THE HENRY J. KAISER FAMILY FOUNDATION

MARCH 2007

MEDICARE

ISSUE BRIEF

PRIVATE PLANS IN MEDICARE: A 2007 UPDATE

March 2007

Prepared by

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

For

The Henry J. Kaiser Family Foundation

ACKNOWLEDGEMENTS

The Kaiser Family Foundation commissioned this work. Michelle Kitchman Strollo, Juliette Cubanski, and Tricia Neuman of the Foundation provided valuable suggestions and feedback as it proceeded. At MPR, Miriam Loewenberg and Dawn Phelps provided programming support. Sarah Davis contributed to coding data. Felita Buckner provided secretarial support. Tim Lake provided feedback on earlier drafts of this paper. Caitlin Johnson and Daryl Hall provided editorial support for the work.

EXECUTIVE SUMMARY

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that established the Medicare Prescription Drug Benefit in 2006 gave beneficiaries a choice to remain in traditional Medicare and receive the benefit through a freestanding prescription drug plan (PDP) or to enroll in one of several types of authorized Medicare Advantage (MA) plans that integrate all Medicare benefits and typically provide additional supplemental coverage. In December 2006, 16.7 million beneficiaries were enrolled in PDPs and 7.6 million were enrolled in MA (6.6 million of whom were in plans offering a prescription drug benefit).

In this Issue Brief, we extend our earlier work reviewing available PDP and MA choices to examine how the marketplace has evolved in the time (more than a year) in which MA changes have been effective and how beneficiaries responded. The analysis draws upon publicly available CMS data files that we have built upon to profile trends. The brief focuses mainly on understanding evolution in the MA market, but it also reviews the changes in the PDPs with whom they compete. We review first how PDP, and then MA, choices changed from 2006 to 2007. We then examine beneficiary response to MA in 2006 and the kinds of plans that have attracted the most enrollment. We also look at market dynamics, to identify which firms dominate and are driving the market and how they and others are positioning themselves in 2007.

Our results profile a very active and expanding Medicare market for private plans, but one in which some products hold more industry and beneficiary appeal than others. The question for policymakers is whether the Medicare program will be stronger for these recent changes.

KEY FINDINGS

Changes in PDP Availability, 2006 to 2007

- Medicare beneficiaries had many PDP choices in 2006 and have even more in 2007, with 17 firms sponsoring plans nationally (up from 10 in 2006) and others more selectively in parts of the country.
- In 2007, three new firms have entered the PDP market with national offerings, one an insurance company (Envision Rx Plus) and two pharmacy benefits companies (Express Scripts and NMHC). Five others already in the PDP market in 2006 expanded nationwide—two "near-national" firms (Humana and United American) and three in fewer regions (Rx America, Health Net, and New Quest).
- In 2007, regardless of where they live, beneficiaries can choose among no fewer than 45 PDP plans from at least 19 organizations. Those eligible for the low income subsidy (LIS) have fewer choices, although in all but 11 states the number of sponsors with eligible LIS plans is the same or more than in 2006.

Changes in MA Availability, 2005 to 2007

- MA availability continued to expand in 2007, with 98 percent of all beneficiaries (including 100 percent in urban areas and 94 percent in rural areas) having a choice of least one MA plan.

- While the share of beneficiaries with one or more choices did not change that much, there was relatively dramatic change in availability in some sectors of the market in 2007—including a moderate growth in HMO availability, a dramatic increase in the number of private fee-for-service (PFFS) choices available, and the first offering of Medical Savings Account (MSA) type MA choices within the program.

- With the expansion, 52 percent of Medicare beneficiaries have a choice of PFFS from six or more sponsors and 86 percent have three or more PFFS choices. This reflects the continued widespread availability of PFFS plans from Humana and UnitedHealthcare; the significant expansion of such offerings nationwide by Sterling, Wellpoint, and Heritage Health Systems in 2007; the new PFFS products from Coventry and Sierra available in many parts of the country; and the more limited expansion by others firms such as Wellcare and Health Net.

- In 2007, for the first time, 70 percent of Medicare beneficiaries can chose to enroll in an MSA plan with a high deductible and associated annual deposit that can be used to cover qualified expenses. This is due primarily to Wellpoint, which is offering such plans across broad areas of the country. However, American Progressive also has a more geographically limited plan authorized under demonstration authority.

- Beneficiaries who meet selected criteria also may enroll in MA's Special Needs Plans (SNPs) if they are available in their location; the number of contracts offering such plans has increased from 2006. (In September 2006, 602,881 enrollees were in SNPs, 491,877 of them in plans serving dual eligibles (beneficiaries eligible for both Medicare and Medicaid).) Because SNPs are not available to all Medicare beneficiaries, we exclude contracts that *only* offer such plans from our overall analysis of availability and enrollment.

MA Enrollment Trends, 2005 to 2007

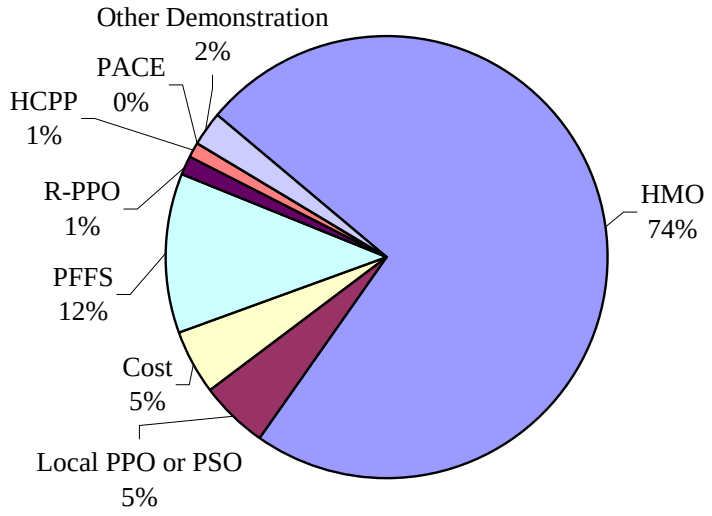
- Between March 2005 and November 2006, MA enrollment increased 37 percent, from 5.1 million to 7.0 million enrollees. The dominant HMO sector of the market added about 0.7 million enrollees for a net growth rate of 20 percent. Some of this growth probably reflects dually eligible beneficiaries automatically enrolled in Special Needs Plans. Local PPO enrollment grew much more rapidly—143 percent over the period—but still attracted only about 356,000 enrollees. Regional PPOs (R-PPOs), first available in 2006, attracted only 89,000 enrollees. In contrast, PFFS enrollment increased nine-fold over the period. The 740,000 enrollees in PFFS plans are 2 percent of all Medicare beneficiaries and the net gain in PFFS accounts for 39 percent of MA growth over the period examined.

- Seventy-seven percent of Medicare beneficiaries live in urban areas but 91 percent of MA enrollees were drawn from this area in November 2006. PFFS has increased MA enrollment in rural areas. Forty-five percent of MA enrollment in rural areas is in PFFS plans.

- MA enrollment continues to be uneven geographically across the country, although PFFS has had a small leveling effect. MA penetration rates are higher in most states in 2007 than 2006. There are at least some PFFS enrollees in each state. While R-PPOs have attracted some enrollment where offered, 40,000 of the 89,000 enrollees live in Florida where 1.2 percent are enrolled in a R-PPO plan.

- CMS data for February 2007 indicate continued growth in MA in 2007, with 8.3 million enrolled in any MA plan (including over 1.3 million in PFFS). PDP enrollment, including those in employer only plans, was at 16.9 million.

MA ENROLLMENT BY CONTRACT TYPE, 2006



Total Enrollment in All Plan Types* = 6,962,353

Source: MPR analysis for the Kaiser Family Foundation of CMS's GSA file for November 2006.
Excludes enrollment in Puerto Rico and the territories but includes enrollment in "800" contracts that are available only to employer groups.
*Excludes enrollment in contracts offering only SNP plans.

MA Market Concentration and Competition

- A small number of firms historically have dominated the MA market and this continues to be true in 2007. In November 2006, UnitedHealthcare, Blue Cross-Blue Shield affiliates, Humana and Kaiser-Permanente had 4.2 million enrollees together, 58 percent of all MA enrollment. These firms each have distinct preferences in MA products as reflected, for example, in Humana relying almost exclusively on PFFS and R-PPOs to expand enrollment, Kaiser-Permanente staying with its traditional HMO product, and the other two falling in between.

- The PDP market is also concentrated and led by some of the same firms active in MA. UHC-PacifiCare, Humana, and Wellpoint, a BCBS affiliate, held 50 percent of the PDP market in mid 2006.

CONCLUSIONS

Both the PDP and MA markets expanded in 2007—current participants stayed in the market and often expanded products and others entered for the first time. For the most part, this expansion reflects further choice among additional types of indemnity coverage, whether in PDPs designed to complement the traditional Medicare program or in MA plans that integrate all Medicare benefits with supplemental coverage but also do so by building around a fee-for-service model, such as PFFS and MSAs. In contrast to the traditional form of HMO coverage, these plans tend to be less managed or unmanaged, without networks that add to the costs of entry. Clearly Medicare Part D and the MA program have industry appeal, at least in the short term. Whether beneficiaries are well served by having to choose among a large number of plans that typically vary little from one another is an issue to be debated and researched.

INTRODUCTION

Medicare's new and voluntary prescription drug benefit has now been effective for over a year; beneficiaries are required, for the first time in the program's history, to enroll in a private plan to receive these benefits (MedPAC 2006, 2007; Gold 2005; Berenson 2004; Biles et al. 2004). In earlier work, we reviewed the choices available to beneficiaries seeking to enroll in the benefit in 2006 and the landscape of the marketplace—including the firms offering products (Gold 2006a, b).[1] Now, a year later, we examine how the marketplace has evolved and how beneficiaries have responded to the choices offered them. Our results profile a very active and expanding Medicare market for private plans, but one in which some products hold more industry and beneficiary appeal than others. The question for policymakers is whether the Medicare program will be stronger for these recent changes.

Focus of the Brief

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established the new Medicare drug benefit effective 2006, giving beneficiaries a choice to remain in traditional Medicare and receive the benefit through a freestanding private prescription drug plan (PDP) or to enroll in one of several types of authorized Medicare Advantage (MA) plans. The latter integrate drug benefits (Part D) with other Medicare benefits (Parts A and B) and supplemental coverage. This brief focuses mainly on the MA side of the market, but it also reviews offerings from the freestanding private prescription drug plans (PDPs) with which the MA plans compete.[2] At year-end 2006, 7.6 million beneficiaries were enrolled in MA—6.6

[1] See Marsha Gold. "The Growth of Private Plans in Medicare 2006" and "The Landscape of Private Plans in Medicare 2006." Washington DC: Kaiser Family Foundation, March 2006 (a,b).

[2] For additional details on Part D and PDP offerings see Juliette Cubanski and Patricia Neuman. "Status Report on Medicare Part D Enrollment in 2006: Analysis of Plan-Specific Market Share and Coverage." *Health Affairs Web Exclusive*, 21 November 2006.

million of them in plans offering a Medicare Part D prescription drug benefit (MA-PDs).[3] Over twice as many beneficiaries (16.7 million) were enrolled in PDPs, although this includes approximately 6 million dual eligibles automatically enrolled in PDPs. Readers seeking background on the new Medicare prescription drug benefit and MA can find it in Box 1.

Organization of the Brief

The findings in this brief are organized in four sections. In the first two sections, we review first how PDP choices, and then MA choices, have changed from 2006 to 2007. The third section examines the beneficiary response to MA in 2006 and which MA plan types have been most popular. The fourth section looks at how this affects the market share of diverse firms offering MA and how they are positioning themselves in 2007. In the concluding section of the brief, we summarize the main ways the market has evolved since 2006 and comment on their implications.

Data Sources

The data upon which this brief is based come from files Mathematica Policy Research, Inc. (MPR) has developed over time using publicly available data from the Centers for Medicare and Medicaid Services (CMS). The analysis has historically relied on files created around the monthly "Geographical Service Area" (GSA) report on MA contracts and enrollment in each county. Because CMS did not release this file for most of 2006, we have made accommodations. MA plan availability in 2006 and 2007 is based on files created from the CMS Medicare Personal Plan Finder. The enrollment analysis relies mainly on the first (November) 2006

[3] Plans authorized under MA must offer at least one plan with a Medicare Part D prescription drug benefit (MA-PD plans). The exceptions are PFFS and cost contracts, for which it is optional. Medical Savings Accounts (MSAs), an option under the MMA, may not offer a prescription drug benefit and regional PPOs must include this benefit in all their plans. Beneficiaries enrolling in a type of plan that does not offer a prescription drug benefit may also enroll in a freestanding PDP. Otherwise, MA enrollees who desire prescription drug coverage must elect it through their MA plan rather than a freestanding PDP.

release of the GSA file. These data are the first files that CMS released since the prescription drug benefit was added that allow MA availability to be assessed by county at the plan sponsor (contract) level. Our analysis of these data excludes MA in Puerto Rico and the territories. Because the brief focuses on choices available to all beneficiaries, we exclude contracts that only offer SNPs. We address a few topics through the CMS Annual Plan Report released in July 2006. This file has total enrollment by contract but does not break it down geographically.

Major Types of Free-Standing Prescription Drug and Medicare Advantage Plans

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

Local Coordinated Care Plans. These are network-based plans offered in defined aggregations of counties. Authority for Health Maintenance Organizations (HMOs) has existed the longest; in 1997, the BBA added authority for other types of coordinated care plans. Both of these types, as well as private fee-for-service (PFFS) plans define their service area on a county-by-county basis and the plans they offer are called "local plans."

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

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

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

Medical Savings Accounts. These plans have a high deductible that is accompanied by an annual deposit in an interest-bearing checking account that can be used to cover qualified medical expenses. MSAs do not provide drug coverage but beneficiaries can purchase it through a PDP.

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

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

Evolution of the Freestanding PDP Marketplace between 2006 and 2007

Medicare beneficiaries had many PDP choices in 2006 and they have even more in 2007. Ten organizations sponsored PDPs nationally in each of the 34 regions established for this purpose in 2006, and 17 do so in 2007—even though two of the 2006 national sponsors merged and are only counted once in 2007. Other organizations are sponsoring PDPs in single regions or subsets of regions. Beneficiaries, regardless of where they live, are able to select PDPs from at least 19 organizational sponsors in 2007 and almost always more (Table 1). Because sponsors typically offer more than one plan to provide a choice of benefit packages, beneficiaries—regardless of region—have no fewer than 45 PDP plans available to them in 2006 and most often more. Nationwide, the number of PDPs being offered across regions increased from 1,429 in 2006 to 1,875 in 2007.

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 and 2006 enrollment for all PDP and MA sponsors. In interpreting this requirement in 2007, CMS made certain accommodations to limit the number of LIS-eligible beneficiaries whose current plan would no longer be eligible for an LIS subsidy in 2007.[4] In most states, beneficiaries eligible for the LIS subsidy are able to choose among plans from at least as many sponsors in 2007 as in 2006. The exceptions are Delaware, the District of Columbia, Louisiana, Maryland, Michigan, Missouri, Nevada, North Carolina, South Carolina, Texas, and Virginia.

[4] This was a realistic concern because premiums for PDPs varied widely and beneficiaries were more likely to enroll in lower-premium plans. Whereas all PDPs counted equally in 2006 (because none had enrollment), the calculation in 2007 weighted PDPs by their 2006 enrollment. To limit the impact on beneficiaries, CMS allowed LIS-enrolled individuals whose 2006 PDP premium was no more than $2 per month above the benchmark to stay in that plan.

TABLE 1

AVAILABILITY OF PDPs BY STATE, 2006 – 2007

	PDP Organizations		Organizations with 1+ LIS Plans[a]		Benefit Plans Available[b]	
State	2006	2007	2006	2007	2006	2007
Alabama	17	24	8	12	41	57
Alaska	11	19	7	12	27	45
Arizona	18	22	5	7	43	53
Arkansas	15	24	12	15	40	58
California	18	23	8	8	47	55
Colorado	17	23	10	11	43	55
Connecticut	17	21	9	12	44	51
Delaware	19	24	15	11	47	56
District of Columbia	19	24	15	11	47	56
Florida	18	25	6	4	43	58
Georgia	18	24	13	11	42	56
Hawaii	12	20	7	10	29	46
Idaho	18	23	12	12	44	56
Illinois	16	23	12	11	42	56
Indiana	17	23	12	13	42	54
Iowa	17	22	11	12	41	53
Kansas	15	22	10	12	40	53
Kentucky	17	23	12	13	42	54
Louisiana	16	23	10	6	39	53
Maine	17	22	12	13	41	53
Maryland	19	24	15	11	47	56
Massachusetts	17	21	9	12	44	51
Michigan	18	23	13	11	40	54
Minnesota	17	22	11	12	41	53
Mississippi	15	23	11	10	38	53
Missouri	16	22	9	8	41	53
Montana	17	22	11	12	41	53
Nebraska	17	22	11	12	41	53
Nevada	18	22	8	6	44	54
New Hampshire	17	22	12	13	41	53
New Jersey	18	24	10	13	44	57

Table 1 *(continued)*

State	PDP Organizations		Organizations with 1+ LIS Plans[a]		Benefit Plans Available[b]	
	2006	2007	2006	2007	2006	2007
New Mexico	17	23	8	8	43	57
New York	21	26	11	11	46	61
North Carolina	16	21	11	10	38	51
North Dakota	17	22	11	12	41	53
Ohio	18	27	9	11	43	61
Oklahoma	16	24	10	10	42	57
Oregon	20	24	12	12	45	57
Pennsylvania	21	28	14	14	52	66
Rhode Island	17	21	9	12	44	51
South Carolina	19	25	14	10	45	59
South Dakota	17	22	11	12	41	53
Tennessee	17	24	8	12	41	57
Texas	20	24	14	10	47	60
Utah	18	23	12	12	44	56
Vermont	17	21	9	12	44	51
Virginia	17	22	14	12	41	53
Washington	20	24	12	12	45	57
West Virginia	21	28	14	14	52	66
Wisconsin	17	23	13	14	45	54
Wyoming	17	22	11	12	41	53

Source: MPR analysis for KFF of CMS data on PDPs from "Landscape Tables" in October 2005 and 2006.

[a]CMS designated LIS plans on the basis of 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. In some regions, more plans are available for LIS enrollment because some organizations have more than one LIS eligible plan, and some may also have an LIS plan that is not the lowest premium plan (see Kaiser Fact Sheet).

[b]Nationwide there were 1,429 plans in 2006 and 1,875 plans in 2007.

LIS enrollees typically have more choice of sponsors, both because the number of national sponsors has increased in 2007 and because many sponsors appear to want to be LIS eligible and have gotten better at setting premiums in order to be, as discussed below (see Table 2).

Each of the 2006 national PDP sponsors is continuing to offer such plans nationally in 2007. Because of their merger, UnitedHealthcare and PacifiCare consolidated their offerings in 2007—nevertheless, the combined entity is offering as many different plans in 2007 as they did separately in 2006. Two "near-national" firms (that served 30 or more regions in 2006)—Humana and United American—are now offering products in all regions. Three firms that offered plans in fewer regions in 2006—Long's Drug Stores with its RxAmerica plans, Health Net (a managed care firm long active in MA), and New Quest Health Solutions (a Health Spring affiliate, also with MA history)—have now "gone national." In 2007, three new sponsors are entering the PDP market and doing so nationwide: Envision RxPlus (an insurance company), Express Scripts (a large national pharmacy benefits management firm that also has a pending hostile takeover bid for Caremark and their national PDP firm), and NMHC Systems, also a pharmacy benefits management firm. None of the three appear to have existing PDP or MA products.

The changes in the PDP market indicate that scale remains attractive. National firms account for a much higher share of plans in 2007 (1,507 of 1,875) than in 2006 (886 of 1,429). Other firms, while still not offering nationwide PDPs in 2007, are still expanding their reach. Sierra, a Nevada-based firm in the MA market for years, is expanding its PDP offerings from 8 to 24 regions. Elder Care, in the MA market, is starting to offer PDPs in 2007 in 10 regions. AmeriHealth Advantage also is increasing its regions from 8 to 10. Most other sponsors are in only one region or a few (data not shown). In 2007, there appears to be less change in number of

TABLE 2

PROFILE OF NATIONAL, NEAR NATIONAL, AND OTHER PDP SPONSORS IN 10+ REGIONS IN 2007 AND IN 2006 OFFERINGS

	Number of Regions		Number of LIS Eligible Plans		Number of Plans		Mean Plans per Region		Percent of Beneficiaries with Access	
Sponsor	2006	2007	2006	2007	2006	2007	2006	2007	2006	2007
National										
Aetna Inc.	34	34	6	21	102	102	3	3	100	100
CIGNA	34	34	6	27	102	102	3	3	100	100
Caremark (Silverscript)	34	34	27	20	68	102	2	3	100	100
Coventry[a]	34	34	10	15	102	160	3	4.7	100	100
Envision Rx Plus, Inc.	0	34	0	0	0	68	0	2	0	100
Express Scripts	0	34	0	0	0	34	0	1	0	100
Health Net	6	34	6	33	12	102	2	3	20	100
Humana	31	34	31	34	93	102	3	3	99	100
Long's Drug Store Corp (Rx America)	20	34	13	27	40	68	2	2	50	100
Medco Health Solutions	34	34	19	0	34	34	1	1	100	100
MemberHealth (Community Care)	34	34	23	14	102	102	3	3	100	100
NMHC Systems Inc.	0	34	0	2	0	34	0	1	0	100
New Quest Health Solutions, LLC (Health Spring)	4	34	4	29	4	34	1	1	12	100
Torchmark Corporation (United American)	31	34	3	3	31	68	1	2	96	100
UHC/PacifiCare[b]	34	34	[b]	34	170	170	5	5	100	100
Wellcare Health Plans	34	34	34	23	102	102	3	3	100	100
Wellpoint, Inc.[a]	34	34	34	23	102	123	3	3	100	100
Near National (30+ Regions)										
Sterling	32	33	0	4	32	66	1	2	89	90
Prescription Pathways[c] (Pennsylvania Life)	31	33	25	27	102	93	3	3	96	93
10+ Regions (10-29 Regions)										
Sierra	8	24	8	4	8	56	1	2.3	19	34
Ameri Health Advantage	8	10	8	0	11	10	1.4	1	50	53
Bravo of Elder Care	0	10	0	8	0	20	0	2	0	12

Table 2 *(continued)*

Source: MPR analysis of the Kaiser Family Foundation of CMS data on PDPs from "Landscape Tables" in October 2005 and 2006. See Gold (2006b) for details on 2006 analysis.

[a]In 2006, Coventry also offered plans in 13 regions under its "First Health" name, all of which were LIS eligible. Advantra had just one plan per region, which was available to 56 percent of beneficiaries.

[b]In 2005, PacifiCare and United Health offered separate plans in each region; the former had three per region, and the latter had two per region with an AARP endorsement. The merger did not lead to a reduction in offerings. (In 2006, PacifiCare plans were LIS eligible in 31 regions, and UnitedHealthcare plans were LIS eligible in 33 regions.)

[c]In 2006, Wellpoint also offered 36 separate plans in 12 regions under its Anthem brand. These products were available to 53 percent of beneficiaries.

[d]In 2006, Marquette Insurance Company also offered this product in 22 regions, and Progressive Life offered it in 8. Its unclear whether or not such shared offerings are still supported.

plans offered per region than in regions covered, although any change typically involves more offerings.

Enrollment in the PDP market is relatively concentrated despite the wide range of choice (Figure 1). UHC/PacifiCare accounts for 25 percent of the market, a share expedited by the fact that each firm had separate offerings last year and was thus eligible for auto-assignment under each sponsor. Humana—which last year had a near-national plan that reached almost all beneficiaries—has 19 percent of the market. Six other firms (all national or near-national) have another 19 percent of the market, the largest being Wellpoint (6 percent), Wellcare (4 percent) and Coventry (3 percent). The rest of the market, about 28 percent of enrollees, is divided among the other sponsors. Being national or near-national clearly had an enrollment advantage in 2006, but did not guarantee enrollment. Among national PDP sponsors, both Aetna and Cigna qualified for LIS enrollees in few regions and had fewer enrollees than many other national firms. Caremark and MemberHealth also have a more limited enrollment.

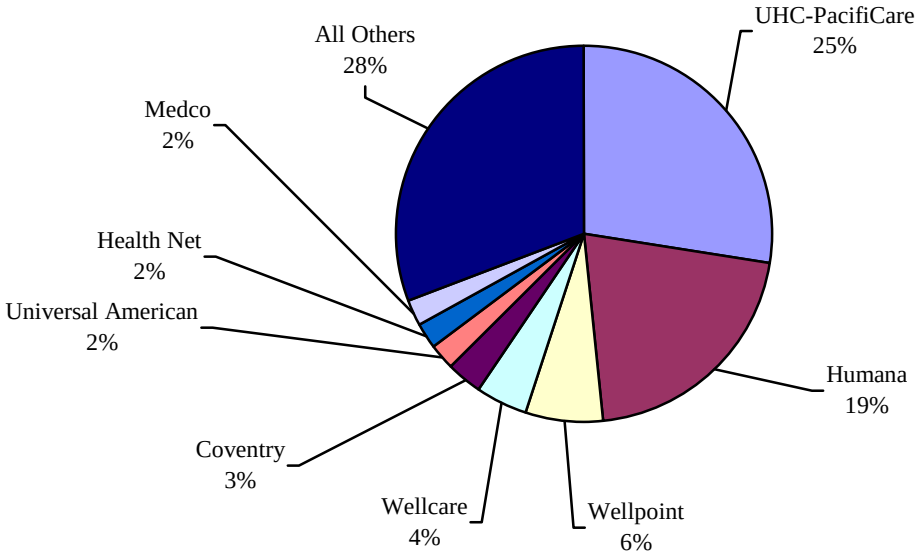
Expansion in MA Availability and Choice, 2005 to 2007

Although MA was available in most parts of the country before 2006, coverage was uneven across urban areas, and rural availability was largely due to the growth in PFFS from 2000 to 2005.[5] MA expanded in 2006 and continued to do so in 2007. In 2007, 98 percent of beneficiaries have some MA plan availability to them, including all beneficiaries in urban areas and 94 percent in rural areas—in each case, only slightly more than in 2006. However, what is notable about 2007 is the uneven growth across sectors of the MA market (Table 3). In 2007, the

[5]In 1999, 72 percent of all Medicare beneficiaries had access to MA, including 86 percent in urban areas and 25 percent in rural areas. Enrollment was almost exclusively in HMOs (Gold 2006a). By March 2005, there were eight PFFS contracts reaching 41 percent of beneficiaries, including 51 percent in rural areas. Enrollment however grew slowly. There were 25,897 enrollees in these plans at year-end 2003 and 51,214 at year-end 2004, according to CMS's monthly MA summary reports on enrollment.

FIGURE 1

PDP ENROLLMENT BY FIRM, 2006



Total = 16.1 million beneficiaries

Source: Cubanski and Neuman (2006) from analysis of CMS's Annual Report by Plan (7/26/06).

TABLE 3

AVAILABILITY OF MA BY CONTRACT AND COUNTY TYPE, 2005-2007

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

Source: MPR analysis of publicly available CMS data from the Geographic Services Area Report (March 2005) and from the Medicare Personal Plan Finder (November 2005 and October 2006 release). Excludes employer-only contracts and contracts that offer SNP only plans because they are not available to all beneficiaries.

[a]For 2005 and 2007, figures also include available HCPP, PACE, and "other" (largely demonstration contracts). Data were not available in 2006 for these three contract types.

[b]Includes PPO demonstration in 2005. (The demonstration was discontinued in 2006, with many contracts converting to regular local PPOs.)

growth in MA was most apparent in the most and least managed ends of the MA spectrum, and particularly strong in the latter.

Coordinated Care Plan Availability. Moderate HMO growth drove change in the coordinated care share of the market in 2007. The share of beneficiaries with an available HMO plan increased from 70 percent to 74 percent nationwide, including an increase from 25 percent to 33 percent in rural areas. In 2007, local PPOs were precluded from entering the market under a short-term moratorium meant to encourage R-PPO entry.[6] PPO availability declined slightly in 2007 as sponsors of a few local PPOs withdrew.[7] There was no change in R-PPO contracts or availability.

We are uncertain what is driving these trends, but there are several possibilities. First, HMOs are the most tightly managed products, which likely leads sponsors to view them as having the greatest revenue-generating potential. Second, sponsors wishing to offer new HMOs were limited in doing so in 2006 because of competing demands associated with the introduction of the new drug benefit (Gold and Peterson 2006). By 2007, they had more time to invest in the necessary network development. Third, the appeal of HMOs may be heightened by firms' interest in offering Special Needs Plans (SNPs), many of which are offered through HMO contracts.[8] Those dually eligible for Medicare and Medicaid are a particular target for SNPs. It

[6] The moratorium covered 2006 and 2007 and will be lifted in 2008. Although local PPO availability has been shown to change in 2006, the movement actually reflects approvals of new local PPOs and service areas expansion in the second half of 2005 before the moratorium. There were 64 local PPO or PSO contracts in March 2005 (including the PPO demonstration), 72 in June 2005, 132 in September 2005 and 133 in December 2005. By 2006, local PPOs in the PPO demonstration had to convert to regular status or withdraw. The total number of local PPO contracts in March 2006 was 116 (Gold and Peterson 2006).

[7] These included two local PPO contracts from UnitedHealthcare, one from Humana, one from HealthNet, and one from Health Spring, along with others that appear more locally based.

[8] While MA contracts generally require that they be available to all beneficiaries in a locale, SNPs can restrict enrollment to one of three categories of beneficiaries: dual eligibles, institutionalized beneficiaries, or individuals with severe or disabling chronic conditions. Because SNPs are a form of plan, not contract, their availability is complex to track using the data in this analysis. We have excluded from our counts the 79 contracts that *only* offer SNP plans because these are not available to all beneficiaries, only those who qualify. Of the MA contracts that are

could be that the expanded presence of HMOs in rural areas reflects an attempt to encourage state interest in coordinating Medicaid coverage with Medicare's SNP products by offering them across the state.

PFFS Expansion. PFFS availability expanded more rapidly in 2007 than did other options available in 2006. In 2007, the share of beneficiaries with an available PFFS plan increased to 97 percent from 78 percent nationwide in 2006, with 100 percent availability in urban areas and 94 percent availability in rural areas. With this expansion, 52 percent of Medicare beneficiaries have a choice of available PFFS plan from six or more sponsors (Table 4) and 86 percent have at least three such choices in 2007. The number of PFFS sponsor plans available to Medicare beneficiaries is substantially greater than for the entire coordinated care sector overall, including R-PPOs—even in urban areas where coordinated care is more prominent.

TABLE 4

NUMBER OF COORDINATED CARE AND PFFS CONTRACTS AVAILABLE TO BENEFICIARIES BY COUNTY TYPE, 2007

	All Beneficiaries		Urban Beneficiaries		Rural Beneficiaries	
Percentage of Beneficiaries with:	CCP[a]	PFFS	CCP[a]	PFFS	CCP[a]	PFFS
None	1.5%	0.3%	0.7%	0.0%	4.3%	0.0%
1	12.5	2.7	5.8	3.4	36.3	0.4
2	16.0	6.1	11.1	7.5	33.9	1.6
3-5	33.9	35.9	39.3	35.2	16.7	40.0
6 or More	33.7	52.4	43.2	53.4	2.3	51.4

Source: MPR analysis of a file created from the 2007 Personal Plan Finder.

Note: Contracts reflect unique organizational sponsors. Each contract may include several plans (that is, different benefit packages). Excludes employer-only "800" plans.

[a]Includes R-PPOs.

(continued)

available to all beneficiaries and included in our analysis, 119 offer a SNP along with plans available to all beneficiaries. Of the 119, 95 are HMO contracts. The rest are local PPOs (9), local PSOs (4), R-PPOs (3), and demonstration contracts (8).

The large number of sponsor choices available to most beneficiaries reflects the continued availability of PFFS plans across most of the country by Humana and UnitedHealthcare; the significant expansion in the geographic scope of PFFS offerings by Sterling, Wellpoint, and Heritage Health Systems in 2007; and Coventry's and Sierra's 2007 entry into the market, with broad based offerings (Table 5). Wellcare, a firm that aggressively pursued the PDP market in 2006 with a national plan (as well as local MA products) is offering PFFS for the first time in 2007 in over 700 counties. Health Net, an MA sponsor, is expanding its PFFS offerings in 2007 as it also shifts to offering a national PDP.

MSAs Available. For the first time in 2007, 70 percent of Medicare beneficiaries also have a choice of an MSA,[9] including 73 percent in urban areas and 66 percent in rural areas (see Table 3). For the most part, this is due to Wellpoint's UniCare plans that are available to individuals and employer groups in all states except 12.[10] Blue Cross of California (also a Wellpoint company) is offering an MSA structured the same way for individuals and employer groups in California. Beneficiaries in New York and Pennsylvania, as well as employer groups nationwide, also have an MSA available from American Progressive under demonstration authority.[11]

[9] See the CMS Fact Sheet on 2007 Medicare Medical Savings Accounts: http://www.cms.hhs.gov/HealthPlansGenInfo/02_WhatsNew.asp#TopOfPage. All MSAs cover Part A and B services and may cover other supplemental services (although no plan is doing so in 2007) – but are prohibited from covering prescription drugs. Individuals can still join a freestanding PDP. Members receive an annual deposit into an interest-bearing account they can use tax-free to cover qualified expenses as defined by the IRS (these can include Part D cost sharing but not premium). Unused funds can carry over from year to year. Under demonstration authority, plans may limit authority to employer groups, require cost sharing after meeting the deductible (if below $9,500), vary cost sharing between in and out of network services, and provide additional coverage for preventive services.

[10] Three plans are available with deductibles of $2,500, $3,500, and $4,500 (the employer group plans has a deductible of $4,500). The states without these are: California, Colorado, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio, Virginia, and Wisconsin. California however will have similar choices through Blue Cross of California.

[11] The demonstration plan has a $4,000 deductible with 20 percent cost sharing after the deductible is met up to a $4,800 out of pocket maximum. There is some coverage for preventive services before the deductible is met.

TABLE 5

PFFS CONTRACTS BY FIRM AND CHANGE 2006-2007

Firm Name/Contract Number	In 2006	In 2007	Counties 2006	Counties 2007
Humana				
H1407 (Humana)	✓	✓	1	1
H1804 (Humana)	✓	✓	2,731	2,908
H1906 (Humana, Louisiana)	✓	✓	64	64
H5657 (Humana, New York)		✓		51
UnitedHealthcare				
H2408 (Secure Horizons)	✓	✓	277	300
H4720 (Secure Horizons)		✓		1
H5435 (SecureHorizons-Medicare Direct)	✓	✓	1,557	1,481
Sterling				
H 5006 Option I	✓	✓	1,268	2,773
H 5602 Partners Pennsylvania	✓		1	
H5839 Partners Montana	✓	✓	2	2
Wellpoint				
H5419 Blue Cross of CA	✓	✓	5	5
H0540 UniCare Life and Health[a]	✓	✓	636	1,181
H1689 BCBS of Wisconsin		✓		145
H5308 Empire BCBS		✓		1
Other BCBS Affiliates				
H2319 BCBS of Michigan	✓	✓	83	83
H2613 BCBS of Missouri	✓	✓	13	85
H4205 BCBS of South Carolina	✓	✓	22	22
H5884 BCBS of Tennessee	✓	✓	95	95
H5849 Arkansas BC MediPak Advantage		✓		75
H5862 BC of Idaho Health Services		✓		44
WellCare				
H1340 WellCare		✓		451
H4577 WellCare		✓		292
H6499 WellCare		✓		50
Medica		✓		
H2409 Health Plans of Wisconsin	✓	✓	13	13
H2410 Health Plans	✓	✓	91	91
Heritage Health Systems				
H3333 Today's Option	✓	✓	89	277
H5421 Today's Option	✓	✓	366	2,318
Coventry				
H0846 Advantra Freedom		✓		2,275
H5227 Advantra Freedom		✓		35
H5952 Advantra Freedom		✓		52
HealthNet				
H5721 Health Net		✓		48
H5996 Health Net		✓		146

Table 5 *(continued)*

Firm Name/Contract Number	In 2006	In 2007	Counties 2006	Counties 2007
Other Companies				
H4205 Instil Health Insurance Company[b]	✓	✓	83	205
H5812 Geisinger Health Plan Gold Choice	✓	✓	8	14
H5909 MediSun PFFS	✓	✓	1	1
H1254 UMPC Health Plan		✓		21
H1850 Windsor Medicare Extra		✓		95
H4449 Sierra Optima		✓		2,232
H5485 Prime Time Health Plan		✓		7
H5736 Aetna Medicare		✓		69
H5820 Any, Any, Any Plan		✓		651
H6421 Bravo by Elder Care		✓		19
H6499 Harvard Pilgrim HealthCare		✓		5
H8201 Metropolitan Health Plan		✓		22
H9519 Independent Health		✓		62

Source: MPR analysis of files created from the 2006 and 2007 CMS Personal Plan Finder.

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

[b]This firm is a non-Blues brand affiliate of BCBS of South Carolina.

Availability across States. In 2007, beneficiaries in almost all states have at least one MA choice (Table 6). MA availability remains more limited in Alaska than elsewhere in the country but the share of beneficiaries in Alaska with MA availability is 83 percent in 2007, up from 14 percent in 2006 (Gold 2006a). As before however, Alaska's choices are restricted to PFFS, except for newly available MSA choices; no coordinated care plans of any type operate in Alaska. Nor do any operate in New Hampshire, North Dakota, South Dakota, Vermont and Wyoming. For some reason, HMOs are also mostly absent in Indiana, where only 4 percent have access to such an option in 2007.

MA Enrollment Trends 2005 to 2006

Since the beginning of 2005, MA enrollment has increased by about 37 percent nationwide (Table 7), from 5.1 million to 7.0 million enrollees in November 2006. HMOs continue to dominate MA enrollment but enrollment in HMOs—which were once the sole or primary MA option—is increasing more slowly than some other types of MA.

Enrollment by Plan Type. From March 2005 to November 2006, HMO enrollment increased 20 percent, a net gain of 0.7 million enrollees. Some of this growth probably includes dually eligible enrollees automatically enrolled in Special Needs Plans, most of which use the HMO model. Enrollment in local PPOs increased much more rapidly than in HMOs—with a 143 percent growth rate over the period--but they were starting from a much lower base and still only account for about 356,000 of all MA enrollees. R-PPOs, new in 2006, attracted relatively few enrollees—there were only about 89,000 enrollees in these products by November 2006 though they were available to 86 percent of all beneficiaries. In contrast, PFFS enrollment increased more than nine-fold between March 2005 and November 2006, growing to almost 820,000 enrollees or 2 percent of all Medicare beneficiaries. The net gain in PFFS enrollment accounts for 39 percent of the growth in MA enrollment over that period of time.

TABLE 6

MA AVAILABILITY BY STATE AND PLAN TYPE, 2007
(Percent of Beneficiaries with Contracts Available to Them)

State	Any Plan	Local CCP							
		Any	Local HMO	Local PPO	R-PPO	PFFS	Cost	MSA	Other (HCPP Pace Demo)
All States	**98**	**79**	**74**	**60**	**86**	**97**	**13**	**70**	**32**
Alabama	100	75	68	57	100	100	0	100	13
Alaska	83	0	0	0	0	83	0	83	0
Arizona	100	92	92	81	100	100	0	100	0
Arkansas	100	60	60	0	100	100	0	100	0
California	100	93	93	33	100	100	3	100	48
Colorado	100[a]	84	84	62	0	100[a]	0	0	43
Connecticut	100	100	100	0	0	100	0	5	92
Delaware	100	54	54	0	100	100	0	100	0
District of Columbia	100	100	100	100	100	100	100	100	0
Florida	100[a]	94	93	78	100[a]	100[a]	0	100[a]	11
Georgia	100	51	45	45	100	100	0	0	0
Hawaii	100	100	100	72	100	100	100	100	0
Idaho	100	86	83	70	0	100	65	100	0
Illinois	100	90	75	88	100	100	0	100	10
Indiana	100	39	4	39	100	100	33	0	0
Iowa	100	77	77	22	100	100	7	100	0
Kansas	100	39	39	30	100	100	0	100	15
Kentucky	100	38	35	38	100	100	0	0	0
Louisiana	100	66	66	24	100	100	0	100	0
Maine	100	57	57	44	0	100	0	0	0
Maryland	100	79	79	79	100	100	83	100	57
Massachusetts	100	97	97	97	0	82	0	100	91
Michigan	100	81	81	50	100	100	0	100	43
Minnesota	100	97	97	0	100	100	100	100	0
Mississippi	100	33	33	0	100	100	0	100	0
Missouri	100	68	65	65	100	100	0	0	23
Montana	100	74	12	71	100	100	0	100	0
Nebraska	100	32	32	0	100	100	0	100	0
Nevada	100	100	89	100	100	100	0	0	0
New Hampshire	100	0	0	0	0	100	0	0	0
New Jersey	100	100	100	87	100	100	0	100	13
New Mexico	100	100	49	100	0	100	0	100	39

Table 6 *(continued)*

State	Any Plan	Local CCP			R-PPO	PFFS	Cost	MSA	Other (HCPP Pace Demo)
		Any	Local HMO	Local PPO					
New York	100	100	94	99	100	100	64	0[b]	100
North Carolina	100	58	58	41	100	100	0	100	0
North Dakota	100	0	0	0	100	100	45	100	0
Ohio	100	91	89	89	100	100	28	0	25
Oklahoma	100	71	64	63	100	100	0	100	0
Oregon	100	100	95	100	0	100	36	100	17
Pennsylvania	100	98	95	98	100	100	0	100	100
Rhode Island	100	100	100	86	0	100	0	100	100
South Carolina	100	65	40	47	100	100	0	100	11
South Dakota	100[a]	0	0	0	100[a]	100[a]	34	100[a]	0
Tennessee	100	82	82	56	100	100	0	100	27
Texas	100	77	76	55	100	100	9	100	49
Utah	100	87	61	87	0	100	0	100	0
Vermont	100	0	0	0	0	100	0	100	20
Virginia	100[a]	71	36	57	100[a]	100[a]	16	0	7
Washington	100	96	94	78	0	100	0	100	25
West Virginia	100	100	28	100	100	100	9	100	0
Wisconsin	100	78	73	48	100	100	32	0	16
Wyoming	100	0	0	0	100	100	0	100	0

Source: MPR analysis of a file constructed from CMS's 2007 Personal Plan Finder. Excludes employer only contracts and contracts that only offer SNPs because these are not available to all beneficiaries.

[a]Not all beneficiaries have access, but the share that does is at least 99.8 percent, and it rounds to 100 percent.

[b]Less than 0.5 percent had access, so it rounds to 0 percent.

TABLE 7

TRENDS IN ENROLLMENT BY CONTRACT TYPE, 2005-2006

	Number			Change March 2005-November 2006	
	March 2005	December 2005	November 2006	Net	Percent
All Contracts*	5,066,067	5,466,247	6,962,353	+1,896,286	+37%
Local HMO, PPO, or PSO	4,508,188	4,757,955	5,483,159	+974,971	+22%
HMO	4,361,672	4,547,311	5,102,128	+740,456	+20%
Local PPO or PSO	146,516	210,644	355,794	+209,278	+143%
Cost	317,932	317,749	313,405	-4,527	-1%
PFFS	79,372	199,063	819,098	+739,726	+932%
R-PPO	0	0	89,393	+89,393	N/A
HCPP	20,779	20,756	75,477	+54,698	+263%
PACE	9,618	10,612	12,116	+2,498	+26%
Other Demonstration	130,178	160,113	169,705	+39,527	+30%

Source: MPR analysis of files created from available CMS data in the Geographic Service Area File, selected months. Excludes enrollment in Puerto Rico and the territories but includes enrollment in "800" contracts that are available only to employer groups.

*Excludes enrollment in SNP only contracts

Urban versus Rural Enrollment. MA enrollment continues to be more concentrated in urban than rural areas. In November 2006, 6.4 million MA enrollees were in urban counties and 0.6 million were in rural areas. The 91percent of MA beneficiaries who reside in urban counties compares against residence patterns that show a substantially smaller share—77 percent—living in urban areas (Table 8).[12] While HMO enrollment is particularly concentrated in urban areas (96 percent of enrollees reside there), so is enrollment in most other MA forms. PFFS is a notable exception: only 67 percent of PFFS enrollment comes from urban areas. In fact, 45 percent of all MA enrollment in rural areas is in PFFS plans.

There are several ways such data can be interpreted. They clearly show that PFFS is a major factor in the relatively quick expansion of MA enrollment in rural areas. But PFFS was available in 91 percent of rural counties in 2006, whereas HMOs were only available in 25 percent of rural counties. From this perspective, the fact that rural enrollment in PFFS plans (at 271,000) exceeds that in HMOs (194,000) is less striking. PFFS plans, of course, are newer and less well known to beneficiaries. In other work, we have analyzed benefits and premiums across types of MA plans and found that the financial protection offered by PFFS is substantially less than in HMOs (Gold, Hudson, and Davis 2006). It remains too early to determine the ultimate market appeal of PFFS.

Geographical Diversity. MA enrollment has always been uneven geographically and this continues to be true today, although PFFS growth appears to have had something of a leveling effect on enrollment (Table 9). In March 2005, MA penetration was less than 5 percent in 23 states (Gold and Peterson 2006). In November 2006, that was true for only 10 states: Alaska, Delaware, Maine, Maryland, Mississippi, New Hampshire, North Dakota, South Dakota, Vermont and Wyoming. Penetration also has grown, and remains higher, in some states, such as

[12] Based on 2005 data from CMS on the MA Tracker.

TABLE 8

DISTRIBUTION OF MA ENROLLMENT BETWEEN URBAN AND RURAL COUNTIES, BY CONTRACT TYPE, 2006

	All Counties	Urban Counties	Rural Counties	Urban as a Percent of All Enrollees
All Plan Types*	6,962,353	6,363,755	596,914	91%
Local HMO, PPO, or POS	5,483,159	5,262,064	219,559	96%
HMO	5,102,128	4,906,270	194,322	96%
Local PPO/POS	381,031	355,794	25,237	93%
Cost	313,045	257,457	55,847	82%
PFFS	819,098	548,465	270,606	67%
R-PPO	89,393	75,199	14,194	84%
HCPP	75,477	45,080	30,397	60%
PACE	12,116	12,116	0	100%
Other demonstration	169,705	163,394	6,311	96%

Source: MPR analysis for the Kaiser Family Foundation of CMS's GSA file for November 2006. Excludes enrollment in Puerto Rico and the territories but includes enrollment in "800" contracts that are available only to employer groups.

*Excludes enrollment in contracts offering only SNP plans

TABLE 9

MA ENROLLMENT AND PENETRATION BY STATE, 2006

	MA Enrollment						MA Penetration*		
State	Total	HMO	Local PPO	R-PPO	PFFS	Other	All	Urban	Rural
Alabama	97,134	82,466	3,538	11	9,841	1,278	12.4%	16.5%	4.3%
Alaska	13	0	0	0	13	0	0.0%[a]	0.0%[a]	0.0%
Arizona	248,136	214,781	770	1,663	30,388	534	30.3%	33.3%	12.5%
Arkansas	25,027	3,009	0	27	21,284	707	5.1%	5.8%	4.4%
California	1,395,974	1,245,306	19,989	17,688	13,135	99,856	31.8%	32.8%	4.8%
Colorado	153,949	116,355	1,496	0	9,912	26,186	28.4%	31.7%	11.0%
Connecticut	38,629	36,796	1,803	0	30	0	7.1%	7.7%	1.9%
Delaware	1,401	83	18	497	771	32	1.1%	1.2%	0.7%
District of Columbia	5,462	818	29	0	16	4,599	7.0%	7.0%	-[b]
Florida	702,350	601,652	50,063	40,378	5,855	4,402	22.4%	23.7%	5.6%
Georgia	68,732	18,745	2,021	282	47,673	11	6.4%	7.0%	4.7%
Hawaii	66,758	21,608	3,642	1,642	373	39,493	35.3%	35.2%	35.4%
Idaho	32,264	14,083	3,490	0	11,170	3,521	16.2%	21.0%	8.6%
Illinois	114,011	65,827	14,309	970	21,512	11,393	6.5%	7.0%	4.5%
Indiana	57,595	58	6,631	1,139	33,195	16,572	6.2%	6.3%	5.8%
Iowa	45,721	3,653	135	100	25,497	16,336	9.1%	13.3%	5.4%
Kansas	23,881	10,208	3,591	17	7,387	2,678	5.8%	9.0%	1.7%
Kentucky	36,628	9,134	4,032	2,465	14,982	6,015	5.2%	6.6%	3.7%
Louisiana	91,132	76,907	645	650	12,861	69	14.2%	18.6%	3.6%
Maine	1,844	24	1,165	0	655	0	0.8%	1.0%	0.5%
Maryland	32,812	10,647	4,271	174	272	17,448	4.6%	4.9%	0.2%
Massachusetts	152,278	148,667	1,832	0	96	1,683	15.1%	15.1%	0.0%
Michigan	84,335	34,544	701	1,514	47,196	380	5.5%	6.1%	3.3%
Minnesota	156,245	36,319	0	263	43,612	76,051	21.7%	26.6%	13.3%
Mississippi	17,424	1,114	0	133	16,150	27	3.7%	5.2%	2.8%
Missouri	133,943	107,010	8,030	27	17,546	1,330	14.2%	18.8%	4.8%
Montana	10,963	0	978	119	9,850	16	7.2%	9.8%	5.8%
Nebraska	19,696	9,268	0	256	8,289	1,883	7.4%	11.0%	4.2%
Nevada	88,847	32,889	158	1,227	1,442	53,131	28.8%	30.9%	15.2%
New Hampshire	1,489	1,259	0	0	230	0	0.8%	1.2%	0.2%
New Jersey	107,262	98,367	7,785	114	29	967	8.5%	8.5%	-[b]
New Mexico	55,603	42,664	7,155	0	4,991	793	20.0%	29.2%	5.6%
New York	618,151	534,735	36,936	4,407	9,567	32,506	21.5%	22.6%	10.9%
North Carolina	141,252	76,334	2,887	132	61,677	222	10.7%	12.9%	7.0%

Table 9 *(continued)*

State	MA Enrollment						MA Penetration*		
	Total	HMO	Local PPO	R-PPO	PFFS	Other	All	Urban	Rural
North Dakota	4,867	0	0	0	4,078	789	4.6%	5.1%	4.3%
Ohio	276,721	203,421	12,777	4,377	30,209	25,937	15.3%	17.9%	5.2%
Oklahoma	56,596	44,623	488	0	11,225	260	10.1%	16.1%	2.1%
Oregon	195,103	120,923	31,763	0	8,525	33,892	35.0%	42.0%	18.9%
Pennsylvania	634,553	538,991	63,325	155	21,932	10,150	29.0%	31.7%	16.4%
Rhode Island	58,959	58,249	476	0	190	44	33.2%	33.2%	-[b]
South Carolina	40,161	0	375	946	38,429	411	6.0%	6.7%	4.1%
South Dakota	2,598	17	0	16	2,543	22	2.0%	3.3%	1.3%
Tennessee	137,592	113,404	546	51	22,452	1,139	14.4%	17.8%	7.5%
Texas	309,951	200,778	47,687	7,389	27,269	26,828	11.7%	13.8%	3.2%
Utah	40,781	4,521	13,546	0	16,697	6,017	16.6%	17.6%	11.5%
Vermont	185	0	0	0	185	0	0.2%	0.0%	0.3%
Virginia	70,346	5,960	1,544	103	49,027	13,712	6.9%	6.7%	7.8%
Washington	144,499	113,118	7,867	0	21,553	1,961	17.0%	18.9%	7.7%
West Virginia	30,725	3,814	6,333	0	5,765	14,813	8.4%	9.1%	7.6%
Wisconsin	129,176	38,979	6,204	447	69,800	13,746	15.1%	14.7%	15.9%
Wyoming	2,599	0	0	14	1,722	863	3.5%	5.0%	2.9%

Source: MPR analysis for the Kaiser Family Foundation of a database from CMS's November 2006 GSA file. Includes enrollment in "800" contracts that are available only to employer groups. Enrollment in SNP only contracts is excluded.

*Across all states, MA penetration is 15.8 percent, with 18.8 percent penetration in urban counties and 6.5 percent penetration in rural counties.

[a]Less than 0.5 percent so it rounds to 0.

[b]There are no rural areas in this state.

Arizona, California, Hawaii, Oregon, Pennsylvania, and Rhode Island that had 30 percent or more Medicare beneficiaries enrolled in MA in November 2006. However, penetration in rural areas remains under 10 percent in each state except in Arizona, Colorado, Hawaii, Minnesota, Nevada, New York, Oregon, Pennsylvania, and Wisconsin.

The growth in PFFS availability has attracted at least some enrollees in every state in 2007. The highest number of enrollees are in Wisconsin (69,800) where penetration of this product is over 8 percent of beneficiaries, and North Carolina (61,667), which has a 5 percent penetration rate for this product (data not presented). Georgia, Michigan, and Minnesota also have over 44,000 enrollees. PFFS enrollment is relatively spread out, however—only 12 states have under 1,000 enrollees.

In contrast, R-PPO enrollment is to some extent skewed, with over 40,000 of the 89,000 enrollees in Florida. California also has over 17,000 but the state is large and this accounts for only 0.3 percent penetration (versus 1.2 percent in Florida). Because SNPs are not available to all beneficiaries, they are not the focus for this issue brief; however CMS data for September 2006 indicates that about 600,000 beneficiaries are enrolled in SNPs (see Box).[13]

Looking to 2007. Preliminary indications are that both PDP and MA enrollment will continue to increase in 2007. CMS's release of enrollment data for February 2007 shows a total of 8.3 million enrolled in any form of MA plan, up from 7.6 million in December 2006.[14] PFFS enrollment continues to grow with over 1.3 million enrolled in February 2007. As of February

[13] The GSA file upon which our analysis is based includes enrollment only at the contract level so it cannot be used to calculate SNP enrollment. The overall enrollment figures provided include SNP enrollment in contracts that include both general and SNP plans but exclude all enrollment in SNP only contracts because the focus of this analysis is on contracts that include plans available to the general population.

[14] CMS Monthly Summary Report, February 2007. The analysis used in the tables is based on the GSA report because it supports sub-national estimates. CMS's enrollment data are not consistent between the two files. CMS reported 7.5 million in the Monthly Summary Report for November 2006 versus the 7.0 million we show from the November 2006 GSA file. The former include beneficiaries in Puerto Rico and the territories as well, possibly, as those in SNP only contracts. The data also may not be for the same time period as used in the GSA.

2007, there were just over 2,000 enrollees in the MSA plans, and R-PPO enrollment increased to just over 114,000 from 89,000 in December 2006. PDP enrollment, excluding employer/union direct contracts, was 16.8 million, slightly up from December 2006 (16.7 million). (Total enrollment in PDPs, including employer/union direct contracts is 16.9 million)

TRENDS IN AVAILABILITY AND ENROLLMENT IN SNPs

Special Needs Plans (SNPs) differ from other types of MA plans because they are defined based on the population they serve rather than the type of contract. In contrast to other MA offerings which must serve all Medicare beneficiaries, SNPs may restrict enrollment to those qualifying for one of three reasons: those who are eligible for both Medicare and Medicaid (dual eligibles), those who are institutionalized, and those with serious chronic or disabling conditions. Because SNPs may be offered through the same contracts as regular MA plans, their availability is difficult to analyze using the data sets employed in this paper; enrollment in SNPs also is not separately identified. However SNP availability was extensive in 2006 (Gold 2006a) and increased in 2007. We summarize below selected statistics on the availability and enrollment in these plans based on information available from diverse sources.

SNP Availability in 2007

- Medicare's Personal Plan Finder for 2007 shows 198 contracts offering SNPs in 2007. Of these, 79 contracts *only* offer SNPs and 119 others include SNPs along with other MA plans that are available to the general population. Of the 119, 95 are HMO contracts. The rest are local PPOs (9), R-PPOs (3), and demonstration contracts (8).
- While SNPs for dual eligible enrollees continue to dominate SNP enrollment, the number of MA contracts that offer SNPs for those with serious chronic and disabling conditions is 37 in 2007, up from 13 in 2006. (Forty-three contracts offer SNPs for institutionalized beneficiaries and 134 contracts offer SNPs for dual eligibles in 2007.)

SNP Enrollment, 2006

- As of September 2006, there were 602,881 enrollees in SNPs, according to CMS's 2006 SNP Enrollment Report by SNP Type. There were 491,877 enrollees in dual eligible SNPs, 39,232 enrolled in institutional SNPs, and 71,635 enrolled in SNPs serving those with chronic or disabling conditions. The latter reflects mainly the enrollment of 69,446 enrollees in the MMM Healthcare Plan in Puerto Rico.

Sources: CMS's Report of 2007 SNPs by SNP type; 2006 SNP Enrollment Report by SNP Type; and MPR analysis of a file created from the 2007 Personal Plan Finder.

MA Market Concentration and Competition

While there remain important independent competitors in local markets, the national MA market has for many years been driven by the decisions of a small number of dominant firms (Gold 2006b). This was the case in 2006 and remains so today.

Dominant Players. Two firms are particularly dominant: Humana and UnitedHealthCare (now merged with PacifiCare) each offer a broad range of MA plans (Table 10). In 2007, Humana offers MA plans to 83 percent of beneficiaries, a fact heavily driven by their PFFS and R-PPO offerings. UnitedHealthcare's products are available to 73 percent of beneficiaries with the firm offering a mix of plans that varies by market. In aggregate, the Blue Cross-Blue Shield (BCBS) affiliates also are widely available (63 percent of beneficiaries). Among BCBS affiliates, Wellpoint provides the broadest national scope, with 18 percent of beneficiaries having a Blues-branded product available and many more served by the firm's non-Blues-branded UniCare offerings. However, independent BCBS companies offer geographically targeted products that nonetheless have some of the largest enrollments in the nation. For example, both Highmark (a western Pennsylvania-based BCBS company) and Independence BC (in eastern Pennsylvania) have enrollments that put them among the 10 largest sponsors.[15]

[15] The July 2006 CMS Annual Report by Plan shows Highmark as the fourth-largest firm with 239,443 MA enrollees, Wellpoint the fifth-largest with 208,410, and Independence BC the seventh-largest with 179, 323. The three largest firms are UHC/PacifiCare (1,397,785 enrollees), Humana (953,276) and Kaiser-Permanente (827,051). The figures included in this report include employer-only plans. This is a particularly important source of enrollment for Kaiser-Permanente—42 percent of its enrollment is employer-only. HIP, next largest after Independence BC, has 125,700 enrollees of whom 50 percent are from employer groups. (In contrast to the rest of the analysis in this paper, these counts include enrollees in Puerto Rico and the Territories.)

TABLE 10

PERCENT OF BENEFICIARIES WITH AVAILABLE MA PLAN BY FIRM CONTRACT TYPE, 2007

	Any Contract[a]	Local HMO	Local PPO	Regional PPO	PFFS	MSA
Humana	83%	11%	13%	59%	83%	0
UnitedHealthcare	73%	37%	10%	14%	40%	0
BCBS Affiliate	63%	32%	28%	22%	12%	0
Wellpoint[b]	18%	8%	5%	8%	4%	0
Other	54%	29%	23%	14%	8%	10
Aetna	28%	23%	11%	5%	4%	0
Cigna	1%	1%	0	0	0	0
Health Net	20%	16%	1%	2%	2%	0
Kaiser-Permanente	15%	12%	0	0	0	0
All Others[b]	100%	62%	32%	5%	97%	60%

[a]Also includes cost contracts.

[b]Under UniCare (a non-Blue branded entity), Wellpoint also offers MSAs to 60 percent of beneficiaries, PFFS plans to 24 percent, and HMOs to one percent. UniCare products by Wellpoint are included in the "other" category because they are not Blue branded. In total, Wellpoint products (including UniCare) were available to at least 68 percent of all Medicare beneficiaries.

In November 2006, UnitedHealthcare, BCBS affiliates, Humana, and Kaiser-Permanente together had 4.2 million enrollees, 58 percent of the total enrollment in the MA sector. Each of these firms appears to be unique in its strategy, viewed both in terms of offerings (see Table 10) and enrollment (see Table 11). UnitedHealthcare, reflecting its legacy firms, varies its offerings across the marketplace, although most enrollment is concentrated in either HMOs or in PFFS. Humana's rapid enrollment growth is fueled by expanded PFFS offerings, although the firm continues to offer its long-standing HMO products in selected areas of the country. BCBS affiliates are almost as likely to offer local PPOs as HMOs, which is consistent with the pattern of BCBS local commercial offerings. Typically, BCBS firms do not offer PFFS MA offerings, perhaps because doing so presents conflicts with the Medigap products many of them also market. However some BCBS organizations—Wellpoint, Instill, and HCSC—appear to be using both Blues- and non-Blues-branded affiliates to position themselves flexibly in the marketplace. Kaiser-Permanente, in contrast, remains an integrated delivery organization, offering HMO-like MA products both as HMOs and under MA cost contracts as it has in the past. Kaiser-Permanente is an important player in the marketplace but its enrollment is growing only slowly, primarily in its traditional product and a substantial share of it through the aging in of enrollees from its commercial group accounts.

In 2006, UnitedHealthcare, Humana, and BCBS affiliates (including Wellpoint's non-Blues-branded products) accounted for all but 3 percent of the enrollment in R-PPOs and 92 percent of the enrollment in PFFS (Figures 2 and 3).

TABLE 11

DISTRIBUTION OF ENROLLMENT, TOP FOUR NATIONAL FIRMS OR AFFILIATES CONTRACT TYPE, 2006

	UnitedHealthcare[a]		Blue Cross/Blue Shield Affiliates		Humana		Kaiser-Permanente	
	N	%	N	%	N	%	N	%
All Contracts	1,359,991[a]	100%	1,076,093[b]	100%	910,822	100%	882,437	100%
Local HMO	1,112,196	81.8%	826,092	76.8%	378,442	41.5%	814,526	92.3%
Local PPO/POS	36,348	2.7%	108,360	10.1%	34,610	3.8%	0	0
R-PPO	33,651	2.5%	21,543	2.0%	29,706	3.3%	0	0
PFFS	176,810	13.0%	34,161	3.2%	468,064	0.0%	0	0
Cost	0	0.0%	77,110	7.2%	0	51.4%	62,947	7.1
Other	986	0.0%	8,827	0.8%	0	0.0%	4,964	0.6%

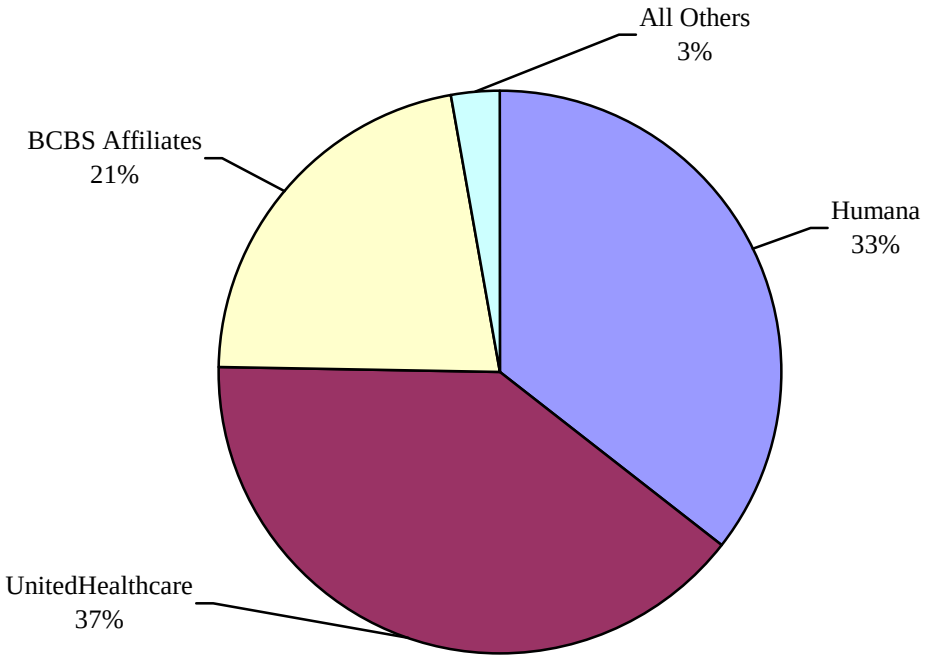
Source: MPR analysis of a file created from CMS data in the GSA file, November, linked to MPR firm codes for each contract. Excludes enrollment in Puerto Rico and the Territories but includes enrollment in employer group plans.

[a]Of this enrollment, 898,740 are in contracts once sponsored by PacifiCare, and 461,251 are in contracts once sponsored by UnitedHealthcare before the merger in early 2006. While both companies had extensive pre-merger product lines, PacifiCare had a more expansive set of PFFS offerings, which account for 162,449 of the PFFS enrollees in the new firm. In contrast, legacy UnitedHeatlhcare accounts for all of the regional PPO enrollment.

[b]Of this enrollment, 46,956 are in "Blues-branded" Wellpoint products (35,226 in HMOs; 5,895 in PPOs; 2,762 in PFFS; and 3,073 in regional PPOs). Under its non-Blues-branded companies (e.g., UniCare), Wellpoint has an additional 72,700 enrollees, all in PFFS plans. Thus in total, Wellpoint had an enrollment of 119,656 in MA in November 2006.

FIGURE 2

REGIONAL PPO ENROLLMENT BY FIRM, 2006

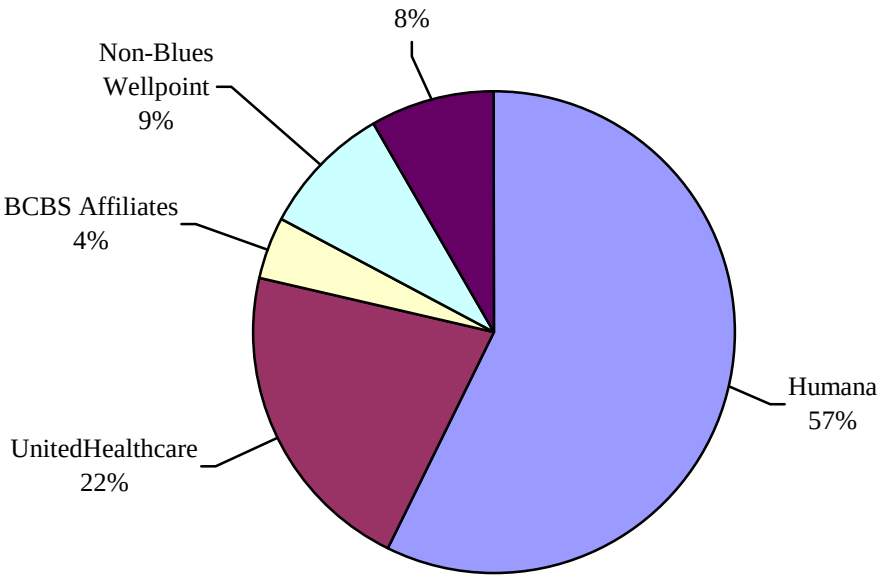


Total Regional PPO Enrollment = 89,393

Source: MPR analysis of CMS's November 2006 GSA file using MPR firm codes. Includes employer group only enrollees but excludes enrollment in Puerto Rico and the Territories

FIGURE 3

PFFS ENROLLMENT BY FIRM, 2006



Total Enrollment = 819,098

Source: MPR analysis of CMS's November 2006 GSA file using MPR firm codes. Includes employer group only enrollees but excludes enrollment in Puerto Rico and the Territories.

CONCLUSIONS

Both the PDP and MA markets expanded in 2007, with current participants staying in the market and often expanding products. Others entered for the first time. Scale clearly has appeal in the PDP sector, with five firms expanding their offerings nationwide in 2007, three new firms entering, and none of the existing national plans leaving. In the MA sector, PFFS offerings are available across broad areas of the country from Humana, UnitedHealthcare, Wellpoint, Coventry, Heritage, Sierra, and Sterling. Wellpoint is also offering MSA plans across most of the nation. The MA sector grew 37 percent between March 2005 and November 2006, as the 2006 changes in MA and Part D were implemented. The availability of HMOs—the dominant form of MA plan—is growing moderately, as did its enrollment; the availability of PFFS plans is expanding much more rapidly. In 2007, 2 percent of Medicare beneficiaries are enrolled in such plans, and they account for 39 percent of all MA growth over the period.

The findings in this paper indicate that expanded private plan choice in Medicare is dominated by the addition of indemnity coverage, whether in PDPs that complement traditional Medicare benefits or in MA plans that integrate all Medicare benefits and supplemental coverage around a fee-for-service model (PFFS, MSAs). In contrast to the traditional form of HMO coverage, these plans do not have networks and cost less to develop. However, they also tend to lack features that make care management a priority or even possible. Clearly, Medicare Part D and the MA program have industry appeal, at least in the short term. Whether beneficiaries are well served by having to make choices among large numbers of plans that may vary little from one another is an issue to be debated and researched.

REFERENCES

Berenson, Robert A. "Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field'." *Health Affairs Web Exclusive*, December 15, 2004. Available at [http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.572v1]. Accessed February 1, 2007.

Biles, Brian, Gerri Dallek, and Lorren H. Nicholas. "Medicare Advantage: Déjà vu All over Again." *Health Affairs Web Exclusive.* December 15, 2004. Available at [http://content.healthaffairs.org/cgi/content/abstract/ hlthaff.w4.586v1]. Accessed February 1, 2007.

Cubanski, Juliette, and Patricia Neuman. "Status Report on Medicare Part D Enrollment in 2006: Analysis of Plan-Specific Market Share and Coverage." *Health Affairs Web Exclusive*, November 21, 2006. Available at [http://content.healthaffairs.org/cgi/content/abstract/26/1/w1]. Accessed February 13, 2007.

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

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

Gold, Marsha. "Premiums and Cost-Sharing Features in Medicare's New Prescription Drug Program, 2006." Washington, DC: Kaiser Family Foundation, May 2006c.

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

Gold, Marsha, and Lori Achman. "Medicare's Experience with PPOs and Private Fee-for-Service Plans." *Operational Insights*, No. 12. Washington, DC: Mathematica Policy Research, Inc., October 2003.

Gold, Marsha, and Stephanie Peterson. "Analysis of the Characteristics of Medicare Advantage Plan Participation." Washington, DC: Mathematica Policy Research, Inc., 2006.

Gold, Marsha, Maria Cupples Hudson, and Sarah Davis. "2006 Medicare Advantage Benefits and Premiums." Washington DC: AARP Public Policy Institute #2006-23, November 2006. Available at [http://www.aarp.org/research/medicare/advantage/2006_23_medicare.html]. Accessed February 8, 2007.

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

Medicare Payment Advisory Commission. "Report to Congress: Increasing the Value of Medicare." Washington, DC, June 2006.

The Henry J. Kaiser Family Foundation

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
(650) 854-9400 Fax: (650) 854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
(202) 347-5270 Fax: (202) 347-5274

www.kff.org

Additional copies of this publication (#7622) are available on the
Kaiser Family Foundation's website at www.kff.org.