number of MA Plans Available by Type**

| Number of Plans Offered in County | Percentage of Beneficiaries | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Any Private Plan | Any MA Contract | Any MA Except SNP-Only | HMO | Local PPO or POS | PFFS | RPPO | MSA |
| **All MA Plans** | | | | | | | | |
| 0 | 0.2% | 0.2% | 0.2% | 17.9% | 31.8% | 0.2% | 9.1% | 31.9% |
| 1 | 0.0 | 0.0 | 0.0 | 3.5 | 6.5 | 0.0 | 19.3 | 64.3 |
| 2 | 0.0 | 0.0 | 0.0 | 3.1 | 13.0 | 0.0 | 41.1 | 3.9 |
| 3-5 | 0.0 | 0.0 | 0.0 | 14.8 | 24.5 | 2.4 | 30.5 | 0.0 |
| 6-10 | 0.3 | 0.3 | 0.3 | 18.3 | 18.7 | 5.0 | 0.0 | 0.0 |
| 11-15 | 0.3 | 0.7 | 0.9 | 13.3 | 4.5 | 9.5 | 0.0 | 0.0 |
| 16-19 | 1.4 | 1.7 | 2.7 | 8.4 | 0.9 | 10.5 | 0.0 | 0.0 |
| 20-29 | 8.8 | 10.6 | 13.4 | 10.1 | 0.2 | 39.6 | 0.0 | 0.0 |
| 30-39 | 16.6 | 19.8 | 28.4 | 5.2 | 0.0 | 27.1 | 0.0 | 0.0 |
| 40-49 | 24.3 | 22.7 | 24.9 | 3.6 | 0.0 | 5.5 | 0.0 | 0.0 |
| 50-59 | 14.8 | 13.6 | 13.6 | 2.0 | 0.0 | 0.2 | 0.0 | 0.0 |
| 60-69 | 12.4 | 14.1 | 7.2 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 70+ | 20.9 | 16.3 | 8.4 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **MA-PD Plans Only** | | | | | | | | |
| 0 | 0.2% | 0.2% | 0.2% | 17.9% | 31.8% | 0.2% | 9.1% | 100.0% |
| 1 | 0.0 | 0.0 | 0.0 | 5.0 | 7.3 | 0.0 | 57.6 | 0.0 |
| 2 | 0.0 | 0.0 | 0.0 | 5.2 | 15.0 | 2.7 | 25.6 | 0.0 |
| 3-5 | 0.3 | 0.3 | 0.3 | 19.3 | 29.9 | 4.0 | 7.8 | 0.0 |
| 6-10 | 1.9 | 2.5 | 2.5 | 18.7 | 14.6 | 21.8 | 0.0 | 0.0 |
| 11-15 | 11.2 | 14.5 | 14.5 | 15.4 | 1.8 | 45.3 | 0.0 | 0.0 |
| 16-19 | 15.4 | 17.0 | 17.0 | 6.0 | 0.2 | 20.3 | 0.0 | 0.0 |
| 20-29 | 36.6 | 33.6 | 33.6 | 6.6 | 0.0 | 5.7 | 0.0 | 0.0 |
| 30-39 | 22.3 | 20.4 | 20.4 | 4.7 | 0.0 | 0.0 | 0.0 | 0.0 |
| 40-49 | 5.8 | 5.4 | 5.4 | 1.3 | 0.0 | 0.0 | 0.0 | 0.0 |
| 50-59 | 5.1 | 4.8 | 4.8 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 60-69 | 1.3 | 1.3 | 1.3 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 70+ | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**Table A.6** *(continued)*

| Number of Plans Offered in County | Percentage of Beneficiaries | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Any Private Plan | Any MA Contract | Any MA Except SNP-Only | HMO | Local PPO or POS | PFFS | RPPO | MSA |
| **MA-Only Plans** | | | | | | | | |
| 0 | 0.2% | 0.2% | 0.2% | 25.8% | 61.8% | 0.2% | 31.2% | 31.9% |
| 1 | 0.0 | 0.0 | 0.0 | 17.3 | 23.7 | 1.4 | 61.7 | 64.3 |
| 2 | 0.0 | 0.0 | 0.0 | 15.6 | 8.4 | 2.4 | 7.1 | 3.9 |
| 3-5 | 0.5 | 0.8 | 1.1 | 24.9 | 4.1 | 5.4 | 0.0 | 0.0 |
| 6-10 | 3.6 | 3.9 | 11.5 | 11.4 | 0.1 | 26.9 | 0.0 | 0.0 |
| 11-15 | 10.3 | 14.1 | 26.3 | 4.9 | 0.0 | 35.0 | 0.0 | 0.0 |
| 16-19 | 14.8 | 14.3 | 22.6 | 0.0 | 0.0 | 18.9 | 0.0 | 0.0 |
| 20-29 | 36.0 | 36.0 | 36.3 | 0.0 | 0.0 | 9.7 | 0.0 | 0.0 |
| 30-39 | 23.3 | 19.5 | 1.9 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 40-49 | 5.3 | 6.7 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 50-59 | 4.3 | 2.7 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 60-69 | 1.7 | 1.8 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 70+ | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

Source: MPR analysis of CMS's Contract-Plan-County enrollment file.

Note: Plans exclude group and SNPs.

**Table A.7. Number of MA Plans by Enrollment Size and Type, United States, March 2009 (excludes SNPs and group plans)**

| Contract Enrollment Category | Number of Plans | Percentage of Plans | Number of Plans | Percentage of Plans |
|---|---|---|---|---|
| **All MA Plans** | | | | |
| All | 2,735 | 100.0% | 7,106,356 | 100.0% |
| None (or 10 or fewer) | 461 | 16.9 | 0 | 0.0 |
| 11–99 | 462 | 16.9 | 21,046 | 0.3 |
| 100–499 | 579 | 21.2 | 149,264 | 2.1 |
| 500–999 | 285 | 10.4 | 202,954 | 2.9 |
| 1,000–1,499 | 189 | 6.9 | 233,781 | 3.3 |
| 1,500–1,999 | 121 | 4.4 | 207,821 | 2.9 |
| 2,000–2,499 | 84 | 3.1 | 190,368 | 2.7 |
| 2,500–2,999 | 63 | 2.3 | 174,466 | 2.5 |
| 3,000–4,999 | 156 | 5.7 | 608,001 | 8.6 |
| 5,000–9,999 | 138 | 5.0 | 972,781 | 13.7 |
| 10,000 or more | 197 | 7.2 | 4,345,874 | 61.2 |
| **HMO Plans** | | | | |
| All | 1,449 | 100.0 | 4,601,879 | 100.0 |
| None (or 10 or fewer) | 171 | 11.8 | 0 | 0.0 |
| 11–99 | 240 | 16.6 | 10,700 | 0.2 |
| 100–499 | 312 | 21.5 | 79,538 | 1.7 |
| 500–999 | 159 | 11.0 | 113,873 | 2.5 |
| 1,000–1,499 | 105 | 7.2 | 129,823 | 2.8 |
| 1,500–1,999 | 69 | 4.8 | 119,314 | 2.6 |
| 2,000–2,499 | 40 | 2.8 | 90,140 | 2.0 |
| 2,500–2,999 | 37 | 2.6 | 102,321 | 2.2 |
| 3,000–4,999 | 91 | 6.3 | 356,069 | 7.7 |
| 5,000–9,999 | 91 | 6.3 | 624,023 | 13.6 |
| 10,000 or more | 134 | 9.2 | 2,976,078 | 64.7 |
| **Local PPO Plans** | | | | |
| All | 532 | 100.0 | 690,046 | 100.0 |
| None (or 10 or fewer) | 95 | 17.9 | 0 | 0.0 |
| 11–99 | 98 | 18.4 | 4,550 | 0.7 |
| 100–499 | 118 | 22.2 | 32,364 | 4.7 |
| 500–999 | 69 | 13.0 | 48,224 | 7.0 |
| 1,000–1,499 | 33 | 6.2 | 41,665 | 6.0 |
| 1,500–1,999 | 25 | 4.7 | 42,233 | 6.1 |
| 2,000–2,499 | 28 | 5.3 | 63,358 | 9.2 |
| 2,500–2,999 | 14 | 2.6 | 38,166 | 5.5 |
| 3,000–4,999 | 22 | 4.1 | 83,441 | 12.1 |
| 5,000–9,999 | 18 | 3.4 | 137,280 | 19.9 |
| 10,000 or more | 12 | 2.3 | 198,765 | 28.8 |

**Table A.7** *(continued)*

| Contract Enrollment Category | Number of Plans | Percentage of Plans | Number of Plans | Percentage of Plans |
|---|---|---|---|---|
| **Regional PPO Plans** | | | | |
| All | 51 | 100.0 | 291,643 | 100.0 |
| None (or 10 or fewer) | 2 | 3.9 | 0 | 0.0 |
| 11–99 | 2 | 3.9 | 34 | 0.0 |
| 100–499 | 10 | 19.7 | 2,238 | 0.8 |
| 500–999 | 5 | 9.8 | 3,236 | 1.1 |
| 1,000–1,499 | 4 | 7.8 | 5,337 | 1.8 |
| 1,500–1,999 | 3 | 5.9 | 4,665 | 1.6 |
| 2,000–2,499 | 2 | 3.9 | 4,486 | 1.5 |
| 2,500–2,999 | 2 | 3.9 | 5,935 | 2.0 |
| 3,000–4,999 | 9 | 17.6 | 34,271 | 11.8 |
| 5,000–9,999 | 3 | 5.9 | 25,657 | 8.8 |
| 10,000 or more | 9 | 17.6 | 205,784 | 70.6 |
| **PFFS Plans** | | | | |
| All | 696 | 100.0 | 1,521,083 | 100.0 |
| None (or 10 or fewer) | 190 | 27.3 | 0 | 0.0 |
| 11–99 | 121 | 17.4 | 5,732 | 0.4 |
| 100–499 | 137 | 19.7 | 34,371 | 2.3 |
| 500–999 | 51 | 7.3 | 36,699 | 2.4 |
| 1,000–1,499 | 47 | 6.8 | 56,956 | 3.7 |
| 1,500–1,999 | 24 | 3.4 | 41,609 | 2.7 |
| 2,000–2,499 | 14 | 2.0 | 32,384 | 2.1 |
| 2,500–2,999 | 10 | 1.4 | 28,044 | 1.8 |
| 3,000–4,999 | 34 | 4.9 | 134,220 | 8.8 |
| 5,000–9,999 | 26 | 3.7 | 185,821 | 12.2 |
| 10,000 or more | 42 | 6.0 | 965,247 | 63.5 |
| **MSA Plans** | | | | |
| All | 7 | 100.0 | 1,705 | 100.0 |
| None (or 10 or fewer) | 3 | 42.9 | 0 | 0.0 |
| 11–99 | 1 | 14.3 | 30 | 1.8 |
| 100–499 | 2 | 28.6 | 753 | 44.2 |
| 500–999 | 1 | 14.3 | 922 | 54.1 |
| 1,000–1,499 | 0 | 0.0 | 0 | 0.0 |
| 1,500–1,999 | 0 | 0.0 | 0 | 0.0 |
| 2,000–2,499 | 0 | 0.0 | 0 | 0.0 |
| 2,500–2,999 | 0 | 0.0 | 0 | 0.0 |
| 3,000–4,999 | 0 | 0.0 | 0 | 0.0 |
| 5,000–9,999 | 0 | 0.0 | 0 | 0.0 |
| 10,000 or more | 0 | 0.0 | 0 | 0.0 |

Source: MPR analysis of CMS's Contract-County-Enrollment file for March 2009.

Note: Contracts are for MA contracts only (excluding cost, HCPP, PACE, and demonstration contracts). With MA, the count excludes group-only and SNP-only contracts. Total enrollment includes all plans offered in contracts (including SNP and group plans of that type).

**Table A.8. Number of MA Plans by Enrollment Size and Whether Part D Coverage Is Included, United States, March 2009 (excludes SNPs and group plans)**

| Plan Type and Enrollment Category | Number of Plans | Percentage of Plans | Number of Enrollees | Percentage of Enrollees |
|---|---|---|---|---|
| **All MA Plans** | | | | |
| All | 2,735 | 100.0% | 7,106,356 | 100.0% |
| None (or 10 or fewer) | 461 | 16.9 | 0 | 0.0 |
| 11–99 | 462 | 16.9 | 21,046 | 0.3 |
| 100–499 | 579 | 21.2 | 149,264 | 2.1 |
| 500–999 | 285 | 10.4 | 202,954 | 2.9 |
| 1,000–1,499 | 189 | 6.9 | 233,781 | 3.3 |
| 1,500–1,999 | 121 | 4.4 | 207,821 | 2.9 |
| 2,000–2,499 | 84 | 3.1 | 190,368 | 2.7 |
| 2,500–2,999 | 63 | 2.3 | 174,466 | 2.5 |
| 3,000–4,999 | 156 | 5.7 | 608,001 | 8.6 |
| 5,000–9,999 | 138 | 5.0 | 972,781 | 13.7 |
| 10,000 or more | 197 | 7.2 | 4,345,874 | 61.2 |
| **MA-PD Plans** | | | | |
| All | 2,035 | 100.0 | 6,266,595 | 100.0 |
| None (or 10 or fewer) | 1,254 | 12.5 | 0 | 0.0 |
| 11–99 | 312 | 15.3 | 14,114 | 0.2 |
| 100–499 | 413 | 20.3 | 108,457 | 1.7 |
| 500–999 | 227 | 11.2 | 159,949 | 2.5 |
| 1,000–1,499 | 162 | 8.0 | 200,578 | 3.2 |
| 1,500–1,999 | 105 | 5.2 | 180,800 | 2.9 |
| 2,000–2,499 | 67 | 3.3 | 152,072 | 2.4 |
| 2,500–2,999 | 48 | 2.4 | 131,979 | 2.1 |
| 3,000–4,999 | 143 | 7.0 | 555,606 | 8.9 |
| 5,000–9,999 | 127 | 6.2 | 893,732 | 14.3 |
| 10,000 or more | 177 | 8.7 | 3,869,308 | 61.7 |
| **MA-Only Plans** | | | | |
| All | 700 | 100.0 | 839,761 | 100.0 |
| None (or 10 or fewer) | 207 | 29.6 | 0 | 0.0 |
| 11–99 | 150 | 21.4 | 6,932 | 0.8 |
| 100–499 | 166 | 23.7 | 40,807 | 4.9 |
| 500–999 | 58 | 8.3 | 43,005 | 5.1 |
| 1,000–1,499 | 27 | 3.9 | 33,203 | 4.0 |
| 1,500–1,999 | 16 | 2.3 | 27,021 | 3.2 |
| 2,000–2,499 | 17 | 2.4 | 38,296 | 4.6 |
| 2,500–2,999 | 15 | 2.1 | 42,487 | 5.1 |
| 3,000–4,999 | 13 | 1.9 | 52,395 | 6.2 |
| 5,000–9,999 | 11 | 1.6 | 79,049 | 9.4 |
| 10,000 or more | 20 | 2.9 | 476,566 | 56.8 |

Source: MPR's analysis of CMS's Contract-County-Plan enrollment file for March 2009.

Note: Includes MA plans only (excluding cost, HCPP, PACE, and demonstration plans). Group plans and SNPs are excluded.

**Table A.9. Number of MA Contracts and Enrollees by Size of Contract Enrollment, United States, March 2009**

| Contract Enrollment Category | Number of Contracts | Percentage of Contracts | Number of Enrollees | Percentage of Enrollees |
|---|---|---|---|---|
| **All MA Contracts** | | | | |
| All | 538 | 100.0% | 9,882,425 | 100.0% |
| None (or 10 or fewer) | 27 | 5.0 | 0 | 0.0 |
| 11–99 | 26 | 4.8 | 1,275 | 0.0 |
| 100–499 | 53 | 9.9 | 14,711 | 0.1 |
| 500–999 | 43 | 8.0 | 31,733 | 0.3 |
| 1,000–1,499 | 40 | 7.4 | 49,478 | 0.5 |
| 1,500–1,999 | 23 | 4.3 | 39,552 | 0.4 |
| 2,000–2,499 | 23 | 4.3 | 51,968 | 0.5 |
| 2,500–2,999 | 21 | 3.9 | 56,989 | 0.6 |
| 3,000–4,999 | 54 | 10.0 | 212,870 | 2.2 |
| 5,000–9,999 | 50 | 9.3 | 361,693 | 3.7 |
| 10,000 or more | 178 | 33.1 | 9,062,156 | 91.7 |
| **HMO Contracts** | | | | |
| All | 298 | 100.0 | 6,409,504 | 100.0 |
| None (or 10 or fewer) | 5 | 1.4 | 0 | 0.0 |
| 11–99 | 10 | 3.4 | 503 | 0.0 |
| 100–499 | 21 | 7.0 | 5,527 | 0.1 |
| 500–999 | 19 | 6.4 | 14,390 | 0.2 |
| 1,000–1,499 | 19 | 6.4 | 23,194 | 0.4 |
| 1,500–1,999 | 13 | 4.4 | 22,586 | 0.4 |
| 2,000–2,499 | 12 | 4.0 | 27,618 | 0.4 |
| 2,500–2,999 | 12 | 4.0 | 32,613 | 0.5 |
| 3,000–4,999 | 31 | 10.4 | 124,125 | 1.9 |
| 5,000–9,999 | 30 | 10.1 | 215,110 | 3.4 |
| 10,000 or more | 126 | 42.3 | 5,943,838 | 92.7 |
| **Local PPO Contracts** | | | | |
| All | 157 | 100.0 | 834,726 | 100.0 |
| None (or 10 or fewer) | 13 | 8.3 | 0 | 0.0 |
| 11–99 | 10 | 6.4 | 503 | 0.1 |
| 100–499 | 24 | 15.3 | 6,864 | 0.8 |
| 500–999 | 20 | 12.7 | 14,443 | 1.7 |
| 1,000–1,499 | 14 | 8.9 | 17,522 | 2.1 |
| 1,500–1,999 | 6 | 3.8 | 10,508 | 1.3 |
| 2,000–2,499 | 7 | 4.5 | 15,263 | 1.8 |
| 2,500–2,999 | 5 | 3.2 | 13,586 | 1.6 |
| 3,000–4,999 | 18 | 11.5 | 68,522 | 8.2 |
| 5,000–9,999 | 14 | 8.9 | 102,640 | 12.3 |
| 10,000 or more | 26 | 16.6 | 584,875 | 70.1 |

**Table A.9** *(continued)*

| Contract Enrollment Category | Number of Contracts | Percentage of Contracts | Number of Enrollees | Percentage of Enrollees |
|---|---|---|---|---|
| **Regional PPO Contracts** | | | | |
| All | 11 | 100.0 | 328,109 | 100.0 |
| None (or 10 or fewer) | 0 | 0.0 | 0 | 0.0 |
| 11–99 | 0 | 0.0 | 0 | 0.0 |
| 100–499 | 0 | 0.0 | 0 | 0.0 |
| 500–999 | 0 | 0.0 | 0 | 0.0 |
| 1,000–1,499 | 1 | 9.1 | 1,480 | 0.5 |
| 1,500–1,999 | 0 | 0.0 | 0 | 0.0 |
| 2,000–2,499 | 2 | 18.2 | 4,540 | 1.4 |
| 2,500–2,999 | 0 | 0.0 | 0 | 0.0 |
| 3,000–4,999 | 2 | 18.2 | 7,237 | 2.2 |
| 5,000–9,999 | 0 | 0.0 | 0 | 0.0 |
| 10,000 or more | 6 | 54.5 | 314,852 | 96.0 |
| **PFFS Contracts** | | | | |
| All | 70 | 100.0 | 2,308,220 | 100.0 |
| None (or 10 or fewer) | 9 | 12.9 | 0 | 0.0 |
| 11–99 | 6 | 8.6 | 269 | 0.0 |
| 100–499 | 7 | 10.0 | 1,980 | 0.1 |
| 500–999 | 4 | 5.7 | 2,900 | 0.1 |
| 1,000–1,499 | 6 | 8.6 | 7,282 | 0.3 |
| 1,500–1,999 | 3 | 4.3 | 4,932 | 0.2 |
| 2,000–2,499 | 2 | 2.9 | 4,547 | 0.2 |
| 2,500–2,999 | 4 | 5.7 | 10,790 | 0.5 |
| 3,000–4,999 | 3 | 4.3 | 12,986 | 0.6 |
| 5,000–9,999 | 6 | 8.6 | 43,943 | 1.9 |
| 10,000 or more | 20 | 28.6 | 2,218,591 | 96.1 |
| **MSA Contracts** | | | | |
| All | 2 | 100.0 | 1,866 | 100.0 |
| None (or 10 or fewer) | 0 | 0.0 | 0 | 0.0 |
| 11–99 | 0 | 0.0 | 0 | 0.0 |
| 100–499 | 1 | 50.0 | 340 | 18.2 |
| 500–999 | 0 | 0.0 | 0 | 0.0 |
| 1,000–1,499 | 0 | 0.0 | 0 | 0.0 |
| 1,500–1,999 | 1 | 50.0 | 1,526 | 81.8 |
| 2,000–2,499 | 0 | 0.0 | 0 | 0.0 |
| 2,500–2,999 | 0 | 0.0 | 0 | 0.0 |
| 3,000–4,999 | 0 | 0.0 | 0 | 0.0 |
| 5,000–9,999 | 0 | 0.0 | 0 | 0.0 |
| 10,000 or more | 0 | 0.0 | 0 | 0.0 |

Source: MPR analysis of CMS's Contract-County-Enrollment file for March 2009.

Note: Contracts are for MA contracts only (excluding cost, HCPP, PACE, and demonstration contracts). With MA, the count excludes group-only and SNP-only contracts. Total enrollment includes all plans offered in contracts (including SNP and group plans of that type).

**Table A.10. Firms with the Most PFFS Enrollees, 2009 (individual enrollment only)**

| | Number of Enrollees | Percentage of PFFS Enrollees | Percentage of Firm's Total MA Enrollment |
|---|---|---|---|
| Humana | 492,209 | 32.4% | 37.1% |
| Coventry | 190,249 | 12.5 | 55.4 |
| UnitedHealthcare | 152,532 | 10.0 | 10.0 |
| Universal American | 139,819 | 9.2 | 70.6 |
| WellPoint | 123,578 | 8.1 | 32.9 |
| WellCare | 97,382 | 6.4 | 38.8 |
| Sterling (Munich American) | 83,991 | 5.5 | 99.7 |
| Aetna | 26,929 | 1.8 | 15.9 |
| Health Net | 11,939 | 0.8 | 5.3 |
| Blue Cross Blue Shield affiliates (other than WellPoint) | 140,666 | 9.2 | 12.5 |
| Other | 61,821 | 4.1 | 2.8 |
| **All** | 1,521,115 | 100% | 17.7% |

Source: MPR analysis of CMS's Contract-County file for March 2009.


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