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THE MEDICARE Rx DRUG LAW

Profile and Analysis of the 26 Medicare Advantage Regions

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EXECUTIVE SUMMARY

In 2006, the role of private plans in Medicare is expected to expand substantially. Under the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, Congress laid out a structure to add regional preferred provider organizations (PPOs) to the existing locally based private plans in Medicare Advantage (MA). The goal is to give every beneficiary in Medicare a chance to receive all their Medicare benefits through MA plans as an alternative to staying with traditional Medicare and receiving drug benefits separately through a stand-alone private prescription drug plan (PDP). There will be 26 MA regions comprised of states or aggregations of states and 34 private PDP regions.

There are tradeoffs between enrolling in a private plan or staying with traditional Medicare. From the point of view of beneficiaries, the biggest attraction of MA plans has always been defined by the ability of these plans to offer beneficiaries more benefits than traditional Medicare at a relatively attractive premium, and often, with relatively low cost-sharing requirements. MA's more attractive benefits are financed in part by payments to MA plans that are, on average, higher than would be the case in traditional Medicare. However, beneficiaries can only benefit from these payments if a plan is available to them and they find the option of enrolling attractive. Unstable offerings, reduced benefits and higher premiums (as occurred from 1999-2003) have made private plans less attractive to beneficiaries. The ability of private plans to integrate Medicare drug coverage with other Medicare benefits may generate new interest in 2006.

Regional MA plans provide beneficiaries a more uniform choice of private plans across large regions of the country than do local plans. Regional plans are required to enroll any beneficiary living in that region and all enrollees receive the same benefits and pay the same premium, regardless of where they live within that region. Regional MA plans also must provide some coverage for out-of-network care. In contrast, availability, premium, and benefits for local MA plans vary substantially by county of residence and most local MA products now have very limited access to out-of-network providers (though this is not required by statute). This variation has been controversial since Medicare benefits and premiums are uniform nationally. Variation still will exist with regional plans but over larger areas.

This brief reviews the characteristics of the new MA regions and the extent of MA presence currently in those regions. It also analyzes how regions compare to current service markets for some of the firms that may be best positioned to offer regional MA plans and what that may mean for regional MA offerings. Key findings include:

- Most MA regions are single states (11) or two-state regions (11) but four regions have three states or more and one of these has seven states. The number of Medicare beneficiaries in each region varies widely as does the mix of urban and rural beneficiaries. Seven highly populated regions account for almost half (47 percent) of all Medicare beneficiaries. But 16 regions have 20 percent or more of their Medicare beneficiaries living in rural areas, and in three of these, rural beneficiaries outnumber urban beneficiaries. In less densely populated regions, MA offerings will be more challenging to develop.

- The current experience with MA varies widely across the regions. In 7 regions, fewer than a third of beneficiaries now have access to a local coordinated care plan (generally, a Medicare HMO) and in six regions less than half of Medicare beneficiaries have access to *any* private MA plan (the latter includes private fee-for-service plan offerings, which are relatively new and have few enrollees in them). Even in regions where choice exists, there may be considerable variation across states within a region. For example, in the seven-state region #19 (which includes Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming), 89 percent of beneficiaries across the region have some choice of private MA plans, yet there are no such plans for beneficiaries in Montana or Wyoming, and the Dakotas have only a single, private-fee-for-service option. There is a relatively high rate of choice across the region, despite limited choice in three states because of the extensive availability of private plans in more heavily-populated Minnesota. Attracting regional plans to serve areas that previously have not been attractive for MA will be key to whether the MMA succeeds in making a choice of a private plan more available to Medicare beneficiaries.

- While firms new to Medicare may choose to offer MA plans, the speed of implementation and infrastructure requirements are likely to make it easier for experienced firms already in the Medicare market to participate than new ones. In 2004, almost half of MA enrollees were in a few national or regional firms that dominate the market—Kaiser Permanente, PacifiCare, Humana, United Healthcare, Health Net, Aetna and CIGNA. For these firms, the decision to offer a regional MA plan involves a trade-off between potentially larger markets in regions and the control firms now have with the local option to define the market and shape their product to meet it. Our analysis of the distribution of each firm's current enrollment indicates unique patterns that are likely to be important to their decision-making on regional MA participation.

- Blue Cross and Blue Shield (BCBS) plans are national affiliates of organizations that typically serve the population in a particular state. BCBS plans now account for 17 percent of MA enrollment. Because BCBS organizations often serve large numbers of people in their area through PPO-type products that involve large provider networks, they also are potential regional PPO sponsors—especially if the boundaries of the region coincide with their boundaries. Of the 26 regions, 10 are single states where there is also a BCBS plan or equivalent that could potentially enter the MA market as a regional plan. In addition, three multi-state regions include states that are served by a set of related organizations. In the remaining 13 regions, the ability of BCBS firms to sponsor plans depends on whether they can work out agreements on a shared venture with other BCBS affiliated plans.

- We classified regions by the current availability of MA plans to identify which ones were most likely to benefit from expanded choice through MA regional plans. Choice already is relatively extensive in 11 regions that include just under half of all Medicare beneficiaries. Choice is more limited in other regions, including regions that serve the majority of all rural beneficiaries. Whether or not plans choose to move into regions that are disproportionately rural is an important measure of plans' willingness to assume financial risk in less populated areas of the country.

- In many regions, significant barriers to regional entry and stable offering appear to exist. Factors that are likely to influence the ability to attract firms willing to sponsor MA plans in each region include the presence of a national firm in the region currently, how regional boundaries relate to BCBS service areas, and the unique geography of each region. Previous MA history, including extensive plan withdrawals, may make plans wary of entering or indicate barriers to MA that could lead to future instability in available offerings.

Our analysis highlights the substantial gap between the current availability and enrollment in Medicare's private plans with that intended after 2006. The analysis provided here indicates that if the MMA does succeed in establishing MA choices more widely across the country, beneficiaries are likely to face a substantially altered program. Efforts to educate beneficiaries and help them understand their choices will be essential to the success of the program, as will the ability of Medicare not just to attract private plans but to retain their participation over time.

INTRODUCTION

In 2006, the role of private plans in Medicare is expected to expand substantially. Under the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, Congress laid out a structure to add regional preferred provider organizations (PPOs) to the existing locally based private plans in Medicare Advantage (MA). The goal is to provide every beneficiary in Medicare with a choice to receive all their Medicare benefits through MA plans as an alternative to staying with traditional Medicare and receiving drug benefits separately through a stand-alone private prescription drug plan (PDP). There will be 26 MA regions comprised of states or aggregations of states and 34 private PDP regions. This brief reviews the characteristics of the new MA regions and the extent of MA presence currently in the regions. It also analyzes factors that relate to firms' decisions to participate in the program, which may be key to its success.

PRIVATE PLAN OPTIONS AND THE MMA: AN HISTORICAL OVERVIEW

The MMA represents one of a continuing series of attempts by Congress to expand the role private plans play in Medicare. Although there was a limited role for such plans almost from the start of the program, permanent authority to contract with private plans came about in the early to mid-1980s through the Medicare risk-contracting program. This program authorized Medicare contracts between risk-based health maintenance organizations (HMOs) and similar plans. Under the Balanced Budget Act (BBA) of 1997, Congress expanded Medicare's authority to contract with a variety of private plans through the Medicare+Choice (M+C) program to include a variety of coordinated care options (not just HMOs), private fee-for-service plans and other options. However, enrollment in private plans—which had been rapidly expanding before the BBA—actually declined after the introduction of M+C because of other provisions in the bill, such as plan payment levels and market factors such as the managed care backlash and growing provider consolidation (Gold, 2001).

Under the MMA, Medicare+Choice was renamed Medicare Advantage (MA) in 2004. In addition, new regional MA plans were authorized to begin operating across the country in 2006. In anticipation of 2006, the MMA authorized increased payment rates to existing MA plans in 2004 and 2005 as a way to stabilize the market and provide more incentive for private plans to participate in Medicare (Achman and Gold, 2004). Current data on MA plan availability suggest that this stabilization has occurred, even though MA enrollment still accounts for only a small share of all Medicare beneficiaries (Table 1). Most MA enrollment is in HMOs through coordinated care contracts with Medicare. Between March 1999 and March 2003, the number of coordinated care contracts fell from 303 to 144 but has since increased to 173 contracts by December 2004. Enrollment, which fell from 6.1 million to 4.5 million beneficiaries between March 1999 and March 2003, also has risen slightly, with a total of 5.3 million beneficiaries, or 12.3 percent of all Medicare beneficiaries, in December 2004.

The share of beneficiaries nationwide with access to a coordinated care plan (CCP) has increased from 61 percent to 65 percent in 2004, but the share of beneficiaries with access to any private plan contracting with Medicare under MA has increased more over this period. The main reason for this is that some firms have offered private fee-for-service (PFFS) plans. First authorized in the BBA, these MA private plan options do not require networks and can be more easily offered over larger geographical areas (Gold and Achman, 2003). About 85 percent of beneficiaries nationwide now have access to a private plan.[1] But while the number of enrollees in both PFFS and PPO demonstrations has grown, less than 200,000 Medicare beneficiaries are

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1 Availability of such plans has varied markedly since they were first introduced because the initial sponsor (Sterling) entered counties in many states but later withdrew from a large number of them (Gold and Achman, 2003).

TABLE 1
MEDICARE ADVANTAGE CONTRACTS, ENROLLMENT AND AVAILABILITY BY TYPE, 1999-2004

Measure	1999 (March)	2003 (March)	2004 (March)	2004 (September)	2004 (December)
Contracts					
All*	412	235	234	251	262
CCP only	303	144	143	153	173
PPO demonstration only	0	30	35	35	34
PFFS only	0	2	4	5	6
Enrollment					
All*	6,573,435	5,140,293	5,120,966	5,261,171	5,300,903
CCP only	6,065,575	4,560,459	4,535,442	4,629,897	4,672,514
PPO demonstration only	0	56,156	89,408	105,173	107,730
PFFS only	0	18331	26,932	38,561	47,639
Percent of Medicare Beneficiaries Enrolled in an MA Plan	16.8%	12.2%	12.1%	12.2%	12.3%
Percent of Beneficiaries with MA Plan Available					
Any Plan**	72	82	77	84	85
CCP Only	72	62	61	64	65

Source: MPR Analysis of geographic service area reports
* The total also includes cost contracts and other demonstrations. It excludes HCPP contracts and PACE plans. Breakdowns are shown for selected indicated groups. CCPs include HMOs, PPOs and PSOs as authorized by the BBA and now called MA Plans. PPO demonstration refers to contracts under the PPO demonstration. PFFS are private fee-for-service contracts authorized under the MMA.
** Any plan includes CCP, PPO Demo and PFFS plans.

enrolled in these products. Because their structures may lend themselves to the needs of a regional MA plan, these products could still provide their sponsors with experience relevant to MA regional plan decisions.

MA Choices in 2006

Under the MMA, firms contracting with Medicare can continue to offer a full range of local plans in 2006, including CCPs, PFFS plans, and/or new medical savings accounts that were reauthorized under the MMA (Health Policy Alternatives, 2004). The only restriction is that new PPO products cannot be offered locally and existing PPO service areas cannot be expanded in 2006 and 2007 because the intent is to encourage firms to sponsor regional MA PPOs.

From the point of view of beneficiaries, the biggest attraction of MA plans has always been the fact that the plans offered more benefits than traditional Medicare at relatively attractive

premiums, something that some beneficiaries, especially those with limited incomes and no subsidized source of Medicare supplemental benefits, felt offset the more limited choice of providers in MA versus traditional Medicare (Gold et al. 2004). Private plans have become less attractive to beneficiaries as benefits have declined and premiums have increased, but on balance, they still provide more coverage than traditional Medicare (MedPAC 2004). Further, the ability of MA plans to integrate Medicare's new drug benefit with existing Medicare benefits could make them more attractive to some beneficiaries than staying in traditional Medicare and having to select a separate private PDP for drug coverage. MA's more attractive benefits are financed in part by payments to MA plans that are, on average, higher than would be the case in traditional Medicare (Achman and Gold 2004; Biles, Nicholas and Cooper 2004). However, beneficiaries can only benefit from these payments if a plan is available to them and they find the option of enrolling attractive. The attraction may diminish to the extent that beneficiaries are concerned about the stability of plan choices, a salient issue after the extensive withdrawals of private plans from the program in the early 2000s (Gold et al. 2004; Gold and McCoy 2002).

How beneficiaries will react to a choice between a regional and a local MA plan is not clear. From a technical perspective, the main advantage of a regional MA plan versus a local MA plan to a beneficiary should stem from the ability of a regional MA plan to provide a more uniform plan choice and set of benefits across larger areas of the country. There are three main differences between the regional and local plan options:

- In areas where a regional MA plan is offered, the plan will be available to all beneficiaries living in that region. Beneficiaries will pay the same regional MA premium and get the same benefits regardless of where they live in the region. In contrast, local MA plans define their service areas by county, and benefits and premiums for these products can vary within the service area.

- Because the MMA requires that regional MA plans offer benefits for out-of-network care, beneficiaries selecting regional plans, in theory, have access to all providers in a region, even if they are not in the regional plan's network. However, beneficiaries can incur substantial cost-sharing if they choose to use providers outside the network. Most local plans limit coverage to those in the network or referred by the plan; some plans, however, offer an out-of-network benefit.
- If a beneficiary selects a regional plan rather than traditional Medicare, the benefits will be structured through a benefit package that has a single deductible for Part A and Part B benefits, along with an annual limit on covered out-of-pocket expenses that may be higher for out-of-network services. This structure is designed to resemble common commercial policies. Drug coverage, however, is more limited under MA. Although many local plans currently use such a structure, they are not required to, and the use of out-of-pocket limits varies by plan.

The MMA includes short-term financial incentives for regional plans to participate by authorizing:

- the federal government to share risk with health plans in 2006 and 2007, as long as the risk-sharing is symmetrical (same potential for losses as for gains); and
- temporary increases in rates from a regional stabilization fund beginning 2007 to encourage entry of national and regional plans and to prevent withdrawals.

Beyond these differences, it is not clear whether MA payments for beneficiaries in a given county will differ greatly between regional and local plans. While the geographic calculations of benchmarks vary, rates for both regional and local plans will be set using plan bids and benchmarks based on historical Medicare fee-for-service experiences. In both cases, plans benefit by pre-2006 statutory provisions that resulted in MA plans being paid what analysts

estimated to be 7.8 percent more than they would have been in 2005 had costs been based solely on traditional Medicare experience (Biles, Nicholas and Cooper 2004).

Because the legislation stipulates that premiums within a region will be the same for all beneficiaries, some have assumed this would mean CMS would pay regional MA plans the same amount regardless of where a beneficiary lived in the region and such payments would encourage regional plan entry because it results in higher payments to beneficiaries living in low-cost areas that typically do not have MA options (NHPF 2004). However, CMS has announced that it intends to adjust the total amount regional MA plans receive for an enrollee for the county where the enrollee resides. CMS also intends to make geographic adjustments on a budget-neutral basis, though the details on how this will be accomplished are not yet defined (CMS Open Door Forum, Dec. 6th, 2004). In other words, regional MA plans, like local plans, still will receive less for enrollees living in lower payment counties. As a result, total capitated payments to local and regional plans for beneficiaries residing in any given county are likely to be similar even though the share of the rate paid by the government versus the beneficiary will vary. Differentials in total payments per capita are important largely because firms have historically cited these as among the reasons they do not enter specific counties.

From the point of view of a firm considering offering an MA plan, the decision between offering a local and regional plan involves a trade-off between potentially larger markets in regions that expand potential enrollment, often a firm objective, and the control that firms have under local options to define the geographic size and location of their market and shape the product to meet it. Regional expansion also can be riskier than the local option because Medicare beneficiaries use a lot of services. Therefore, high Medicare enrollment has a disproportionate effect on the firm's dependence on Medicare for its revenue. Such dependence tends to make plans and outside investors uncomfortable because of concerns about the

reliability of government as a business partner, particularly when policies can be changed by Congress or administrative rulings and regulations. Regional offerings also require an ability to generate affiliated provider networks that will meet Medicare standards across large geographical areas. In making these trade-offs, firms considering regional MA plans also are likely to pay careful attention to how the details of MA rate setting influence payment levels for local versus regional plans.

How private industry will respond to the new authority of the MMA will be known soon (Kaiser Family Foundation Medicare Prescription Drug, Improvement and Modernization Act Implementation Timeline, 2004). In early December 2004, CMS established definitions for MA regions, and in January 2005, it published final rules for both the Medicare drug benefit and MA plans. Plans wishing to participate in either program must submit an application to CMS by June 6, 2005; CMS will make awards to plans in September 2005. If no regional plan contract is awarded, beneficiaries where no local plan is available will continue to have access to traditional Medicare, but they will have to purchase their drug benefits from a local PDP. In regions without adequate PDP sponsors, CMS is required to enter into a contract with a "fall-back plan" that will administer such benefits for the government so that all beneficiaries in the nation have access to the new drug benefit.

PROFILE OF THE MA REGIONS

Figure 1 shows the assignment of states to MA and PDP regions. Of the 26 regions, most are either single states (11) or two-state regions (11); four include three states or more (Table 2). The largest is the expansive seven-state region (#19) in the north central part of the United States: Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming. There is substantial variation across the regions on several other dimensions, which collectively

could affect the ability and willingness of firms to develop regional plans. See the Appendix for more detailed region-specific information.[2]

Regional Size

The size of the regions, as reflected in the number of Medicare beneficiaries, varies widely by location (Table 3). Seven of the regions have 2.0 million or more beneficiaries and account for almost half (47 percent) of Medicare beneficiaries: #24 (California), #9 (Florida), #3 (New York), #14 (Illinois and Wisconsin), #6 (Pennsylvania and West Virginia), #17 (Texas), and #7 (North Carolina and Virginia). In contrast, the eight regions with fewer than 1 million beneficiaries account for about 10 percent of all beneficiaries. Half of these regions have fewer than half a million beneficiaries.[3] The limited population in these regions, which often span large and/or lightly populated areas, will make it difficult to establish regional plans.

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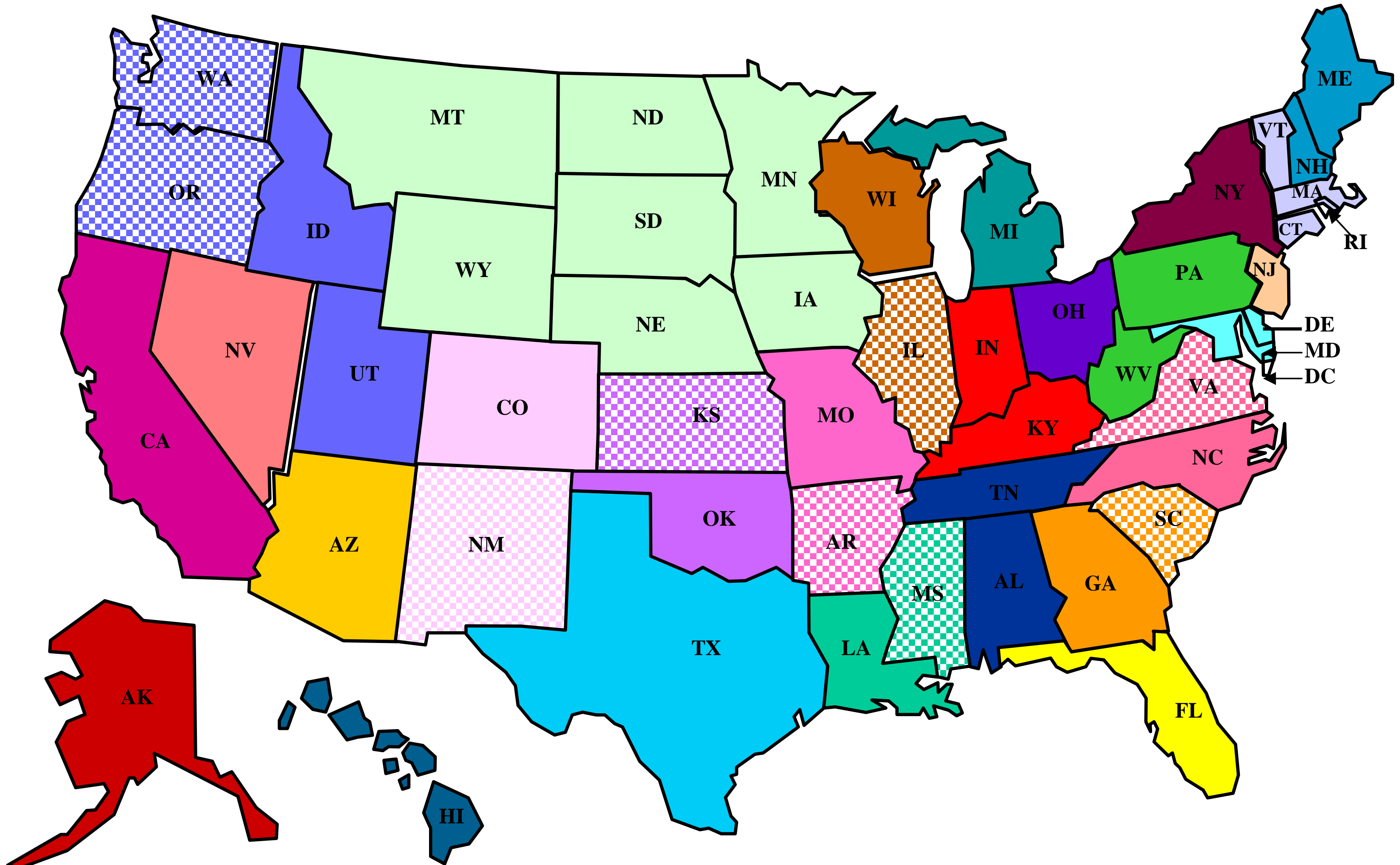
2 Table A-1 provides information on the number of beneficiaries in each region and affiliated state and their distribution in urban and rural areas. Table A-2 profiles current local MA plan availability, penetration, and payment rates. Table A-3 shows current MA enrollment by firm and in each region, including both regional market shares and distributions by firm.

3 The four regions are: #26 –Alaska (42,565), #25 – Hawaii (182,651), #22 – Nevada (291,959), and #1 -- Maine and New Hampshire (422,515).

FIGURE 1

MA and PDP Regions



Note: An MA region is one color. A difference in shading indicates that there are multiple PDP regions nested within the MA region No change indicates that the MA and PDP regions are the same. For example, Wisconsin and Illinois are in one MA region; they are each a separate PDP region. Each territory is its own PDP region.

TABLE 2
SELECTED CHARACTERISTICS OF REGIONS

MA Region	States	Medicare Beneficiaries	Percent of Beneficiaries in Rural Areas	Percent of Beneficiaries with Access to a Private Plan: All	Percent of Beneficiaries with Access to a Private Plan: CCP/PPO Demo	MA Penetration (%): All	MA Penetration (%): CCP/PPO Demo
TOTAL		4,2359,734	23.6%	76.6%	62.0%	12.1%	10.9%
Region 1	ME, NH	422,515	54.2%	11.9%	11.9%	0.3%	0.3%
Region 2	CT, MA, RI, VT	1,805,085	8.3%	85.7%	85.7%	13.7%	13.4%
Region 3	NY	2,845,450	8.9%	87.6%	87.6%	16.6%	15.3%
Region 4	NJ	1,255,829	0.0%	100.0%	100.0%	6.6%	6.6%
Region 5	MD, DC, DE	901,259	11.4%	72.9%	59.0%	3.2%	0.7%
Region 6	PA, WV	2,527,088	22.9%	87.1%	79.3%	19.7%	19.6%
Region 7	NC, VA	2,239,954	35.3%	32.9%	26.5%	2.8%	2.4%
Region 8	GA, SC	1,655,581	36.8%	45.7%	20.2%	1.0%	0.9%
Region 9	FL	3,041,852	8.0%	81.3%	81.3%	17.7%	17.5%
Region 10	AL, TN	1,663,097	37.0%	70.5%	51.4%	6.6%	6.6%
Region 11	MI	1,501,197	22.0%	48.6%	48.6%	1.3%	1.3%
Region 12	OH	1,784,284	19.7%	84.3%	80.4%	12.1%	10.7%
Region 13	IN, KY	1,588,640	41.6%	64.4%	27.7%	1.7%	0.7%
Region 14	IL, WI	2,555,008	12.8%	100.0%	58.0%	4.4%	3.4%
Region 15	AR, MO	1,389,193	45.4%	51.5%	40.7%	7.6%	7.6%
Region 16	LA, MS	1,107,824	45.3%	48.0%	23.4%	6.0%	5.7%
Region 17	TX	2,504,912	21.9%	73.2%	45.5%	6.2%	5.2%
Region 18	KS, OK	947,170	47.7%	53.9%	36.9%	5.2%	5.1%
Region 19	IA, MN, MO, NE, ND, SD, WY	1,913,827	54.9%	88.5%	23.7%	6.2%	2.6%
Region 20	CO, NM	778,442	30.2%	85.6%	68.2%	21.9%	18.8%
Region 21	AZ	769,443	16.3%	91.2%	87.8%	26.5%	26.2%
Region 22	NV	291,959	13.9%	95.5%	89.1%	27.6%	11.0%
Region 23	ID, OR, UT, WA	1,764,310	35.7%	92.9%	61.9%	17.4%	14.4%
Region 24	CA	4,257,579	4.4%	92.8%	92.8%	31.1%	29.3%
Region 25	HI	182,651	27.4%	94.9%	94.9%	32.4%	11.2%
Region 26	AK	42,565	50.8%	1.0%	0.0%	0.0%	0.0%

Source: MPR analysis of CMS data

MA Penetration includes CCP, PPO demonstration, PFFS, cost and other demonstration plans

Private plans include CCP, PPO demo and PFFS plans

The number of beneficiaries on the March 2004 market penetration file is larger than the sum of the regions because the total also includes Puerto Rico and beneficiaries for whom CMS was unable to determine residency status.

TABLE 3
MA REGIONS BY NUMBER AND SHARE OF MEDICARE BENEFICIARIES, 2004

Number of Medicare Beneficiaries in a Region	Number of Regions	Percent of All Medicare Beneficiaries
2.0 million or more	7	47.2%
1.5 – 1.99 million	8	32.3%
1.0 – 1.49 million	3	8.9%
0.5 – 0.99 million	4	7.9%
Under 0.5 million	4	2.2%

Source: MPR Analysis of CMS Data, Medicare beneficiary data from March 2004

Extent of Rural Areas

The distribution of Medicare beneficiaries across urban and rural areas is important because private plans, like those desired under MA, historically have been more difficult to develop in rural areas. All of the regions except #4 (New Jersey) have at least some beneficiaries in rural areas, although the share varies across them. Sixteen of the 26 MA regions have more than 20 percent of their Medicare beneficiaries living in rural areas. The 16 include three regions where rural beneficiaries outnumber urban beneficiaries (Table 4). Some regions, including the three most populous ones that span California, Florida, and New York, are almost entirely urban.

TABLE 4
REGIONS WHERE RURAL BENEFICIARIES OUTNUMBER URBAN BENEFICIARIES

Region #	States in Region	Share of Region's Beneficiaries Residing in Rural Areas
19	IA, MN, MT, ND, SD, NE, WY	54.9%
1	ME, NH	54.2%
26	AK	50.8%

Source: MPR Analysis of CMS Data

Existing MA Availability and Penetration

Some regions have a lot of experience with private plans in MA, while others have much less (Table 5). There also can be wide variation in the amount of experience across a region.

Establishing regional plans in areas where there presently are few local MA plans will make the most difference to beneficiaries, but sponsors seeking to do so will have to overcome the reasons that have led to limited availability of private plans there in the past.

TABLE 5
NUMBER OF MA REGIONS BY CURRENT ACCESS TO PRIVATE PLANS AND RURAL POPULATIONS, 2004

Percent of Medicare Beneficiaries	Number of Regions
Percent of Medicare Beneficiaries with Access to Any Private Plan	
90 percent or more	7
80-89 percent	7
50-79 percent	6
40-49 percent	3
20-39 percent	1
Under 20 percent	2
Percent of Medicare Beneficiaries with Access to a Private CCP Plan	
90 percent or more	3
80-89 percent	6
50-79 percent	6
40-49 percent	3
20-39 percent	6
Under 20 percent	2
Percent of Medicare Beneficiaries Residing in Rural Areas	
90 percent or more	0
80-89 percent	0
50-79 percent	3
40-49 percent	4
20-39 percent	9
Under 20 percent	10

Source: MPR Analysis of CMS data, private plan data as of March 2004

Fewer than half of all Medicare beneficiaries currently have access to any private plan in six regions. In 7 regions, less than a third have such access to a CCP.[4] Region #26 has virtually no private plans, and in region #1, only 12 percent of beneficiaries currently have access to one private plan. Penetration is also very low in regions #7, #8, #15, and #16, each of which has less than half of their beneficiaries left with any choice of private plan. In some cases, MA

4 Here a private plan is defined as a coordinated care plan, a PPO demonstration plan or a private fee-for-service plan (the percentage of beneficiaries with access to a CCP is weighted by Medicare beneficiaries in each of the 11 regions).

availability is deceptive as it rests solely on the offering of a PFFS plan that has limited enrollment.

Even in a region where there is an option of enrolling in at least one private plan, choices are not uniform across all states within a region. Plan choices may be quite varied across a region, something Congress hopes will change with the MMA (Table 6). For example, 86 percent of beneficiaries in region #2 have access to a private plan, but no beneficiaries in the state of Vermont do. In region #19, the seven-state region, most beneficiaries have a choice of private plans, but within the region there currently are no such plans for beneficiaries in Montana or Wyoming, and the Dakotas have only a private fee-for-service plan. In fact, the high levels of availability of private plans in this region are heavily influenced by the extensive availability of private plans in more heavily-populated Minnesota.

Penetration rates tend to be relatively limited, even in regions where private plans are offered. As a result, even if the MMA is successful in encouraging private plans to enter it is unclear how substantial enrollment is likely to be (Table 7). Penetration exceeds 30 percent in only two regions[5] and exceeds 20 percent in an additional three.[6] In contrast, penetration is less than 10 percent in 15 regions, including eight where it is less than 5 percent. Such low penetration rates reflect more than rural populations: in 12 regions, penetration is less than 10 percent even for urban beneficiaries.

5 The two regions are: #25 (Hawaii at 32 percent) and #24 (California at 31 percent).
6 The three regions are: #22 (Nevada at 28 percent), #21 (Arizona at 27 percent), and #20 (Colorado and New Mexico at 22 percent).

TABLE 6
SELECTED REGIONS WITH SUBSTANTIAL INTERSTATE VARIATION IN MA AVAILABILITY AND PENETRATION, 2004

Region	States in Region	Percent of Medicare Beneficiaries with Access to Any Plan	Percent of Medicare Beneficiaries with Access to a CCP Plan	MA Penetration
Region 2		85.7%	85.7%	13.7%
	Connecticut	75.8%	75.8%	5.3%
	Massachusetts	96.9%	96.9%	16.2%
	Rhode Island	100.0%	100.0%	32.4%
	Vermont	0.0%	0.0%	0.0%
Region 6		87.1%	73.3%	19.7%
	Pennsylvania	100.0%	90.8%	22.8%
	West Virginia	9.7%	9.7%	1.5%
Region 7		32.9%	26.5%	2.8%
	North Carolina	42.9%	42.9%	4.0%
	Virginia	20.2%	5.5%	1.3%
Region 8		45.7%	20.2%	1.0%
	Georgia	32.8%	32.8%	1.7%
	South Carolina	66.4%	0.0%	0.1%
Region 15		51.5%	40.7%	7.6%
	Arkansas	31.8%	0.0%	0.1%
	Missouri	61.7%	61.7%	11.4%
Region 16		48.0%	23.4%	6.0%
	Louisiana	81.7%	39.8%	10.2%
	Mississippi	0.0%	0.0%	0.0%
Region 19		88.5%	23.7%	6.2%
	Iowa	100.0%	4.9%	3.6%
	Minnesota	100.0%	49.3%	13.2%
	Montana	0.0%	0.0%	0.0%
	Nebraska	100.0%	31.4%	2.9%
	North Dakota	100.0%	0.0%	0.7%
	South Dakota	99.9%	0.0%	0.0%
	Wyoming	0.0%	0.0%	0.0%

Source: MPR Analysis of CMS Data

TABLE 7
NUMBER OF REGIONS BY CURRENT MA PENETRATION, 2004*

	Number of Regions
MA Penetration (All Areas): Enrollment as a Share of Total Beneficiaries in that Region?	
30 percent or more	2
25-29 percent	2
20-24 percent	1
15-19 percent	4
10-14 percent	2
5-9 percent	7
Under 5 percent	8
MA Penetration (Urban Areas Only)	
30 percent or more	4
25-29 percent	1
20-24 percent	1
15-19 percent	2
10-14 percent	6
5-9 percent	5
Under 5 percent	7

Source: MPR Analysis of CMS Data
* MA plan includes CCP, PPO demonstration, PFFS, cost and other demonstration plans

Potential Plan Sponsors

Although a variety of new firms may choose to offer MA plans, the speed of implementation and infrastructure requirements are likely to make it easier for firms already in the market to participate than others. Further, even if they do not currently offer an MA product, Blue Cross Blue Shield (BCBS) plans also may be positioned to offer products in a particular region because their business tends to involve broad networks to support PPOs in the commercial market. Firms will need to consider both the potential success of a regional product and what a decision to sponsor a regional product might do to a firm's existing local MA products, if relevant.

National and Regional MA Firms. A relatively small number of firms account for a disproportionate share of enrollment in MA (Draper, Gold and McCoy, 2002). Almost half of national MA enrollment is in a few firms that dominate the market—Kaiser Permanente, PacifiCare, Humana, United Healthcare, Health Net, Aetna, and CIGNA (Table 8). While other firms may be well positioned in particular regions, the decisions of these seven national firms are

important because of the role they currently play in the program. Of these plans, all but two (Kaiser Permanente and CIGNA) appear potential candidates for sponsoring a regional plan.

The following notes each firm's current MA activity and its applicability to offering an MA regional plan.

- ***Kaiser Permanente.*** This group-based integrated delivery system is particularly active in California, where 77 percent of its Medicare enrollment is located. A substantial share of beneficiaries "age in" from workforce-based products. The firm has some presence in five other regions. Because Kaiser-Permanente tends to rely heavily on its own providers and offers few products outside the traditional HMO model, the organization is unlikely to be a regional plan sponsor.
- ***PacifiCare.*** This firm, more so than others except for Humana, relies heavily on Medicare for its revenue. Half of the firm's MA enrollment is located in California, where it is the largest plan and accounts for just under a quarter of the state's MA enrollment. PacifiCare has some MA presence in six other regions where its offerings tend to reflect a substantial share of the market. The firm tends to be geographically concentrated on the west coast and southwestern part of the country, and it has a limited presence in a few other markets.
- ***Humana.*** Like PacifiCare, this firm's development was built around Medicare managed care products, and it still relies heavily on Medicare revenue. More than two-thirds of the firm's MA enrollment is located in region #9 (Florida), where it accounts for 42 percent of the market. Humana also has a presence in seven other regions, most of them in the midwest. In 2005, Humana is starting to offer a local MA PPO that will cover 14 markets

including major metropolitan areas in many of the states it already serves.[7] Since 2003, Humana has offered a PFFS plan in many of the states in the large region #19. Humana will have the option to continue these offerings as local plans in 2006, but they also could serve as the basis for regional plans should the firm elect that strategy.

- ***United HealthCare.*** United HealthCare is a more recent player in MA. It currently offers a variety of Medicare-related products. Under MA, the firm offers both HMO and PPO products in a number of areas of the country. Medicare enrollment is currently concentrated in regions #9 (Florida), #10 (in Alabama), #12 (Ohio), #15 (in Missouri), and the multi-state region #19, where products are offered in several of the states. In addition to MA products, United HealthCare administers AARP's Medigap products and is offering a free-standing Medicare drug discount card.
- ***Health Net.*** Health Net has half of its MA enrollment in region #24 (California) and most of the rest in regions #21 (Arizona) and # 9 (Florida). It also has a presence in three other regions. Beyond its Medicare work, Health Net participates in TRICARE—experience that could be relevant if the firm considers the regional MA option.
- ***Aetna.*** Although Aetna has had a Medicare managed care product since 1985, the mainstay of the company is its large commercial national accounts. After the BBA was enacted, Aetna gradually reduced its Medicare exposure. The company currently has MA enrollment in three regions in the mid-Atlantic area and in California. Aetna also offers a freestanding drug discount card nationally.
- ***CIGNA.*** Like Aetna, CIGNA has a substantial presence nationally in the commercial market. However, it has a limited number of products that serve publicly sponsored

7 "Humana introduces new Medicare Advantage PPO in 14 markets," Humana Press Release, December 15, 2004, Louisville, Kentucky, as accessed at www.humana.com/corporatecomm/newsroom/releases/PR-News-20041215-10510

programs, and it has substantially reduced its involvement in Medicare over time. Currently, the firm's MA enrollment is in two southwestern states in different regions. CIGNA has given no indication whether it intends to modify that position.

Blue Cross Blue Shield Organizations. Blue Cross and Blue Shield (BCBS) affiliated organizations account for 17 percent of current MA enrollment (Table 8). Because BCBS plans almost always operate in single states and tend to have large provider networks that often support PPOs, they are potentially well positioned to offer a regional MA plan—especially where the boundaries of the region coincide with plan boundaries. Of the 26 regions, 10 are single states where there is also a BCBS plan or equivalent that could potentially enter the MA market as a regional plan.[8] There also are three multi-state regions served by a BCBS plan: regions #5 (CareFirst), #1, and #13 (Anthem, now merging with WellPoint). While Anthem is located in a number of states, only four of the regions (with eight states) are exclusively under their control.

Because most BCBS plans serve single states, their ability to offer a product in a multistate region depends on whether they can work out agreements on a shared venture with other BCBS affiliated plans. For example, BCBS plans now collaborate on non-Medicare products to serve the Federal Employees Health Benefits Program and national employer accounts. There also are some states, like New York, where multiple plans function in different parts of the state. In such cases, all the plans would have to agree to participate before a BCBS regional plan could be offered in the area. In addition, a few plans face barriers because areas of their state are not served by the main BCBS licensees in their state. For example, the service area of the Virginia plan in region #7 excludes the Washington, D.C. suburbs, which are served by a sister plan in Maryland (Care First).

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8 The 10 single state regions are: New Jersey, Florida, Ohio, Michigan, Texas, Arizona, Nevada, California, Hawaii, and Alaska.

TABLE 8
DISTRIBUTION OF MA CONTRACTS AND ENROLLMENT BY FIRM OR AFFILIATION, 2004

Firm or Affiliation	Number of MA Contracts*	Percent of MA Contracts	Number of MA Enrollees*	Percent of MA Enrollees
All	232	100.0%	5,144,346	100.0%
Blue Cross Blue Shield Affiliates	23	9.9%	849,482	16.5%
Kaiser Permanente	11	4.7%	832,853	16.2%
PacifiCare	12	5.2%	686,039	13.3%
Humana	8	3.4%	328,807	6.4%
United HealthCare	24	10.3%	227,163	4.4%
Health Net	9	3.9%	186,410	3.6%
CIGNA	2	0.9%	60,772	1.2%
Aetna	8	3.4%	95,134	1.8%
Other or Unaffiliated	135	58.2%	1,847,686	35.9%

Source: MPR analysis of market penetration and geographic service area files from March 2004 and analysis of InterStudy data from January 2004
* The number of contracts and enrollment figures reported here differ from other tables because affiliation data for 2 cost contracts with a total of 6,620 enrollees was unavailable. The number of contracts excludes HCPP contracts and the PACE demonstrations.

THE POTENTIAL AND CHALLENGES FOR EXPANDING CHOICE

The success of the reconfiguration of M+C to MA in 2006 rests in the ability of the new regional structure to supplement the current reach of local MA plans so that all beneficiaries in the country have access to one or more private MA plans that will provide all of their Medicare benefits. To accomplish this, firms must offer regional plans across the nation. In regions where there already are many local MA plans, the main effect of the regional offering will be to fill in the holes with a uniform product that provides more ability than most existing MA products do to get care out-of-network care (albeit for a price). In regions where local MA plans are not now extensive, regional plans can provide—for the first time—access to a private MA plan.

Table 9 classifies regions by their current availability of MA plans in each, as defined by the share of beneficiaries in each region that now have a choice of a CCP.[9] Regions where two-thirds or more of beneficiaries had a choice of CCP plan in March 2004 are classified as having "substantial" choice. Those with at least 30 percent but less than 67 percent are classified as having "moderate" choice. Those with less than 30 percent having a choice of CCP are classified as having limited or no choice. Within each category, we also identify regions that meet the availability criteria for that category but are "highly uneven" because they also include in the region one or more states where no CCPs are available.[10] Readers should note that definitions of choice are relatively generous since the beneficiaries counted with choice could have as little as a single CCP from which to choose.

This analysis highlights regional variation and the potential regional MA could have to expand choice if it successfully attracted—and retained—regional plan sponsors. Only 11 regions that include just under half (46 percent) of all Medicare beneficiaries now have "substantial" choice of a private plan even under the generous definitions used, and two of them include a state where there presently is no or virtually no choice of CCP. Another 10 regions are classified as "moderate" choice with at least a third of beneficiaries having access to at least one CCP; though, again, unevenness exists within regions. The remaining seven regions now have limited or no choice of CCP though they may include a state that has a moderate amount of choice.

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9 CCP availability is used rather than any MA choice to avoid counting PFFS plans that are not network-based managed care products. While PFFS choice is now offered in a growing share of counties, they attracted few enrollees (under 50,000 in December 2004).

10 The "limited" availability category means that the region includes a state that would, on its own, qualify to be placed in the "moderate" category.

TABLE 9
REGIONS SORTED BY CURRENT LEVEL OF MA AVAILABILITY AND SELECTED CIRCUMSTANCES RELEVANT TO REGIONAL FIRM ENTRY

	Existing MA Plan Availability		
	Substantial	Moderate	Limited
Number of Regions	11	8	7
Percent of Medicare Beneficiaries*	46.1%	31.2%	21.2%
Percent of the Nation's Rural Beneficiaries*	22.1%	36.4%	38.6%
Regions Included (*with notes on selected factors that will make regional entry easier (a-f) or harder (g-l)*)	#**3** (NY) *b, d, f, g, j* **#4** (NJ) ***a, b,*** *k* **#9** (FL)***c,*** *d, f* **#12** (OH) *a, d, k* #**20** (CO, NM) ***e*** #**21** (AZ) *a, c**, e,** f* **#22** (NV) a, ***e*** #**24** (CA) *a, b, **e,** f* **#25** (HA) *a*	**#10** (AL, TN) *d* **#11** (MI) *a, k* #**14** (IL, WI) ***c,*** *d, k* #**15** (AK, MO) ***c ,*** *d* **#17** (TX) *a, c ,* ***e ,*** *k* #**18** (KS, OK) *c,* ***e,*** *k*	#**1** (ME, NH) *a, k* **#7** (NC, VA) ***d****, g, j, k* **#8** (GA, SC) ***e,*** *k* **#13** (IN, KY) *a, f* **#26** (Alaska) *a*
	Highly Uneven	**Highly Uneven**	**Highly Uneven**
	#**2** (CT, MA, RI, VT) *f ,h* **#6** (PA, WV) *b,f, g, i, j*	**#5** (DE, DC, MD) *a, b, k* **# 23** (ID, OR, UT, WA) ***e,*** *f, g*	**#16** (LS, MS) **#19** (IA, MN, MT, NE, ND, SD, WY) *c, d, l*

Source: Author's analysis based on a variety of information sources
a=Coincides with BCBS boundaries or company affiliates
b=Aetna presence^
c=Humana presence^
d=United HealthCare presence^
e=PacifiCare presence^
f=Health Net presence (in region #2 limited to CT)^
g=BCBS affiliates subdivide state
h=Includes VT with no or little MA
i=Includes WV with no or little MA
j=Includes an MSA that spans another region
k=Previous history of extensive withdrawals could affect response ^^
l= MN's licensure laws like for profit entry
* Rows do not sum to 100 percent because the denominator also includes beneficiaries in Puerto Rico and those whose state of residence was not identified.
Substantial = At least 67 percent of a region's MA beneficiaries had any choice of a CCP in March 2004.
Moderate = Between 30 percent and 66.9 percent of beneficiaries have any a CCP choice.
Limited or No Choice = Less than 30 percent have a CCP choice; a higher share may have any MA choice (includes PFFS).
Highly Uneven = In multiple state regions includes a state that has no CCP choice (or less than 10 percent with it) for regions in the substantial or some categories. In states with limited choice, means that the region includes a state that would qualify as moderate choice.
^ Presence counted as having at least one percent of the region's MA enrollment. Where the market share is 20 percent or more this is indicated with a bold.
^^ **History of Withdrawals.** Includes a state where MA penetration was 4 percent or more in 1999 and declined by half or more by 2004. There are regions where withdrawals were extensive in sections that are not listed (e.g., in New York, Long Island had a series of large withdrawals.)

If the regional MA option is to guarantee that each Medicare beneficiary has at least some private plan choice, firms will need to be willing to serve a broader variety of markets than they have in the past. Further, MA will have to remain sufficiently attractive, not just to have plans enter but to have them remain in place over time. Otherwise, the M+C experience could be repeated.

While there are ongoing efforts to stimulate regional plan entry,[11] there is little empirical data upon which to base these projections, as the regional structure created under the MMA has not been tested. Nonetheless, we know historically some of the factors that firms consider in making these kinds of entry choices. Table 9 indicates by region three of the factors that might make regional plan entry more likely:

- whether the region is congruent with existing BCBS service areas;
- whether one of the five national MA firms that we think likely to be considering entry into regions (Aetna, Humana, United HealthCare, PacificCare, and Health Net) have a presence in that region; and, if so,
- whether the firm's current MA market share region-wide is 20 percent or more—a potential indicator of whether a given firm will be especially concerned about the effect of a regional product on their local offering.

Table 9 also indicates potential barriers to regional entry, including complex subdivisions of BCBS service areas, having substantial MA penetration in one state and little MA activity in another within a region, and state regulatory issues such as Minnesota's preclusion of for-profit

11 See, for example, CBO's "Analysis of Regional Preferred Provider Organizations under the Medicare Modernization Act," October 2004. Within the Department of Health and Human Services, the office of the Assistant Secretary for Planning and Evaluation also has contracted for work in this area, although results are not yet available.

plans. In addition, the table highlights areas where MA withdrawals have been particularly extensive (Gold and McCoy, 2002). A history of withdrawals could deter firms from entering or staying because such withdrawals could be a negative commentary about the capacity of market conditions to support MA. Firms also may be concerned about the beneficiary or provider response given past instability.

The seven regions where choice is currently most limited include 21 percent of Medicare beneficiaries and 39 percent of rural Medicare beneficiaries. The regions range from those like Alaska (region #26), where virtually no managed care exists, to regions that include states with relatively extensive MA experience (e.g., region #16, which includes Louisiana; region #19 which includes Minnesota).[12] Three of the seven regions (#26, #13, and #1) mirror BCBS boundaries. National firms have a presence in four of these seven regions, but the regions also combine diversely positioned states that will make regional products challenging to support.

Successful regional entry in states where MA penetration currently is already moderate may be more feasible to the extent that current activity indicates capacity to support MA. If regional plans could be attracted to regions where choice is now only moderate, the numbers of Medicare beneficiaries with a choice of private MA plan could expand substantially. The ten regions with moderate penetration include 31 percent of Medicare beneficiaries and 36 percent of rural beneficiaries. The factors that will influence the interest in regional products vary across the regions in this group, although each has some MA experience (Hurley et al; Gold et al, 2004).

12 In region #19, which combines 6 largely rural states with Minnesota, regional products will have to deal with multi-state diversity and the challenges of serving large geographic areas with low population density to be successful. Reconciling multi-state regulatory requirements (including Minnesota's prohibition on for-profit plans) could be an issue despite provisions in the MMA to help regional sponsors address these concerns. On the other hand, the region is currently served by both Humana and United HealthCare, with multi-state PFFS offerings that could provide a potential base for an MA regional product.

For example:

- As a large state, Texas (region #17) has attracted many national firms. However, the region has a history of extensive withdrawals, an active medical society that has fought managed care, and a complex geography that includes major urban centers with large stretches of rural areas. On the positive side, a single BCBS plan serves the entire state.
- In Michigan, the powerful role played by the auto industry and its unionized workers with comprehensive retirement benefits has complicated success under MA, and large national firms have not been active here. Michigan is served by a single BCBS plan that could be in a position to offer a regional product, if it chose to do so.
- Region #5 (Delaware, the District of Columbia, and Maryland) has had a tumultuous history of withdrawals under MA that included national firms and the Maryland BCBS plan. The availability of retirement benefits under the Federal Employees Health Benefits Program (FEHBP) reduces the market for MA plans because FEHBP, like many large employers, provides little incentive for MA enrollment. The complex configuration of states involved in the District market and their different policies also serves to deter MA entry. For example, Maryland's all-payer hospital rate-setting system limits the ability of MA plans to negotiate hospital discounts. Another complication is that the BCBS plan in the District also serves the Virginia suburbs.

In regions that already have substantial MA choice, it is not clear how attractive a regional product will be to firms. MA clearly can thrive in most areas of these regions, but whether firms now offering a local product will be interested in adding another or substitute regional product is

unknown and likely to be influenced by a series of business calculations. The decision may be substantially easier in some regions than others.

For example, New Jersey is a small state where many products already resemble regional offerings. They are available in all or most parts of the state and include PPO models with shared risk under the PPO demonstration. In contrast, developing a viable regional option in New York is more challenging since the state is large and diverse, divided into multiple BCBS regions, and includes a metropolitan statistical area that is not distinct to the region alone. Whether the national firms that serve the heavily populated New York City area (and make distinctions among counties there) will be willing to offer uniform regional products that span a much larger area is uncertain.

Among the regions that already have substantial MA plan offerings, the most obvious gains would be in those that include states with limited or no private plan offerings now with more well-served states (e.g., Vermont in region #2 and West Virginia in Region #6). But attracting firms that are well positioned to offer regional products in these areas may be difficult given MA's lack of previous success in creating private plan choices in Vermont and West Virginia. Current BCBS boundaries also are inconsistent with regional boundaries.

CONCLUSION

Our analysis highlights the substantial gap between current MA availability and that intended in 2006, when regional plans become effective. National firms that already participate in Medicare and/or BCBS plans that have networks that span states with PPO products are among those CMS likely will have to attract if the MA regional option is to be successful. Some regions are better positioned with these organizations than others, and some regions where beneficiaries stand to gain the most from the regional option present challenges that may limit firm entry. Because regional structures have not been part of Medicare before, it is difficult to

predict how firms will respond to the regional option. There are many barriers to such products that could limit the extent of regional plan entry.

The analysis presented indicates that, if the MMA does succeed in establishing MA choices more widely across the country, beneficiaries are likely to face a substantially altered set of Medicare options. Efforts to educate beneficiaries and help them understand their choices will be essential to the success of Medicare Advantage as will the ability of Medicare not just to attract private plans but to retain their participation over time.

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APPENDICES

Table A-1. Medicare Beneficiaries by Regions and Associated States, 2004

		Total Medicare Beneficiaries		Beneficiaries by Location		Selected Measures of Rural Presence	
		Number	Percent of Nation	Urban	Rural	% of Nation's Rural Beneficiaries	Rural as % of Beneficiaries
TOTAL		42359734	100.0	31,723,345	10,003,595	100.0	23.6
Region 1		422,515	1.0	193,552	228,963	2.3	54.2
	Maine	235,804	0.6	90,181	145,623	1.5	
	New Hampshire	186,711	0.4	103,371	83,340	0.8	
Region 2		1,805,085	4.3	1,655,938	149,147	1.5	8.3
	Connecticut	536,258	1.3	488,966	47,292	0.5	
	Massachusetts	995,597	2.4	979,745	15,852	0.2	
	Rhode Island	176,688	0.4	162,073	14,615	0.1	
	Vermont	96,542	0.2	25,154	71,388	0.7	
Region 3		2,845,450	6.7	2,592,081	253,369	2.5	8.9
	New York	2,845,450	6.7	2,592,081	253,369	2.5	
Region 4		1,255,829	3.0	1,255,829	0	0.0	0.0
	New Jersey	1,255,829	3.0	1,255,829	0	0.0	
Region 5		901,259	2.1	798,120	103,139	1.0	11.4
	Delaware	125,231	0.3	88,733	36,498	0.4	
	District of Columbia	77,195	0.2	77,195	0	0.0	
	Maryland	698,833	1.6	632,192	66,641	0.7	
Region 6		2,527,088	6.0	1,949,173	577,915	5.8	22.9
	Pennsylvania	2,167,299	5.1	1,803,215	364,084	3.6	
	West Virginia	359,789	0.8	145,958	213,831	2.1	
Region 7		2,239,954	5.3	1,440,572	791,428	7.9	35.3
	North Carolina	1,258,190	3.0	765,019	493,171	4.9	
	Virginia	981,764	2.3	675,553	298,257	3.0	
Region 8		1,655,581	3.9	1,047,046	608,535	6.1	36.8
	Georgia	1,019,216	2.4	622,185	397,031	4.0	
	South Carolina	636,365	1.5	424,861	211,504	2.1	
Region 9		3,041,852	7.2	2,796,728	243,474	2.4	8.0
	Florida	3,041,852	7.2	2,796,728	243,474	2.4	
Region 10		1,663,097	3.9	1,047,093	616,004	6.2	37.0
	Alabama	750,732	1.8	486,131	264,601	2.6	
	Tennessee	912,365	2.2	560,962	351,403	3.5	
Region 11		1,501,197	3.5	1,171,581	329,616	3.3	22.0
	Michigan	1,501,197	3.5	1,171,581	329,616	3.3	
Region 12		1,784,284	4.2	1,433,425	350,859	3.5	19.7
	Ohio	1,784,284	4.2	1,433,425	350,859	3.5	
Region 13		1,588,640	3.8	927,044	661,596	6.6	41.6
	Indiana	910,980	2.2	631,100	279,880	2.8	
	Kentucky	677,660	1.6	295,944	381,716	3.8	
Region 14		2,555,008	6.0	1,885,490	326,531	3.3	12.8
	Illinois	1,720,335	4.1	1,365,729	11,619	0.1	
	Wisconsin	834,673	2.0	519,761	314,912	3.1	
Region 15		1,389,193	3.3	758,503	630,690	6.3	45.4
	Arkansas	471,368	1.1	185,466	285,902	2.9	
	Missouri	917,825	2.2	573,037	344,788	3.4	
Region 16		1,107,824	2.6	605,914	501,910	5.0	45.3
	Louisiana	650,510	1.5	477,307	173,203	1.7	
	Mississippi	457,314	1.1	128,607	328,707	3.3	
Region 17		2,504,912	5.9	1,955,782	549,130	5.5	21.9
	Texas	2,504,912	5.9	1,955,782	549,130	5.5	
Region 18		947,170	2.2	495,186	451,984	4.5	47.7
	Kansas	405,801	1.0	201,891	203,910	2.0	
	Oklahoma	541,369	1.3	293,295	248,074	2.5	
Region 19		1,913,827	4.5	862,827	1,050,896	10.5	54.9
	Iowa	496,059	1.2	190,857	305,202	3.1	

		Total Medicare Beneficiaries		Beneficiaries by Location		Selected Measures of Rural Presence	
		Number	Percent of Nation	Urban	Rural	% of Nation's Rural Beneficiaries	Rural as % of Beneficiaries
	Minnesota	702,052	1.7	427,703	274,349	2.7	
	Montana	148,409	0.4	34,724	113,685	1.1	
	Nebraska	264,491	0.6	112,538	151,953	1.5	
	North Dakota	105,887	0.2	37,127	68,760	0.7	
	South Dakota	125,645	0.3	37,571	87,970	0.9	
	Wyoming	71,284	0.2	22,307	48,977	0.5	
Region 20		778,442	1.8	542,961	235,468	2.4	30.2
	Colorado	516,005	1.2	398,055	117,937	1.2	
	New Mexico	262,437	0.6	144,906	117,531	1.2	
Region 21		769,443	1.8	643,852	125,551	1.3	16.3
	Arizona	769,443	1.8	643,852	125,551	1.3	
Region 22		291,959	0.7	251,404	40,555	0.4	13.9
	Nevada	291,959	0.7	251,404	40,555	0.4	
Region 23		1,764,310	4.2	1,188,829	630,691	6.3	35.7
	Idaho	186,976	0.4	55,210	186,976	1.9	
	Oregon	535,276	1.3	342,300	192,976	1.9	
	Utah	230,812	0.5	162,514	68,298	0.7	
	Washington	811,246	1.9	628,805	182,441	1.8	
Region 24		4,257,579	10.1	4,071,006	186,573	1.9	4.4
	California	4,257,579	10.1	4,071,006	186,573	1.9	
Region 25		182,651	0.4	132,463	50,135	0.5	27.4
	Hawaii	182,651	0.4	132,463	50,135	0.5	
Region 26		42,565	0.1	20,946	21,619	0.2	50.8
	Alaska	42,565	0.1	20,946	21,619	0.2	

Source: MPR analysis of the March 2004 market penetrator and geographic service area files.

The number of beneficiaries on the March 2004 market penetration file is larger than the sum of the regions because the total also includes Puerto Rico and beneficiaries for whom CMS was unable to determine residency status.

Table A-2. Medicare Advantage Availability and Enrollment by Region and Associated States 2004

			MA Contracts*		% Beneficiaries with access to a private plan		MA Enrollees		MA Penetration (%)**		Enrollees		MA Penetration by Location	
			All	CCP/PPO Demo	All	CCP/PPO Demo	All	CCP/PPO Demo	All	CCP/PPO Demo	Urban	Rural	Urban	Rural
TOTAL		42359734 *	234	178	76.6	62.0	5,120,966	4,624,850	12.1	10.9	4,864,051	212,177	15.3	2.1
Region 1		422,515	1	1	11.9	11.9	1,068	1,068	0.3	0.3	1,068	0	0.55	0
	Maine	235,804	0	0	0.0	0.0	0	0	0.0	0.0	0	0	0.0	0.0
	New Hampshire	186,711	1	1	27.0	27.0	1,068	1,068	0.6	0.6	1,068	0	1.0	0.0
Region 2		1,805,085	10	9	85.7	85.7	247,213	241,531	13.7	13.4	242,317	4,896	14.6	3.3
	Connecticut	536,258	2	2	75.8	75.8	28,432	28,432	5.3	5.3	28,432	0	5.8	0.0
	Massachusetts	995,597	5	4	96.9	96.9	161,565	155,883	16.2	15.7	159,153	2,412	16.2	15.2
	Rhode Island	176,688	3	3	100.0	100.0	57,216	57,216	32.4	32.4	54,732	2,484	33.8	17.0
	Vermont	96,542	0	0	0.0	0.0	0	0	0.0	0.0	0	0	0.0	0.0
Region 3		2,845,450	24	19	87.6	87.6	472,709	436,314	16.6	15.3	464,089	8,620	17.9	3.4
	New York	2,845,450	24	19	87.6	87.6	472,709	436,314	16.6	15.3	464,089	8,620	17.9	3.4
Region 4		1,255,829	7	7	100.0	100.0	83,388	83,388	6.6	6.6	83,388	0	6.6	0.0
	New Jersey	1,255,829	7	7	100.0	100.0	83,388	83,388	6.6	6.6	83,388	0	6.6	0.0
Region 5		901,259	6	2	72.9	59.0	29,185	6,202	3.2	0.7	29,154	31	3.7	0.0
	Delaware	125,231	1	0	100.0	0.0	373	0	0.3	0.0	342	31	0.4	0.1
	District of Columbia	77,195	1	0	0.0	0.0	4,625	0	6.0	0.0	4,625	0	6.0	0.0
	Maryland	698,833	4	2	76.1	76.1	24,187	6,202	3.5	0.9	24,187	0	3.8	0.0
Region 6		2,527,088	20	18	87.1	79.3	499,031	496,524	19.7	19.6	459,668	39,363	23.6	6.8
	Pennsylvania	2,167,299	17	16	100.0	90.8	493,771	492,397	22.8	22.7	454,517	39,254	25.2	10.8
	West Virginia	359,789	3	2	9.7	9.7	5,260	4,127	1.5	1.1	5,151	109	3.5	0.1
Region 7		2,239,954	6	4	32.9	26.5	63,021	54,079	2.8	2.4	54,182	8,406	3.8	1.1
	North Carolina	1,258,190	3	3	42.9	42.9	50,000	50,000	4.0	4.0	42,966	7,034	5.6	1.4
	Virginia	981,764	3	1	20.2	5.5	13,021	4,079	1.3	0.4	11,216	1,372	1.7	0.5
Region 8		1,655,581	3	1	45.7	20.2	17,344	14,639	1.0	0.9	17,044	42	1.6	0.0
	Georgia	1,019,216	2	1	32.8	32.8	16,946	14,639	1.7	1.4	16,688	0	2.7	0.0
	South Carolina	636,365	1	0	66.4	0.0	398	0	0.1	0.0	356	42	0.1	0.0
Region 9		3,041,852	22	19	81.3	81.3	539,291	531,694	17.7	17.5	536,142	3,149	19.2	1.3
	Florida	3,041,852	22	19	81.3	81.3	539,291	531,694	17.7	17.5	536,142	3,149	19.2	1.3
Region 10		1,663,097	11	10	70.5	51.4	109,595	109,049	6.6	6.6	98,820	10,775	9.4	1.7
	Alabama	750,732	5	5	34.7	34.7	47,861	47,861	6.4	6.4	45,834	2,027	9.4	0.8
	Tennessee	912,365	6	5	100.0	65.2	61,734	61,188	6.8	6.7	52,986	8,748	9.4	2.5
Region 11		1,501,197	3	3	48.6	48.6	19,270	19,270	1.3	1.3	19,174	96	1.6	0.0
	Michigan	1,501,197	3	3	48.6	48.6	19,270	19,270	1.3	1.3	19,174	96	1.6	0.0
Region 12		1,784,284	17	14	84.3	80.4	216,462	191,121	12.1	10.7	210,596	5,866	14.7	1.7
	Ohio	1,784,284	17	14	84.3	80.4	216,462	191,121	12.1	10.7	210,596	5,866	14.7	1.7
Region 13		1,588,640	9	3	64.4	27.7	27,567	10,763	1.7	0.7	25,331	2,236	2.7	0.3
	Indiana	910,980	5	1	37.9	29.7	16,863	355	1.9	0.0	14,720	2,143	2.3	0.8
	Kentucky	677,660	4	2	100.0	25.1	10,704	10,408	1.6	1.5	10,611	93	3.6	0.0
Region 14		2,555,008	27	12	100.0	58.0	113,528	86,620	4.4	3.4	93,590	19,938	5.0	6.1
	Illinois	1,720,335	15	9	100.0	59.9	74,732	65,516	4.3	3.8	68,336	6,396	5.0	55.0
	Wisconsin	834,673	12	3	100.0	54.0	38,796	21,104	4.6	2.5	25,254	13,542	4.9	4.3
Region 15		1,389,193	10	8	51.5	40.7	105,498	105,085	7.6	7.6	100,290	5,208	13.2	0.8
	Arkansas	471,368	2	0	31.8	0.0	413	0	0.1	0.0	363	50	0.2	0.0
	Missouri	917,825	8	8	61.7	61.7	105,085	105,085	11.4	11.4	99,927	5,158	17.4	1.5

			MA Contracts*		% Beneficiaries with access to a private plan		MA Enrollees		MA Penetration (%)**		Enrollees		MA Penetration by Location	
			All	CCP/PPO Demo	All	CCP/PPO Demo	All	CCP/PPO Demo	All	CCP/PPO Demo	Urban	Rural	Urban	Rural
Region 16		1,107,824	5	3	48.0	23.4	66,069	63,536	6.0	5.7	64,715	1,354	10.7	0.3
	Louisiana	650,510	5	3	81.7	39.8	66,069	63,536	10.2	9.8	64,715	1,354	13.6	0.8
	Mississippi	457,314	0	0	0.0	0.0	0	0	0.0	0.0	0	0	0.0	0.0
Region 17		2,504,912	8	5	73.2	45.5	154,905	129,126	6.2	5.2	148,016	6,889	7.6	1.3
	Texas	2,504,912	8	5	73.2	45.5	154,905	129,126	6.2	5.2	148,016	6,889	7.6	1.3
Region 18		947,170	7	6	53.9	36.9	49,461	48,532	5.2	5.1	48,784	677	9.9	0.1
	Kansas	405,801	3	3	19.6	19.6	10,014	10,014	2.5	2.5	10,014	0	5.0	0.0
	Oklahoma	541,369	4	3	79.6	50.0	39,447	38,518	7.3	7.1	38,770	677	13.2	0.3
Region 19		1,913,827	26	6	88.5	23.7	118,429	49,040	6.2	2.6	107,593	10,822	12.5	1.0
	Iowa	496,059	6	2	100.0	4.9	17,701	1,879	3.6	0.4	13,633	4,068	7.1	1.3
	Minnesota	702,052	11	2	100.0	49.3	92,352	39,644	13.2	5.6	86,262	6,090	20.2	2.2
	Montana	148,409	0	0	0.0	0.0	0	0	0.0	0.0	0	0	0.0	0.0
	Nebraska	264,491	4	2	100.0	31.4	7,552	7,517	2.9	2.8	7,538	0	6.7	0.0
	North Dakota	105,887	3	0	100.0	0.0	768	0	0.7	0.0	104	664	0.3	1.0
	South Dakota	125,645	2	0	99.9	0.0	56	0	0.0	0.0	56	0	0.1	0.0
	Wyoming	71,284	0	0	0.0	0.0	0	0	0.0	0.0	0	0	0.0	0.0
Region 20		778,442	9	5	85.6	68.2	170,566	146,568	21.9	18.8	154,972	15,581	28.5	6.6
	Colorado	516,005	6	3	78.3	78.3	132,583	108,747	25.7	21.1	117,596	14,974	29.5	12.7
	New Mexico	262,437	3	2	100.0	48.2	37,983	37,821	14.5	14.4	37,376	607	25.8	0.5
Region 21		769,443	11	9	91.2	87.8	203,585	201,273	26.5	26.2	201,581	2,004	31.3	1.6
	Arizona	769,443	11	9	91.2	87.8	203,585	201,273	26.5	26.2	201,581	2,004	31.3	1.6
Region 22		291,959	6	4	95.5	89.1	80,444	32,010	27.6	11.0	79,559	885	31.6	2.2
	Nevada	291,959	6	4	95.5	89.1	80,444	32,010	27.6	11.0	79,559	885	31.6	2.2
Region 23		1,764,310	20	12	92.9	61.9	307,687	254,306	17.4	14.4	154,846	56,700	13.0	9.0
	Idaho	186,976	3	1	100.0	35.1	15,530	10,479	8.3	5.6	3,859	15,530	7.0	8.3
	Oregon	535,276	9	6	88.7	82.2	165,179	121,689	30.9	22.7	37,466	27,713	10.9	14.4
	Utah	230,812	1	0	72.3	0.0	387	0	0.2	0.0	387	0	0.2	0.0
	Washington	811,246	7	5	100.0	72.3	126,591	122,138	15.6	15.1	113,134	13,457	18.0	7.4
Region 24		4,257,579	17	12	92.8	92.8	1,322,123	1,248,447	31.1	29.3	1,320,275	1,848	32.4	1.0
	California	4,257,579	17	12	92.8	92.8	1,322,123	1,248,447	31.1	29.3	1,320,275	1,848	32.4	1.0
Region 25		182,651	3	1	94.9	94.9	59,235	20,373	32.4	11.2	42,711	16,524	32.2	33.0
	Hawaii	182,651	3	1	94.9	94.9	59,235	20,373	32.4	11.2	42,711	16,524	32.2	33.0
Region 26		42,565	1	0	1.0	0.0	0	0	0.0	0.0	0	0	0.0	0.0
	Alaska	42,565	1	0	1.0	0.0	0	0	0.0	0.0	0	0	0.0	0.0

Source: MPR analysis of March 2004 market penetration and geographic service area files

*MA Contracts include CCP, PPO Demo, PFFS, Cost and Other Demonstration plans

Access to a private plan includes CCP, PPO Demo and PFFS plans

**MA Penetration includes CCP, PPO Demonstration, PFFS, Cost and Other Demonstration plans

The number of beneficiaries on the March 2004 market penetration file is larger than the sum of the regions because the total also includes Puerto *Rico and beneficiaries for whom CMS was unable to determine residency status.

Table A-3. Distribution of MA Enrollment by Firm 2004

MA Region	State	MA Enrollment	Percent Distribution of Current Firm MA Enrollment by Region and State									Percent of Firm Market Share in Region and State									
			Aetna	Blue Cross Blue Shield	CIGNA	HealthNet	Humana	Kaiser	PacifiCare	United HealthCare	Other	Aetna	Blue Cross Blue Shield	CIGNA	HealthNet	Humana	Kaiser	PacifiCare	United HealthCare	Other	Total
TOTAL		5,070,054	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	1.9	16.6	1.2	3.6	6.4	16.3	13.4	4.4	36.1	100.0
Region 1		1,068	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	100.0
	Maine	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	New Hampshire	1,068	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	100.0
Region 2		247,213	0.0	8.9	0.0	14.5	0.0	0.0	0.0	0.0	13.9	0.0	30.6	0.0	11.0	0.0	0.0	0.0	0.0	58.4	100.0
	Connecticut	28,432	0.0	0.0	0.0	14.5	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	95.3	0.0	0.0	0.0	0.0	4.7	100.0
	Massachusetts	161,565	0.0	4.0	0.0	0.0	0.0	0.0	0.0	0.0	6.9	0.0	21.2	0.0	0.0	0.0	0.0	0.0	0.0	78.8	100.0
	Rhode Island	57,216	0.0	4.9	0.0	0.0	0.0	0.0	0.0	0.0	6.9	0.0	72.5	0.0	0.0	0.0	0.0	0.0	0.0	27.5	100.0
	Vermont	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Region 3		472,709	16.8	12.4	0.0	2.9	0.0	0.0	0.0	4.4	18.2	3.4	22.3	0.0	1.1	0.0	0.0	0.0	2.1	71.0	100.0
	New York	472,709	16.8	12.4	0.0	2.9	0.0	0.0	0.0	4.4	18.2	3.4	22.3	0.0	1.1	0.0	0.0	0.0	2.1	71.0	100.0
Region 4		83,388	25.7	1.0	0.0	0.0	0.0	0.0	0.0	0.0	2.7	29.3	10.5	0.0	0.0	0.0	0.0	0.0	0.0	62.5	100.0
	New Jersey	83,388	25.7	1.0	0.0	0.0	0.0	0.0	0.0	0.0	2.7	29.3	10.5	0.0	0.0	0.0	0.0	0.0	0.0	62.5	100.0
Region 5		29,185	3.2	0.0	0.0	0.0	0.0	2.4	0.0	0.0	0.3	10.5	0.0	0.0	0.0	0.0	67.9	0.0	0.0	20.3	100.0
	Delaware	373	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	District of Columbia	4,625	0.0	0.0	0.0	0.0	0.0	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	100.0
	Maryland	24,187	3.2	0.0	0.0	0.0	0.0	1.8	0.0	0.0	0.3	12.7	0.0	0.0	0.0	0.0	62.8	0.0	0.0	24.5	100.0
Region 6		497,898	24.0	42.4	0.0	2.2	0.0	0.0	0.0	0.2	6.0	4.6	72.0	0.0	0.8	0.0	0.0	0.0	0.1	22.5	100.0
	Pennsylvania	493,771	24.0	42.2	0.0	2.2	0.0	0.0	0.0	0.2	5.8	4.6	72.6	0.0	0.8	0.0	0.0	0.0	0.1	21.9	100.0
	West Virginia	4,127	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	100.0
Region 7		63,021	0.0	4.0	0.0	0.0	0.0	1.1	0.0	7.0	0.2	0.0	54.1	0.0	0.0	0.0	14.2	0.0	24.8	6.5	100.0
	North Carolina	50,000	0.0	4.0	0.0	0.0	0.0	0.0	0.0	7.0	0.0	0.0	68.2	0.0	0.0	0.0	0.0	0.0	31.2	0.0	100.0
	Virginia	13,021	0.0	0.0	0.0	0.0	0.0	1.1	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	68.7	0.0	0.0	31.3	100.0
Region 8		17,344	0.0	0.0	0.0	0.0	0.0	0.0	1.8	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	84.4	0.0	15.6	100.0
	Georgia	16,946	0.0	0.0	0.0	0.0	0.0	0.0	1.8	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	86.4	0.0	13.6	100.0
	South Carolina	398	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	100.0
Region 9		539,291	0.0	3.4	0.0	8.2	69.3	0.0	0.0	22.4	11.7	0.0	5.4	0.0	2.8	42.2	0.0	0.0	9.4	40.1	100.0
	Florida	539,291	0.0	3.4	0.0	8.2	69.3	0.0	0.0	22.4	11.7	0.0	5.4	0.0	2.8	42.2	0.0	0.0	9.4	40.1	100.0
Region 10		109,595	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.9	4.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	22.6	77.4	100.0
	Alabama	47,861	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.9	1.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	51.8	48.2	100.0
	Tennessee	61,734	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.0
Region 11		19,270	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	100.0
	Michigan	19,270	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	100.0
Region 12		214,996	0.0	9.6	0.0	0.0	0.0	2.8	0.0	15.2	4.1	0.0	38.1	0.0	0.0	0.0	10.9	0.0	16.1	34.9	100.0
	Ohio	214,996	0.0	9.6	0.0	0.0	0.0	2.8	0.0	15.2	4.1	0.0	38.1	0.0	0.0	0.0	10.9	0.0	16.1	34.9	100.0
Region 13		23,546	0.0	1.2	0.0	0.2	0.0	0.0	0.0	0.0	0.7	0.0	44.2	0.0	1.5	0.0	0.0	0.0	0.0	54.3	100.0
	Indiana	12,842	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.7	0.0	0.0	0.0	2.8	0.0	0.0	0.0	0.0	97.2	100.0
	Kentucky	10,704	0.0	1.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	97.2	0.0	0.0	0.0	0.0	0.0	0.0	2.8	100.0
Region 14		113,528	0.0	0.0	0.0	0.0	13.1	0.0	0.0	6.5	3.0	0.0	0.0	0.0	0.0	38.0	0.0	0.0	13.0	49.0	100.0
	Illinois	74,732	0.0	0.0	0.0	0.0	11.9	0.0	0.0	3.7	1.5	0.0	0.0	0.0	0.0	52.3	0.0	0.0	11.3	36.4	100.0
	Wisconsin	38,796	0.0	0.0	0.0	0.0	1.2	0.0	0.0	2.8	1.5	0.0	0.0	0.0	0.0	10.5	0.0	0.0	16.2	73.3	100.0
Region 15		105,498	0.0	0.0	0.0	0.0	3.3	0.0	0.0	22.2	2.4	0.0	0.0	0.0	0.0	10.3	0.0	0.0	47.9	41.8	100.0
	Arkansas	413	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	100.0
	Missouri	105,085	0.0	0.0	0.0	0.0	3.3	0.0	0.0	22.2	2.4	0.0	0.0	0.0	0.0	10.3	0.0	0.0	48.1	41.6	100.0
Region 16		66,069	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	100.0
	Louisiana	66,069	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	100.0
	Mississippi	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Region 17		154,905	0.0	0.0	0.0	0.0	6.3	0.0	10.8	0.0	3.2	0.0	0.0	0.0	0.0	13.4	0.0	47.9	0.0	38.7	100.0
	Texas	154,905	0.0	0.0	0.0	0.0	6.3	0.0	10.8	0.0	3.2	0.0	0.0	0.0	0.0	13.4	0.0	47.9	0.0	38.7	100.0
Region 18		49,461	0.0	0.0	0.0	0.0	2.3	0.0	2.3	0.0	1.4	0.0	0.0	0.0	0.0	15.1	0.0	31.8	0.0	53.1	100.0
	Kansas	10,014	0.0	0.0	0.0	0.0	2.3	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	74.6	0.0	0.0	0.0	25.4	100.0
	Oklahoma	39,447	0.0	0.0	0.0	0.0	0.0	0.0	2.3	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0	39.9	0.0	60.1	100.0
Region 19		118,429	0.0	0.2	0.0	0.0	0.8	0.0	0.0	4.1	5.6	0.0	1.2	0.0	0.0	2.6	0.0	0.0	7.9	88.3	100.0
	Iowa	17,701	0.0	0.0	0.0	0.0	0.6	0.0	0.0	0.8	0.7	0.0	0.0	0.0	0.0	11.8	0.0	0.0	10.6	77.5	100.0
	Minnesota	92,352	0.0	0.2	0.0	0.0	0.2	0.0	0.0	0.0	4.9	0.0	1.5	0.0	0.0	0.8	0.0	0.0	0.0	97.7	100.0

MA Region	State	MA Enrollment	Percent Distribution of Current Firm MA Enrollment by Region and State									Percent of Firm Market Share in Region and State									
			Aetna	Blue Cross Blue Shield	CIGNA	HealthNet	Humana	Kaiser	PacifiCare	United HealthCare	Other	Aetna	Blue Cross Blue Shield	CIGNA	HealthNet	Humana	Kaiser	PacifiCare	United HealthCare	Other	Total
	Montana	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	Nebraska	7,552	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	99.5	0.5	100.0
	North Dakota	768	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	18.9	0.0	0.0	0.0	81.1	100.0
	South Dakota	56	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	100.0
	Wyoming	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Region 20		170,566	0.0	0.0	38.0	0.0	0.0	6.8	7.7	0.0	2.1	0.0	0.0	13.5	0.0	0.0	33.2	30.5	0.0	22.7	100.0
	Colorado	132,583	0.0	0.0	0.0	0.0	0.0	6.8	7.6	0.0	1.3	0.0	0.0	0.0	0.0	0.0	42.7	39.3	0.0	18.0	100.0
	New Mexico	37,983	0.0	0.0	38.0	0.0	0.0	0.0	0.0	0.0	0.8	0.0	0.0	60.8	0.0	0.0	0.0	0.0	0.0	39.2	100.0
Region 21		203,585	0.0	0.0	62.0	18.9	4.8	0.0	13.2	0.0	1.3	0.0	0.0	18.5	17.3	7.7	0.0	44.6	0.0	11.9	100.0
	Arizona	203,585	0.0	0.0	62.0	18.9	4.8	0.0	13.2	0.0	1.3	0.0	0.0	18.5	17.3	7.7	0.0	44.6	0.0	11.9	100.0
Region 22		80,444	0.0	0.0	0.0	0.0	0.0	0.0	3.6	0.0	3.0	0.0	0.0	0.0	0.0	0.0	0.0	30.8	0.0	69.2	100.0
	Nevada	80,444	0.0	0.0	0.0	0.0	0.0	0.0	3.6	0.0	3.0	0.0	0.0	0.0	0.0	0.0	0.0	30.8	0.0	69.2	100.0
Region 23		307,687	0.0	4.8	0.0	1.2	0.0	5.8	10.5	0.0	7.8	0.0	13.2	0.0	0.7	0.0	15.7	23.5	0.0	47.0	100.0
	Idaho	15,530	0.0	1.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	97.3	0.0	0.0	0.0	0.0	0.0	0.0	2.7	100.0
	Oregon	165,179	0.0	2.9	0.0	1.0	0.0	4.1	3.4	0.0	4.4	0.0	14.9	0.0	1.1	0.0	20.6	14.2	0.0	49.3	100.0
	Utah	387	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	100.0
	Washington	126,591	0.0	0.1	0.0	0.2	0.0	1.7	7.1	0.0	3.4	0.0	0.6	0.0	0.2	0.0	11.4	38.5	0.0	49.3	100.0
Region 24		1,322,123	30.3	12.2	0.0	51.9	0.0	76.8	51.9	0.0	5.2	2.2	7.9	0.0	7.3	0.0	48.4	27.0	0.0	7.3	100.0
	California	1,322,123	30.3	12.2	0.0	51.9	0.0	76.8	51.9	0.0	5.2	2.2	7.9	0.0	7.3	0.0	48.4	27.0	0.0	7.3	100.0
Region 25		59,235	0.0	0.0	0.0	0.0	0.0	2.6	0.0	0.0	2.1	0.0	0.0	0.0	0.0	0.0	36.0	0.0	0.0	64.0	100.0
	Hawaii	59,235	0.0	0.0	0.0	0.0	0.0	2.6	0.0	0.0	2.1	0.0	0.0	0.0	0.0	0.0	36.0	0.0	0.0	64.0	100.0
Region 26		0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	Alaska	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Source: MPR analysis of March 2004 market penetration, geographic service area files, and interstudy health plan data.

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