The Growth of Private Plans in Medicare, 2006

Prepared by

Marsha Gold, Sc.D.
Senior Fellow
Mathematica Policy Research, Inc,
Washington, D.C.

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EXECUTIVE SUMMARY

As Medicare's new and voluntary prescription drug benefit goes into effect this year, beneficiaries for the first time in the program's history are required to enroll in a private plan to receive these benefits. If a beneficiary wishes to retain traditional Medicare coverage, he or she can enroll in a private stand-alone prescription drug plan (PDP). Beneficiaries also have the option of enrolling in a private Medicare Advantage (MA) plan that integrates prescription drug coverage with Medicare's other benefits and selected supplemental coverage to offset Medicare's cost sharing or exclusions. These include local health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, and two options new in 2006—regional PPOs and special needs plans (SNPs). In all cases, individuals must be enrolled in a private plan to get the Medicare drug benefit.

This Issue Brief summarizes the kinds of private plans that are available to Medicare beneficiaries in 2006 and how they compare to past offerings. Additional background is provided in the box on the following page. The analysis is based primarily on public data available from the Centers for Medicare and Medicaid Services (CMS) for 2006 and comparable historical data constructed by Mathematica Policy Research, Inc., from similar sources over time to support trend analysis.

KEY FINDINGS

Stand-Alone Prescription Drug Plans

- With the exception of beneficiaries in Alaska and Hawaii, each beneficiary can choose among free-standing PDP plans from at least 15 sponsors in 2006. The number of sponsors vary from 11 (Alaska) and 12 (Hawaii) to 21 (New York, Pennsylvania, West Virginia). Because sponsors typically offer several plans with diverse premiums and benefit structures, the number of available plans per region is two to three times as high.

- Because organizations typically offer more than one plan, each with distinct premiums and benefits, beneficiaries actually will have substantially more options to consider than is reflected by the number of sponsoring organizations in each region. At least 40 different PDPs are being offered in most areas of the country.

Medicare Advantage Plans

- Almost all Medicare beneficiaries in the United States also have at least one kind of MA plan available to them in 2006, with the exception of those living in many areas of Alaska and parts of New England. Availability of such plans is greater than in the past. The expansion reflects mainly the growth of PFFS plans and the introduction of regional PPOs rather than more HMOs, which have traditionally dominated the Medicare managed care market.

BACKGROUND

History of Private Plans in Medicare

As the private market for health insurance has evolved, Medicare has been modified so that beneficiaries can elect to get their Medicare benefits through a qualified private plan rather than the traditional fee-for-service Medicare program. Authorized in 1982, the Medicare risk-contracting program provided for enrollment in health maintenance organizations (HMOs). In 1997, Congress expanded private plan authority to include preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), and private fee-for-service (PFFS) plans as the Medicare risk-contracting program was absorbed into Medicare+Choice (M+C). The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) replaced M+C with the Medicare Advantage (MA) program in 2004, raising payment rates and making other changes in anticipation of the Medicare drug benefit in 2006.

Trends in Private Plan Choice and Enrollment, 1985-2005

The number of Medicare beneficiaries in private plans rose modestly in the ten years after the Medicare risk program took effect, increasing from around 0.4 million people in 1985 to 2.3 million in 1994. Enrollment then began to grow more rapidly, a trend consistent with the growth in HMOs in the private market over that period. By the time M+C was established in 1997, there were 5.2 million enrollees in such plans. Enrollment continued to grow through 1999 but at a slower rate, and then began declining. Between 1999 and 2003, the number of enrollees declined from 6.3 million to 4.6 million. Over this period, payment rates to private plans increased much less rapidly than in the past, a function both of legislative changes under M+C in how payments were constructed and a slow-down in spending in the traditional Medicare program (to which plan payments were linked). Many plans withdrew from the market or reduced their service areas; those that remained cut their benefits and increased premiums. MA enrollment declined as fewer beneficiaries had access to private plans and some beneficiaries found the remaining plans less attractive. In total, 17.3 percent of Medicare beneficiaries were enrolled in private plans in 1999. By year end 2003, this had declined to 12.6 percent. With the passage of the MMA, MA enrollment began to grow again in 2004, and by December 2005 14.0 percent of beneficiaries were in such plans.

Private Plans under the MMA in 2006

In 2006, Medicare will be offering more kinds of private plan options than ever before as Medicare expands to cover prescription drugs. Options include new private stand-alone PDPs and an expanded set of MA options that includes a new regional PPO option. The MMA also authorizes, for the first time, private plans specifically designed to serve beneficiaries with selected special needs, including dual eligibles, institutionalized individuals, and others. (Special provisions in the MMA also modify enrollment, processes, premiums, and benefits for dual eligibles and others with low income and assets.)

- Seventy-two percent of Medicare beneficiaries have one or more local HMOs available to them. This is about the same percentage as in 1999 before the extensive exits of plans from the market in the Medicare+Choice program, the predecessor to MA. As has been true historically, HMOs are more available in urban than rural areas, with 84 percent of urban beneficiaries having access to them versus 27 percent of rural ones.

- Sixty percent of beneficiaries have access to a local PPO plan in 2006, including 51 percent of urban beneficiaries and 25 percent of rural beneficiaries. Local PPOs have had only a limited effect on private plan choice for beneficiaries without access to an HMO because they tend to be located in similar areas. (Overall, 78 percent of beneficiaries have access to either a local HMO or local PPO in 2006.)

- Eighty percent of beneficiaries have access to a PFFS plan in 2006, including 76 percent of urban beneficiaries and 97 percent of rural beneficiaries. The first such plan was introduced in 2001; in 2006, there are 21 contracts for PFFS plans.

- Regional PPOs are available to 88 percent of all Medicare beneficiaries and to beneficiaries in all but 13 of the 50 states plus Washington, D.C. Some areas have two regional PPOs.

Geographical Variation in Medicare Advantage

- The number and type of MA plans varies substantially across the country, as it has historically. For example, Florida has 41 MA contracts whereas eight states have five or fewer. Even in Florida, the number of MA contracts varies greatly across the state with many plans in south Florida and substantially fewer elsewhere. Unique patterns also exist. Local PPOs are rare in California and absent in Minnesota, though each has a regional PPO. There are as many as seven PFFS contracts in Pennsylvania and six each in eight other states, though many states have far fewer. And eight states have no local HMOs: Alaska, Delaware, Maine, Montana, North Dakota, South Dakota, Vermont and Wyoming.

- Alaska is a notable exception to the widespread availability of private plans. Only 14 percent of beneficiaries in Alaska (18 percent in urban areas and 8 percent in rural areas) have access to an MA plan, and their sole choice is a PFFS plan. Alaska also has the fewest PDPs available, though beneficiaries still have 27 plans from 11 sponsors to choose among.

- Special needs plans (SNPs) are available to at least some beneficiaries in all states except nine, with a total of 164 contracts nationwide. Most SNPs are focused on dual-eligible populations, but 32 serve institutionalized beneficiaries and 11 serve beneficiaries with severe chronic and/or disabling conditions. An analysis of SNPs that were approved by early October 2005 indicates that they are much more likely to serve urban than rural beneficiaries.

IMPLICATIONS FOR BENEFICIARIES

Overall, Medicare beneficiaries have many private plan choices in 2006. It remains to be seen whether the extensive range of choice for beneficiaries will modify the historical dynamic, which is that most beneficiaries choose the traditional Medicare option and that HMOs dominate MA offerings and enrollment. Only 13 percent of beneficiaries were in a private plan in September 2005, and most of them were in HMOs. Beneficiaries also are aware that private plan participation has been unstable in the past with firms withdrawing from areas of the country, raising premiums, and/or cutting benefits. Concerns over future changes and instability may limit new enrollment in MA in 2006 and potentially even PDPs. Because the new drug benefit is complex, beneficiaries in traditional Medicare also may focus mainly on understanding their new PDP choices in 2006. However, over time MA plans could become increasingly attractive to beneficiaries, particularly if plan payments enable MA plans to offer benefits that compare favorably to traditional, fee-for-service Medicare. The implications for Medicare depend on how beneficiaries respond to new offerings and the tradeoffs they face now and in the future.

INTRODUCTION

As Medicare's new and voluntary prescription drug benefit goes into effect in 2006, beneficiaries, for the first time in the program's history, are required to enroll in a private plan to receive those benefits. If a beneficiary wishes to be covered under the traditional Medicare program, he or she can enroll in a private stand-alone prescription drug plan (PDP). Beneficiaries also have the option of enrolling in a private Medicare Advantage (MA) plan that integrates prescription drug coverage with Medicare's historical benefits and supplemental services. Though MA is not new to Medicare, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) included a number of provisions—such as enhanced payment rates—designed to expand offerings in ways that may make it more attractive to plan sponsors and beneficiaries (MedPAC, 2005; Gold, 2005; Berenson, 2004).

This issue brief describes the different types of private plan options now available under Medicare and summarizes the number of plans that are available to Medicare beneficiaries in each state in 2006. The paper discusses PDPs first and then MA plans of different types. The paper concludes by discussing what the expanded landscape of new plan choices may mean for beneficiaries and the Medicare program. Our analysis is based primarily on public data available from the Centers for Medicare and Medicaid Services (CMS) for 2006 and comparable historical data constructed by Mathematica Policy Research, Inc., from similar sources to support trend analysis.

OVERVIEW OF THE NEW PRESCRIPTION DRUG BENEFIT

The new Medicare prescription drug benefit represents a major expansion of Medicare, which previously covered only very limited prescription drug use in selected circumstances. To receive the new Medicare benefit, individuals can enroll either in a stand-alone PDP or an MA

plan that offers prescription drug coverage. Medicare beneficiaries who enroll in a plan pay a monthly premium equal to about 25 percent of the costs of standard coverage (KFF, 2005a). The standard benefit has an annual deductible ($250), beneficiary cost sharing of 25 percent up to an initial coverage limit, a coverage gap in which beneficiaries pay all of the costs for prescription drugs, and catastrophic coverage once a beneficiary has incurred $3,600 in of out-of-pocket spending. Additional help such as reduced premiums and cost sharing is available to those with limited income and assets. While enrollment is voluntary, beneficiaries who do not enroll by May 15, 2006 and want to enroll in a subsequent year will incur a permanent premium penalty of 1 percent of the average monthly premium for each month of delayed enrollment. Those with "creditable coverage," meaning drug coverage that is at least as good as the Medicare benefit, such as an employer-sponsored retiree plan, are exempted from the penalty. Medicare beneficiaries who are dually eligible for Medicaid have automatically had their prescription drug coverage switched to Medicare; those who did not select a PDP were automatically randomly assigned to PDPs with premiums at or below the average premium for standard coverage.[1] Beneficiaries have the option of switching from the assigned plan to another.

PRESCRIPTION DRUG ONLY PLANS

Almost nine in 10 beneficiaries (86 percent) now receive their Medicare benefits through the traditional fee-for-service Medicare program (KFF, 2005b). In general, they can go to any hospital, physician or other health care provider they chose. Beneficiaries in traditional Medicare can access the new drug benefit by enrolling in a new prescription drug plan (PDP). PDPs operate in one or more of the 34 PDP regions defined by state or aggregations of states. CMS approved 10 national PDP sponsors that offer plans in each of the 34 regions along with

[1] Each company that offers one or more plans eligible for the low-income subsidy had an equal probability of assignment.

others that serve a more limited number of regions. There are between 11 (Alaska) and 21 (New York, Pennsylvania, West Virginia) sponsors offering drug coverage (Table 1). Beneficiaries have at least 15 choices in all states except Alaska and Hawaii. Because organizations typically offer more than one plan, each with distinct premiums and benefits, beneficiaries actually have substantially more options to consider than is reflected by the number of sponsored firms. At least 40 different PDPs are being offered in most states.

Dually eligible beneficiaries and those otherwise eligible for the low-income subsidy (LIS) have fewer sponsor choices than others because CMS only subsidizes premiums for sponsor plans that fall below the regional LIS subsidy amount. This subsidy calculation takes into account the premiums for plans of all PDP and MA sponsors.[2] About 62 percent of sponsors' lowest-priced premium plans in each region fall below the LIS benchmark. At least five PDP sponsors in each state are eligible for the LIS subsidy. States can have a lower number of PDP sponsors eligible for the LIS either because they have fewer available plans overall (such as Alaska and Hawaii) or because they have substantial enrollment in MA and these plans have lower premiums, on average (such as Arizona and Florida). Only five of Arizona's 18 PDP organizations have a lowest premium plan that is LIS eligible. In Florida, the comparable numbers are six of 18. MA penetration was 26 percent in Arizona in 2005 and 19 percent in Florida (but 38 percent in the populous Miami area).

[2] The low-income premium subsidy amount is the maximum amount CMS will pay in any given region to subsidize the Part D premium for those entitled to the full LIS. The amount ranges from $23.46 in Nevada to $36.30 in North Carolina. This amount is the *lesser* of the actual Part D premium (or share of enhanced alternative coverage reflecting basic coverage); or either (1) the low-income premium amount for a PDP region or (2) the lowest monthly beneficiary premium for a PDP that offers prescription drug coverage (whichever is greater). In calculating the low-income premium amount, CMS takes into account premiums for MA plans offering prescription drug coverage, with these weighted by the level of MA penetration in that region.

TABLE 1

AVAILABILITY OF PDPs BY STATE, 2006

	Number of PDP Organizations	Number of Organizations with 1+ LIS Plans[a]	Total Number of Benefit Plans Available
United States[b]			
Alabama	17	8[c]	41
Alaska	11	7[c]	27
Arizona	18	5[c]	43
Arkansas	15	12[c]	40
California	18	8[d]	47
Colorado	17	10	43
Connecticut	17	9[d]	44
Delaware	19	15	47
District of Columbia	19	15	47
Florida	18	6	43
Georgia	18	13[c]	42
Hawaii	12	7[c]	29
Idaho	18	12[d]	44
Illinois	16	12	42
Indiana	17	12[c]	42
Iowa	17	11[c]	41
Kansas	15	10[c]	40
Kentucky	17	12[c]	42
Louisiana	16	10[c]	39
Maine	17	12[d]	41
Maryland	19	15	47
Massachusetts	17	9[d]	44
Michigan	18	13[c]	40
Minnesota	17	11[e]	41
Mississippi	15	11[c]	38
Missouri	16	9[c]	41
Montana	17	11[e]	41
Nebraska	17	11[e]	41
Nevada	18	8	44
New Hampshire	17	12[d]	41
New Jersey	18	10[e]	44
New Mexico	17	8	43

TABLE 1 *(continued)*

	Number of PDP Organizations	Number of Organizations with 1+ LIS Plans[a]	Total Number of Benefit Plans Available
New York	21	11[e]	46
North Carolina	16	11[d]	38
North Dakota	17	11[e]	41
Ohio	18	9[c]	43
Oklahoma	16	10[d]	42
Oregon	20	12[e]	45
Pennsylvania	21	14[c]	52
Rhode Island	17	9[d]	44
South Carolina	19	14[d]	45
South Dakota	17	11[e]	41
Tennessee	17	8[c]	41
Texas	20	14[d]	47
Utah	18	12[d]	44
Vermont	17	9[d]	44
Virginia	17	14[d]	41
Washington	20	12[e]	45
West Virginia	21	14[c]	52
Wisconsin	17	13[c]	45
Wyoming	17	11[e]	41

Source: MPR analysis for KFF of a file constructed from data on CMS's Landscape file provided on October 13, 2005 and other sources.

[a] CMS designated LIS plans based on premiums below the LIS regional benchmark and other plan features. The count of organizations with an eligible LIS plan is based on whether or not an organization's lowest premium plan is LIS eligible. Fifty-one other plans also are LIS eligible. We assume that these are other plans from those same organizations that are LIS eligible. UnitedHealthcare, for example, has more than one LIS plan in many regions (CMS randomly assigned enrollees to a firm among these plans.) It is possible that in a small number of cases these other LIS plans may be ones from organizations whose lowest cost plan is not LIS eligible.

[b] In each region we defined the number of unique PDPs by counting the lowest premium plan each organization offered. Across all regions there are 583 such units of whom 360 have an LIS eligible lowest premium plan. (Nationwide, there are a total of 411 LIS eligible plans.)

[c] These states have one additional LIS plan other than those that are lowest premium.

[d] These states have two additional LIS plans other than those that are lowest premium.

[e] These states have three additional LIS plans other than those that are lowest premium, except for NJ and NY where there are four.

MEDICARE ADVANTAGE PLANS

Beneficiaries can choose to enroll in an MA plan with or without the new Medicare pharmacy benefit. However, if an MA enrollee wants to be in a plan that offers the Medicare drug benefit, he or she must get it through an MA plan. Exceptions apply for PFFS plans, where drug coverage is optional.

Basic Features of Local MA Plans

Medicare Advantage incorporates and expands the private plan choices previously offered under Medicare+Choice (Gold, 2005). Under MA, there are three main types of local MA plans whose service areas are defined on a county-by-county basis: HMOs, PPOs, and PFFS plans.[3]

HMOs and PPOs are coordinated care plans in which coverage is based on use of a defined provider network. HMOs typically are the most tightly managed plans, and beneficiaries who enroll in them tend to be covered only if they use providers within the network. In a PPO, beneficiaries generally are free to go to any provider they choose but if they use providers outside the network they must pay more out of pocket. PFFS does not restrict provider choice, as long as a provider is willing to see the patient (Gold, 2001a). Though PFFS plans have authority to pay less or more than Medicare, most plans currently pay the same as Medicare.

Local Medicare HMOs, PPOs, and PFFS plans are paid the same way under MA, with a risk-based monthly capitated payment that is set on a county-by-county basis. The amount of this payment is based on historical costs of the traditional Medicare program in that county, but amounts have also been modified by legislation. There have been three important modifications:

[3]Other private plan options, which are not specifically discussed here, involve cost contracts, Health Care Prepayment Plan (HCPP) contracts, the Program of All-Inclusve Care for the Elderly (PACE) program, and various specialized demonstrations with unique features that make them widely available to beneficiaries nationwide. Though the MMA also reauthorized Medical Savings Accounts (MSAs) and removed some of the limitations placed on them previously, no such plans will be offered in 2006. (MSAs are precluded from offering Medicare prescription drug coverage.)

floor payments for rural counties starting in 1998 and urban counties starting in 2001, risk adjustment (which is being phased in), and formulas to update payments from year to year (Berenson, 2004; Gold, 2001b, 2005). Starting in 2006, the rates derived from these policies serve as benchmarks for evaluating sponsor bids. MA payment is being revised to include an element of competitive bidding in 2006.[4] Because MA payment policies yield, on average, higher payments than under the traditional Medicare program (MedPAC, 2005; Biles et al., 2004; Berenson, 2004), MA sponsors can use any savings from the delivery of traditional benefits to make their prescription drug offerings more attractive to beneficiaries. Under the MMA, these features are designed to create incentives for sponsors to offer—and beneficiaries to enroll in—MA plans that provide an integrated private plan alternative to Medicare.

New Authority for Regional PPOs

The MMA authorizes new regional PPOs starting in 2006; CMS defined 26 regions (of single states or aggregations of states) for this purpose.[5] The intent was to expand choice more uniformly across the country, including rural and other areas where MA plans and enrollment have historically been limited. It also aimed to allow PPOs, which dominate private insurance outside of Medicare, to become more pervasive in Medicare (Kaiser/HRET, 2005; MedPAC, 2005).

While regional and local PPOs are similar, sponsors of regional PPOs must make them uniformly available to beneficiaries across the entire region. Premiums, benefits, and cost sharing must be similarly uniform. Regional PPOs also are required to integrate cost sharing

[4] If a sponsor's bid for Medicare covered hospital and physician benefits (Medicare Parts A and B) is below the benchmark, they can use 75 percent of the difference to reduce beneficiary premiums for drug or supplemental coverage or to expand benefits. When bids are above the benchmark, beneficiaries are responsible for the difference in the form of higher premiums.

[5] The 26 regions combine some of the 34 PDP regions. Hence, PDPs are offered either in regions defined the same as in MA or in subsets of those regions.

across hospital and physician services (Part A and Part B) and to include an annual out-of-pocket limit on cost sharing, a feature missing in traditional Medicare. While local MA plans may have such a limit, they are not required to do so.

To encourage sponsors to offer regional PPOs, the MMA allows Medicare to share financial risk with sponsors in 2006 and 2007, provides selected provisions to offset problems of network formation in rural areas, and establishes a regional stabilization fund starting in 2007 to encourage entry of new plans and retention of existing ones. CMS also imposes fewer quality requirements on regional PPOs than on local MA plans, particularly HMOs. To encourage regional PPOs, the MMA set a two-year moratorium on new local PPOs, effective January 1, 2006. Regional plans are paid similarly to local MA plans but the methods used take regional PPO bids (not just traditional Medicare costs) into account in setting benchmarks and include other provisions to accommodate the regional focus.

New Authority for Special Needs Plans

The MMA also authorizes special needs plans (SNPs), which can restrict enrollment to three categories of Medicare beneficiaries: dually-eligible beneficiaries, institutionalized beneficiaries and individuals with severe or disabling chronic conditions (CMS, 2005). Some SNPs are new products while others are conversions of existing products that were approved under CMS's demonstration authority. Though authority for such plans was effective in 2004, SNPs are particularly visible as a new option in 2006.

MEDICARE ADVANTAGE AVAILABILITY, 2006

Trends by Plan Type

Virtually all beneficiaries in the United States have at least one kind of MA plan available to them in 2006, though not necessarily the kind of local HMO plan that has historically dominated the market. (The main exceptions to 100 percent availability are many areas of Alaska and

sections of New England.) For the most part, expanded availability reflects the emergence of PFFS plans in most parts of the country and regional PPOs (Table 2).

The share of beneficiaries with access to a local HMO or PPO is 78 percent in 2006, compared to 71 percent in 1999. The share of Medicare beneficiaries with an HMO available to them in Medicare in 2006 (72 percent) is higher than in previous years, but it is almost the same as in 1999 (71 percent) before there were extensive withdrawals. HMOs remain predominantly an urban product. In 2006, 84 percent of urban beneficiaries have such a product available, while only 27 percent of rural beneficiaries do. The recent growth of local PPOs expanded choice but mainly in the same areas where an HMO was already available.[6] In rural areas, however, 37 percent of beneficiaries now have access to a local HMO or PPO.

PFFS plans, which were authorized in 1999, but not available at that time, are available to 80 percent of Medicare beneficiaries in 2006, including 79 percent of urban beneficiaries and 97 percent of rural beneficiaries. Because they do not require a network, such plans appear to require less effort to establish and present fewer challenges for their sponsors. Since 2001 when the first PFFS was established by Sterling, the number of PFFS contracts expanded to four in 2004 and 21 in 2006.

Regional PPOs, new in 2006, are available to 88 percent of all Medicare beneficiaries, with availability similar for urban and rural beneficiaries (Table 3). At least one sponsor is offering such a plan in 21 of the 26 regions—that is, in all but 13 of the 50 states (plus

[6] Because there is a freeze on new local PPOs or expansion of existing ones in 2006 and 2007, some new offerings, especially in mid-late 2005, may be defensive moves by sponsors to have such options on the books. That is, sponsors may or may not view such products as important sources of new enrollment, at least in the short run, and they may or may not actively market them.

TABLE 2

PERCENTAGE OF MEDICARE BENEFICIARIES RESIDING IN A COUNTY WITH A MEDICARE ADVANTAGE PLAN, BY TYPE, 1999-2006

	All Beneficiaries				Urban Beneficiaries				Rural Beneficiaries			
	1999	2004	2005	2006	1999	2004	2005	2006	1999	2004	2005	2006
Any Type[a]	72	77	85	100	86	84	91	100	25	48	69	99
Any Regional PPO	--	--	--	88	--	--	--	88	--	--	--	89
Any Local HMO or PPO	71	62	69	78	86	74	80	89	25	16	25	37
HMO	71	60	65	72	86	73	77	84	25	15	20	27
PPO[b]	0[c]	26	43	60	0[c]	31	51	69	0[c]	6	13	25
Any PFFS	0	32	43	80	0	29	39	79	0	42	59	97

Source: MPR analysis for KFF of CMS data. Excludes Puerto Rico and the Territories. 1999-2005 data are for March of that year. 2006 data are based on an analysis using access data released by CMS drawn from September 2005 data on 2006 offerings in the Medicare Personal Plan Finder. These data were merged with other CMS sources to support analysis.

[a] Totals exclude HCPP and demonstration plans but include cost contracts; 2006 data include SNPs approved by October 13, 2005.
[b] Includes PPO demonstration plans pre-2006.
[c] CMS's file did not break down contracts by type in 1999, but data on contracts show few PPOs approved.

-- Not an available option that year.

TABLE 3

AVAILABILITY OF MEDICARE ADVANTAGE CONTRACTS BY TYPE AND STATE, 2006
(Percentage of Beneficiaries with 1+ Contract Available of this Type)

	All Counties				All Urban Counties				All Rural Counties			
Region	Any Type[a]	Local HMO	Local PPO	PFFS	Any Type	Local HMO	Local PPO	PFFS	All	Local HMO	Local PPO	PFFS
All	**100[b]**	**73**	**59**	**80**	**100**	**84**	**69**	**71**	**99**	**27**	**25**	**97**
States with a Regional PPO												
Alabama	100	74	57	100	100	80	80	100	100	63	12	100
Arizona	100	92	81	100	100	97	88	100	100	65	37	100
Arkansas	100	30	0	100	100	51	0	100	100	8	0	100
California	100	93	8	25	100	96	9	25	100	19	0	26
Delaware	100	0	0	100	100	0	0	100	100	0	0	100
District of Columbia[c]	100	100	100	100	100	100	100	100	--	--	--	--
Florida	100[b]	90	78	100[b]	100	96	82	100	98	20	30	98
Georgia	100	38	45	100	100	52	58	66	100	0[d]	9	100
Hawaii	100[b]	100[b]	77	100[b]	100	100	100	100	100[b]	100[b]	18	100[b]
Illinois	100	76	88	64	100	89	93	78	100	15	62	100
Indiana	100	4	39	100	100	5	50	100	100	0	8	100
Iowa	100	68	22	100	100	91	46	100	100	48	0	100
Kansas	100	35	30	100	100	63	54	100	100	0	0	100
Kentucky	100	35	37	100	100	63	67	100	100	7	8	100
Louisiana	100	49	47	100	100	68	66	100	100	4	0	100
Maryland	100	79	79	4	100	85	85	5	100	0	0	0
Michigan	100	73	50	100	100	92	65	100	100	7	2	100
Minnesota	100	88	0	100	100	98	0	100	100	70	0	100

TABLE 3 (*continued)*

Region	All Counties				All Urban Counties				All Rural Counties			
	Any Type[a]	Local HMO	Local PPO	PFFS	Any Type	Local HMO	Local PPO	PFFS	All	Local HMO	Local PPO	PFFS
Mississippi	100	19	0	100	100	44	0	100	100	3	0	100
Missouri	100	63	65	100	100	83	87	59	100	24	20	100
Montana	100	0	71	100	100	0	100	100	100	0	57	100
Nebraska	100	32	0	100	100	66	0	100	100	3	0	100
Nevada	100	89	100	100	100	96	100	100	100	47	100	100
New Jersey[c]	100	100	87	35	100	100	87	36	--	--	--	--
New York	100	96	99	34	100	98	100	27	100	73	95	95
North Carolina	100	51	40	100	100	69	57	100	100	21	15	100
North Dakota	100	0	0	100	100	0	0	100	100	0	0	100
Ohio	100	88	89	100	100	96	96	100	100	56	61	100
Oklahoma	100	52	63	100	100	83	93	100	100	12	24	100
Pennsylvania	100	95	96	83	100	100[b]	100[b]	100	100	74	79	100
South Carolina	100	23	47	100	100	32	62	100	100	0	12	100
South Dakota	100	0	100	100	100	0	100	100	100[a]	0	100[b]	100[b]
Tennessee	100	82	68	100	100	99	83	100	100	47	40	100
Texas	100	67	53	100	100	80	65	100	100	14	2	100
Virginia	99	16	57	99	99	16	66	99	100	15	25	100
West Virginia	100	23	100	100	100	24	100	100	100	32	100	100
Wisconsin	100	71	28	56	100	74	41	100	100	66	0	100
Wyoming	100	0	0	100	100	0	0	100	100	00	0	100

TABLE 3 (*continued)*

Region	All Counties				All Urban Counties				All Rural Counties			
	Any Type[a]	Local HMO	Local PPO	PFFS	Any Type	Local HMO	Local PPO	PFFS	All	Local HMO	Local PPO	PFFS
States with No Regional PPO												
Alaska	14	0	0	14	18	0	0	18	8	0	0	8
Colorado	100[a]	84	62	100[b]	100[b]	100	75	100[b]	100	9	0	100
Connecticut	100	100	75	10	100	100	82	5	100	100	0	64
Idaho	100	56	70	100	100	80	97	100	100	19	29	100
Maine	86	0	44	86	100	0	64	100	70	0	21	70
Massachusetts	97	97	97	2	97	97	97	1	69	0	0	69
New Hampshire	76	27	0	76	64	49	0	64	91	0	0	91
New Mexico	100	49	100	100	100	77	100	100	100	5	100	100
Oregon	100	91	100	86	100	100	100	90	100	71	100	75
Rhode Island[c]	100	100	86	100	100	100	6	100	--	--	--	--
Utah	100	61	87	100	100	69	99	100	100	20	20	100
Vermont[e]	70	0	0	70	--	--	--	--	95	0	0	95
Washington	100	87	78	100	100	97	91	100	100	38	13	100

Source: MPR analysis for KFF of an access data released by CMS drawn from September 2005 data on 2006 offerings in the Medicare Personal Plan Finder. These data were merged with other CMS data to support analysis. Excludes demonstration and HCPP contracts. Figures exclude Puerto Rico and the other Territories.

[a] Includes regional PPOs, SNPs, and cost contracts as well as local HMOs, PPOs, and PFFS plans.
[b] Only 100 percent because of rounding (i.e., $\geq$ 99.5%).
[c] DC, NJ, and RI have no rural counties.
[d] Only 0 percent because of rounding (e.g., < 0.5).
[e] Vermont has no urban counties.

Washington, D.C.). Some regions have two sponsors offering plans (Table 4). To a considerable extent, the availability of regional PPOs reflects the decision by Humana to offer such a product in 14 regions. Other sponsors are offering them in four regions or less, most typically one.

Geographic Variation

Because of the new and widespread prevalence of PFFS plans, a substantial number of Medicare beneficiaries have access to an MA plan in 2006 even if there are no regional PPOs where they live. An exception is Alaska, which is notable for the low availability of any type of MA plan: Only 14 percent of all beneficiaries (18 percent of urban and 8 percent of rural beneficiaries) have access to an MA plan, and their sole choice is a PFFS plan.

Data on availability on a state-by-state basis highlight the idiosyncratic features of markets that appear to influence the types of private plans that sponsors offer. For example:

- California and Minnesota both have a long history with HMOs but they appear much less hospitable to PPOs. California has only 8 percent of its Medicare population with access to a local PPO and Minnesota has no local PPO. (Both states have one regional PPO in 2006.)
- Though PFFS plans are widespread nationally, the share of beneficiaries with such a plan available is only 4 percent in Maryland, 10 percent in Connecticut, 25 percent in California, 34 percent in New York, and 35 percent in New Jersey.

These idiosyncrasies could be influenced by MA payment policy, but they also reflect unique features of the market or regulatory environment in particular states.

Number of MA Contracts

Counting the number of MA contracts is the traditional way of measuring availability of MA plans. Sponsors of MA plans typically sign separate contracts for each geographical area they serve.

TABLE 4

MEDICARE ADVANTAGE CONTRACTS BY TYPE AND STATE, 2006

	All Types[a]	Regional PPO	Local HMO	Local PPO	Local SNP[b]	Local PFFS	Cost
All States[c]	**392**	**11**	**200**	**106**	**125**	**21**	**16**
Alabama	8	1	3	2	3	2	0
Alaska	1	0	0	0	0	1	0
Arizona	24	2	9	4	9	5	0
Arkansas	8	1	2	0	1	5	0
California	22	1	15	1	8	2	0
Colorado	10	0	3	1	3	3	1
Connecticut	5	0	3	1	3	1	0
Delaware	4	1	0	0	1	2	0
District of Columbia	7	1	2	1	2	1	1
Florida	41	2	28	5	15	3	0
Georgia	16	2	4	3	5	5	0
Hawaii	6	1	2	1	3	1	1
Idaho	8	0	1	3	1	4	0
Illinois	26	1	11	6	4	6	1
Indiana	17	2	1	5	1	6	3
Iowa	13	1	4	1	2	6	1
Kansas	9	1	2	3	1	3	0
Kentucky	10	2	1	3	0	4	0
Louisiana	9	1	3	2	1	3	0
Maine	4	0	0	1	2	2	0
Maryland	8	1	2	1	3	1	1
Massachusetts	12	0	5	3	4	1	0
Michigan	12	1	4	1	2	4	0
Minnesota	14	1	3	0	3	6	1
Mississippi	4	1	1	0	1	2	0
Missouri	16	1	6	5	1	4	0
Montana	6	1	0	1	0	4	0
Nebraska	10	1	2	2	2	3	0
Nevada	10	1	4	2	1	3	0
New Hampshire	3	0	1	0	0	2	0
New Jersey	9	1	5	1	1	2	0
New Mexico	10	0	2	3	2	4	0

TABLE 4 *(continued)*

	All Types[a]	Regional PPO	Local HMO	Local PPO	Local SNP[b]	Local PFFS	Cost
New York	34	1	19	10	10	1	1
North Carolina	13	1	2	3	2	6	0
North Dakota	4	1	0	0	0	3	0
Ohio	24	2	9	8	1	3	2
Oklahoma	9	1	3	1	1	3	0
Oregon	20	0	10	4	5	4	1
Pennsylvania	30	1	11	9	8	7	0
Rhode Island	6	0	2	1	3	1	0
South Carolina	11	2	1	2	0	6	0
South Dakota	6	1	0	0	1	1	0
Tennessee	14	1	5	3	4	5	0
Texas	22	1	13	4	9	3	1
Utah	10	0	1	3	1	6	0
Vermont	2	0	0	0	0	2	0
Virginia	14	1	2	3	1	6	1
Washington	15	0	7	4	1	3	0
West Virginia	7	1	1	2	0	2	1
Wisconsin	15	1	3	1	2	6	3
Wyoming	4	1	0	0	0	2	1

Source: MPR analysis for KFF of data released by CMS drawn from September 2005 data on 2006 offerings in the Medicare Personal Plan Finder. These data were merged with other CMS data to support analysis. Excludes demonstration and HCPP contracts. Figures exclude Puerto Rico and the Territories.

Note: Defined as including at least one county from that region in the contract service area. Local plans often are offered in only a subset of counties in the states.

[a] The totals do not necessarily match the sum of the columns because the same contract may support two kinds of plans. In particular, firms may offer a SNP under the same contract that they have to offer a general population contract of a given type (e.g. HMOs).

[b] Figure reflects contracts approved as included in the October 13, 2005 CMS Landscape Report. The CMS November 2005 SNP report includes subsequent approvals. The two sources are not entirely consistent (e.g., the Landscape Report appears to count a single contract that includes a disabled and an institutionalized SNP as two separate contracts).

[c] Totals may not match sum of the columns because contracts may serve counties in multiple states. Regional PPO contracts serve an entire region, with 26 regions defined by one or more states.

Each product (e.g., HMO versus PPO) also has a separate contract.[7] Within any given contract, sponsors may offer more than one benefit package which is often described as a separate plan. Thus, plan counts are substantially higher than contract counts. Because our interests here are mainly in the available types of products by diverse sponsors, contract counts provide the more relevant information, and the analyses in this issue brief are based on contracts.

The number of MA contracts available to beneficiaries varies greatly across the country in 2006. At one extreme, Florida has 41 different MA contracts for plans serving one or more counties in the state, including 28 for local HMO plans. Other high-concentration states are New York (34 contracts), Pennsylvania (30 contracts), Illinois (26 contracts), Arizona and Ohio (24 contracts each), California and Texas (22 contracts each), and Oregon (20 contracts). States with five or fewer contracts include Connecticut, Delaware, Maine, Mississippi, New Hampshire, North Dakota, Vermont, and Wyoming.

To some extent these variations reflect differences in the number of beneficiaries across states, but the magnitude of the variation suggests there are other forces at work as well. In previous work, we have found that MA market variation is influenced by the capitation payment rate, history of managed care in an area, area practice patterns and beneficiary expectations, beneficiary characteristics and patterns of supplemental coverage, the extent and form of provider organization, potential sponsor goals across multiple lines of business, state regulation, and geographic location (Brown and Gold, 1999). These factors mean that even in states with high numbers of MA plans, their availability may vary substantially across the state. Historically, for example, MA has been much more prevalent in south Florida (especially Miami) than in other parts of the state.

[7] SNPs are an exception to this policy. Some contracts appear to authorize a regular and SNP product as long as it is the same type of product (e.g., HMO). To the best of our ability, the figures in Table 4 separate out regular MA products available to all beneficiaries and include SNP products under only that code.

Different areas also appear to attract different types of MA products. For example, there are no HMO contracts in eight states: Alaska, Delaware, Maine, Montana, North Dakota, South Dakota, Vermont, and Wyoming. This is not surprising because these are rural states where HMOs have had a hard time thriving. But there also is a high of seven PFFS contracts in Pennsylvania and six each in Illinois, Indiana, Iowa, Minnesota, North Carolina, South Carolina, Utah, Virginia, and Wisconsin. The reasons for this are unclear.

Special Needs Plans (SNP) Availability, 2006

One hundred and sixty-four contracts were approved for SNPs in 2006 from 90 different entities (five are for Puerto Rico, which is not included in the data used for this issue brief) (CMS, 2005). Most commonly these products are geared toward dual eligibles. Thirty-two of the contracts include one or more institutional SNPs. At least 11 of these are sponsored by UnitedHealthcare and are probably built on their Evercare product. Eleven are focused on those with chronic conditions.

The actual form of SNP organization and insurance arrangement can vary. Though most SNP contracts are linked to HMOs, 23 contracts are local PPOs, and three are for regional PPOs (in Hawaii, Florida, and New York); 20 are CMS demonstration contracts. While some SNPs appear to cover entire states, most cover a smaller area. Our analysis of the 125 SNPs approved in time to be included in the October 13, 2005 landscape tables released by CMS indicates that 70 percent of urban beneficiaries but only 20 percent of rural beneficiaries are included in the service area of one or more SNP contracts.

Table 5 summarizes SNP availability by state based on a review of the CMS's November 2005 SNP report. The data indicate that at least one SNP will be located in each state except Alaska, Montana, New Hampshire, North Dakota, South Carolina, Vermont, Virginia, West Virginia, and Wyoming. The states with the largest number of SNP contracts are Florida (14),

TABLE 5

AVAILABILITY OF SPECIAL NEEDS PLANS BY STATE, 2006

State	Total Contracts	Dual	Institutional	Other	Counties with 1+ Available	Number of Companies
Alabama	3	3	2	0	All	3
Alaska	0	0	0	0	None	0
Arizona	10	8	2	1	Selected	9
Arkansas	1	1	0	0	Selected	1
California	10	9	0	3	Selected	9
Colorado	4	3	2	0	Selected	4
Connecticut	3	3	0	0	All	3
Delaware	1	0	1	0	Selected	1
District of Columbia	2	1	1	0	All	2
Florida	14	13	2	0	All	10
Georgia	3	3	1	1	Selected	3
Hawaii	3	3	0	0	All	3
Idaho	1	1	0	0	Selected	1
Illinois	3	2	1	1	Selected	3
Indiana	1	1	0	0	All	1
Iowa	1	1	0	0	Selected	1
Kansas	1	1	0	0	Selected	1
Kentucky	1	1	0	0	Selected	1
Louisiana	2	2	0	0	Selected	2
Maine	1	1	1	0	Selected	1
Maryland	3	2	1	1	Selected	3
Massachusetts	5	5	1	0	Selected	5
Michigan	3	2	1	0	Selected	3
Minnesota	11	11	0	0	All	9
Mississippi	1	0	1	0	Selected	1
Missouri	1	1	0	0	Selected	1
Montana	0	0	0	0	Selected	0
Nebraska	2	1	1	0	Selected	1
Nevada	1	1	0	0	Selected	1
New Hampshire	0	0	0	0	None	0
New Jersey	2	2	0	0	Selected	2
New Mexico	1	1	1	0	Selected	1

TABLE 5 *(continued)*

State	Total Contracts	Dual	Institutional	Other	Counties with 1+ Available	Number of Companies
New York	12	11	1	0	All	9
North Carolina	1	1	0	0	Selected	1
North Dakota	0	0	0	0	None	0
Ohio	1	1	0	0	Selected	1
Oklahoma	1	0	1	0	Selected	1
Oregon	7	7	1	0	Selected	7
Pennsylvania	9	9	1	0	All	8
Rhode Island	3	2	1	0	All	2
South Carolina	0	0	0	0	None	0
South Dakota	1	0	0	1	All	1
Tennessee	4	3	1	0	Selected	4
Texas	10	10	1	0	All	10
Utah	2	2	0	0	Selected	2
Vermont	0	0	0	0	None	0
Virginia	0	0	0	0	None	0
Washington	2	2	1	0	Selected	2
West Virginia	0	0	0	0	None	0
Wisconsin	6	1	5	1	Selected	6
Wyoming	0	0	0	0	None	0

Source: Manual analysis by MPR for KFF of CMS's November 2005 SNP Report (including plans approved for 2006).

Note: Other refers to beneficiaries with severe or disabling chronic conditions. Table counts the same company only once for each type of contract even if the company has separate plans listed for each county in the state. Wellcare, which operates in multiple states, appears particularly likely to have done this though it is not the only company to do so.

New York (12), Minnesota (11), and Arizona and California (10 each). A given company may have more than one contract in a state. Conversely, a single contract may support more than one type of SNP. In Florida for example, there are 10 companies with 14 SNP contracts; 13 contracts have plans that serve duals and two have plans that serve the institutionalized.

Most SNPs are structured around dual-eligible beneficiaries. Their availability, therefore, is likely to reflect sponsor perceptions of market opportunities in both Medicare and Medicaid. For example, some states have been more active than others in encouraging private plan enrollment for the dually eligible (either as dual-eligible demonstrations with Medicare or Medicaid-only products). The variety of sponsors involved in offering SNPs include those historically active in Medicare (e.g., UnitedHealthcare) and those whose business base also builds heavily on Medicaid (e.g., Wellcare, Healthspring, and various local plan sponsors).

Eleven SNPs are focused on particular subgroups of beneficiaries with severe or disabling chronic conditions. Three are located in California and the others are in Arizona, Georgia, Illinois, Maryland, South Dakota, Wisconsin, and Puerto Rico. Details on the focus of these plans are not yet readily available.

Relationships Between MA Plan Availability and Enrollment

Greater availability of MA plans does not necessarily mean enrollment in these plans will increase dramatically. Historically, Medicare beneficiaries are risk-averse, with traditional Medicare highly stable and popular over many years. Choice of MA plan remains voluntary under Medicare.[8] In September 2005, only 13 percent of Medicare beneficiaries (5.7 million

[8] An exception involves dual eligibles in states with Medicaid managed care plans that also participate in Medicare as a SNP. In some cases, SNPs may passively enroll their existing dual eligibles from state programs but the beneficiaries have the option to switch to a PDP or other plan option. Press reports indicate that about 200,000 have been so enrolled for 2006 (120,000 in Pennsylvania alone). (Fahy, December 6, 2005).

beneficiaries) were enrolled in any form of private plan, most (4.8 million) in local HMOs (Table 6).

IMPLICATIONS FOR BENEFICIARIES

Medicare beneficiaries are able to enroll in one of a variety of drug benefit plans in 2006. The choices for beneficiaries are particularly extensive among PDPs, but there are more kinds of MA choices than ever before. It remains to be seen whether enrollment will be sufficient to support all the plans now in the market. In the short term, however, the main question is how beneficiaries will respond to the offerings available in 2006. Many beneficiaries may only consider PDPs because they fit in with traditional Medicare, which most of them have. Beneficiaries also are likely to find it challenging enough just to learn about the Medicare drug benefit itself and the large number of choices available without changing the way they get Medicare. Beneficiaries already in MA are likely to stay, and others may be attracted to the integrated benefits and/or price of these plans.

Greater availability of MA plans does not necessarily mean enrollment in MA will increase dramatically. To the extent that private plans have appeal to beneficiaries, it typically is because the payments they receive from Medicare allow them to offer benefits that compare favorably against private supplements (Gold et al. 2004). Data to assess the competitiveness of PDPs' benefits and premiums vis-a-vis MA plans on a national level are not yet available but most expect that MA plans, on average, will offer price-competitive drug benefits.[9]

[9] Information is available for individual plans through CMS's Personal Plan Finder, but CMS has not released any aggregate analysis and public analysis files are very limited.

TABLE 6

MEDICARE ENROLLMENT BY MA CONTRACT TYPE, 2004-2005

	Number of Enrollees			Distribution of Enrollment[a]			Market Penetration[b]		
	March 2004	March 2005	September 2005	March 2004	March 2005	September 2005	March 2004	March 2005	September 2005
Total Enrollment	**5,085,161**	**5,426,316**	**5,671,480**	**100**	**100**	**100**	**12.0**	**12.5**	**13.0**
HMO	4,486,537	4,686,484	4,829,296	88.2	86.4	85.2	10.6	10.8	11.0
PPO[c]	94,021	146,516	166,172	1.8	2.7	2.9	0.2	0.3	0.4
PFFS	26,932	79,372	141,921	0.5	1.5	2.5	0.1	0.2	0.3
Other[d]	477,611	513,944	534,091	9.4	9.5	9.4	1.1	1.2	1.2

Source: MPR Analysis for KFF of files constructed from CMS data over time.

[a]Percentages may not add up to 100 percent because of rounding.
[b]Calculations are based on beneficiaries of 42,359,734 beneficiaries in March 2004; 43,404,885 beneficiaries in March 2005; and 43,726,526 beneficiaries in September 2005.
[c]Includes PPO demonstration enrollment.
[d]Includes cost contracts and miscellaneous other plans.

MA plans also could be attractive because they provide the potential to integrate traditional Medicare benefits, prescription drug benefits, and supplemental coverage into a single product. Historically, beneficiaries have had to trade off provider choice to get these savings. They may not have to with PFFS, especially if such products are able to offer the broad access to providers that has long been Medicare's appeal.

But Medicare's history with private plans also indicates that high payments may not be sustainable over time. Beneficiary concerns over the viability and stability of this option could diminish the appeal of MA plans to beneficiaries, limiting their participation in the MA program and potentially in the new drug program itself.

Finally, the changes in types of MA plans available could alter the potential benefits and risks to Medicare of MA enrollment. An initial motivation by Congress in authorizing private plan choice was to allow Medicare beneficiaries to retain their existing enrollment in prepaid group practices and HMOs as they transitioned from working to retirement and Medicare (Gold et al., 2004). In addition to offering continuity, HMOs were viewed as providing an

organizational form that would better support care management—something CMS has found difficult to foster in the traditional Medicare program with its national scale and fee-for-service infrastructure. Whether more loosely structured PPOs provide such advantages is unclear. Further, if MA growth comes through PFFS expansion, Medicare may lose some of the market power that enables it to aggressively set prices with providers with no gain in better care management.

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The Henry J. Kaiser Family Foundation:
2400 Sand Hill Road
Menlo Park, CA 94025
(650) 854-9400
Facsimile: (650) 854-4800

Washington, D.C. Office:
1330 G Street, N.W.
Washington, DC 20005
(202) 347-5270
Facsimile: (202) 347-5274

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