Contract No. HHS-100-03-0017
MPR Reference No.: 6219-600

Analysis of the Characteristics of Medicare Advantage Plan Participation

Final Report

July 17, 2006

Marsha Gold
Stephanie Peterson

Submitted to:

DHHS/OS/ASPE
Room 443F, Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attention:
Emily Loriso

Submitted by:

Mathematica Policy Research, Inc.
600 Maryland Ave., SW, Suite 550
Washington, DC 20024-2512
Telephone: (202) 484-9220
Facsimile: (202) 863-1763

Project Director:
Marsha Gold

This page has been intentionally left blank for double-sided copying.

ACKNOWLEDGMENTS

Many people made valuable contributions to this report. Emily Loriso, our project officer at ASPE, and her colleagues provided useful feedback throughout the project. We are also grateful to both the Kaiser Family Foundation and the Robert Wood Johnson Foundation, as our work with them on other projects contributed to the data files that were available to support the ASPE work. Robert Hurley, of the Medical College of Virginia/Virginia Commonwealth University was a consultant on this project responsible both for conducting some of the firm discussions and for providing advice and feedback on the qualitative portion of the analysis.

This report also benefited from the support of a number of Mathematica staff without whom it could not have been produced. Miriam Loewenberg developed the analysis file for this project and advised on programming specifications. Ama Takyi and Dawn Phelps did the programming work for the tables. Sarah Davis and Judy Ng contributed to scheduling and summarizing notes from the firm discussions. Tim Lake and Mary Laschober reviewed the draft report, providing valuable feedback and advice. Caitlin Johnson and Daryl Hall provided editorial support. Felita Buckner produced the report, with assistance from Alfreda Holmes.

This page has been intentionally left blank for double-sided copying.

CONTENTS

Chapter		Page
	EXECUTIVE SUMMARY	xiii
I	PROJECT PURPOSE, METHODS AND SCOPE	1
	A. PROJECT PURPOSE	1
	B. OVERVIEW OF MEDICARE ADVANTAGE IN THE MMA CONTEXT	1
	C. RESEARCH QUESTIONS	4
	D. METHODS AND DATA SOURCES	5
	1. Quantitative Analysis	5
	2. Qualitative Analysis	7
II	NATIONAL TRENDS IN MA OFFERINGS, 2005-2006	13
	A. NUMBER OF CONTRACTS BY TYPE	13
	B. AVAILABILITY BY CONTRACT TYPE NATIONALLY	16
	C. AVAILABLE CHOICE: URBAN AND RURAL COUNTIES	18
	1. Beneficiaries in Urban Areas	18
	2. Beneficiaries in Rural Areas	21
	D. AVAILABILITY OF PRESCRIPTION DRUG PLANS	21
	E. ENTRY, EXIT, AND CONVERSION	21
III	VARIATION IN CHOICE ACROSS MA REGIONS AND STATES	25
	A. NUMBER OF CONTRACTS BY TYPE	25
	B. TRENDS AND DRIVERS IN OVERALL AVAILABILITY 2005-2006	28
	C. AVAILABILITY OF LOCAL COORDINATED CARE (HMO AND PPO) OPTIONS	31

CONTENTS *(continued)*

Chapter **Page**

III. *(continued)*

D. AVAILABILITY OF MA IN URBAN VERSUS RURAL AREAS 35

E. ROLE OF PAYMENT RATES AND SELECT PRODUCT OFFERINGS 43

1. Geography of Regional PPO Entry 43
2. PFFS Entry by County Payment Rate 44

IV MA CONTRACT SPONSORS 47

A. MAJOR SPONSORS IN THE MA MARKET: CHARACTERISTICS AND TRENDS 47

1. Number of Contracts 47
2. Availability of MA Contracts to Beneficiaries by Firm, 2005-2006 49
3. Firm MA Market Share Before 2006 51

V 2006 ENROLLMENT AND PENETRATION TRENDS 55

A. ENROLLMENT TRENDS IN 2005 55

B. EARLY INDICATIONS OF 2006 MA ENROLLMENT 59

C. ENROLLMENT BY COUNTY PAYMENT RATE 62

VI INSIGHTS FROM FIRM DISCUSSIONS 65

A. GENERAL ENVIRONMENT ENTERING 2006 AND FIRM RESPONSE 66

1. Environmental Factors 66
2. Firm Response 67

B. THE INFLUENCE OF MA RATES AND THE DEMANDS OF NETWORK FORMATION 70

1. Process of Decision-Making 71
2. The Influence of County-by-County Rate Variation 71
3. The Demands of Network Formation 72
4. Particular Issues of Network Formation in Rural Areas 73

CONTENTS *(continued)*

Chapter **Page**

IV *(continued)*

C. PRODUCT-SPECIFIC CONSIDERATIONS 74

1. Local HMOs 74
2. Local PPOs 75
3. Regional PPOs 75
4. Local PFFS Plans 77

D. BENEFITS AND PRODUCT POSITIONING 79

1. Product Alignment and Benefit Design 79
2. Special Case: Drug Coverage in PFFS Plans 81
3. Special Case: Prescription Drug Coverage Design in Delivery-Based HMOs 81
4. Product Distribution and Marketing 82

E. FIRM EXPERIENCE WITH THE 2006 ENROLLMENT PROCESS AND PLANS FOR 2007 84

1. 2006 Experience with MA Enrollment 84
2. Strategies for 2007 86

F. LONG-TERM PROSPECTS AND CONCERNS 88

VII CONCLUSIONS 91

REFERENCES 93

APPENDIX A-1

This page has been intentionally left blank for double-sided copying.

TABLES

Table		Page
I.1	TRENDS IN MA CONTRACTS, ENROLLMENT, AND AVAILABILITY, 1999-2005	3
I.2	MAIN ELEMENTS IN THE FILE FOR THE ASPE PROJECT	7
I.3	DISCUSSION TOPICS	9
I.4	INTERVIEWS AND FIRMS PARTICIPATING IN DISCUSSIONS	11
II.1	MA AND RELATED PRIVATE PLAN CONTRACTS BY TYPE, UNITED STATES 2005-2006	14
II.2	SELECTED MEASURES OF AVAILABILITY OF MA AND RELATED PRIVATE PLAN CONTRACTS TO MEDICARE BENEFICIARIES BY TYPE, UNITED STATES, 2005-2006	17
II.3	SELECTED MEASURES OF AVAILABILITY OF MA AND RELATED PRIVATE PLAN CONTRACTS TO MEDICARE BENEFICIARIES BY TYPE, URBAN COUNTIES ONLY, UNITED STATES, 2005-2006	20
II.4	SELECTED MEASURES OF AVAILABILITY OF MA AND RELATED PRIVATE PLAN CONTRACTS TO MEDICARE BENEFICIARIES BY TYPE, RURAL COUNTIES ONLY, UNITED STATES, 2005-2006	22
II.5	AVAILABILITY OF PLANS WITH PRESCRIPTION DRUG COVERAGE UNDER MEDICARE ADVANTAGE CONTRACTS, 2006	23
II.6	CHARACTERISTICS OF SELECTED NEW CONTRACTS BY TYPE, 2005-2006	23
III.1	MA CONTRACTS BY MA REGION AND STATE, 2006	26
III.2	SELECTED MEASURES OF MA PLAN AVAILABILITY BY REGION AND STATE, 2006	29
III.3	SELECTED MEASURES OF CHANGE IN MA PLAN AVAILABILITY BY REGION AND STATE, 2005-2006	32
III.4	STATES BY AVAILABILITY OF LOCAL HMO OR PPO CONTRACT, 2006	36
III.5	SELECTED MEASURES OF CHANGE MA PLAN AVAILABILITY IN URBAN AREAS BY REGION AND STATE, 2006	37

TABLES *(continued)*

Table **Page**

III.6 SELECTED MEASURES OF CHANGE MA PLAN AVAILABILITY IN RURAL AREAS BY REGION AND STATE, 2006 40

III.7 SELECTED CHARACTERISTICS OF MA REGIONS WITH AND WITHOUT REGIONAL PPOS, 2006 45

III.8 PFFS CONTRACTS BY SELECTED CHARACTERISTICS OF PAYMENT, 2006.. 46

IV.1 MA CONTRACTS BY SPONSOR AND TYPE, 2006 48

IV.2 SELECTED MEASURES OF SCOPE OF MA PLAN OFFERINGS NATIONALLY, SELECTED FIRMS OR AFFILIATES, 2005-2006......................... 50

IV.3 MA ENROLLMENT & MARKET SHARE BY CONTRACT TYPE AND PRE-2006 TREND: MARCH-SEPTEMBER 2005... 53

IV.4. GROWTH IN MA ENROLLMENT, VARIOUS SECTORS, MARCH-SEPTEMBER 2005.. 54

V.1 MA ENROLLMENT TRENDS BY CONTRACT TYPE, UNITED STATES BY QUARTER 2005 56

V.2 MA ENROLLMENT AND PENETRATION BY REGION AND STATE, MARCH AND DECEMBER 2005... 57

V.3 MA ENROLLMENT IN TOP 10 VERSUS OTHER STATES, MARCH 2005.......... 60

V.4 MA ENROLLMENT BY SELECTED CONTRACT TYPES, 2005-2006.................. 60

V.5 MA ENROLLMENT IN LARGEST THREE FIRMS, 2005-2006............................. 61

V.6 DISTRIBUTION OF DECEMBER 2005 ENROLLMENT BY PRODUCT AND 2006 COUNTY PAYMENT RATES... 63

V.7 DISTRIBUTION OF DECEMBER 2005 PFFS ENROLLMENT BY SELECTED FIRM OR AFFILIATE AND 2006 COUNTY PAYMENT RATES 63

FIGURES

Figure **Page**

II.1 PERCENTAGE OF URBAN AND RURAL BENEFICIARIES WITH AT LEAST ONE AVAILABLE MA CONTRACT, BY TYPE, MARCH 2005-2006 19

This page has been intentionally left blank for double-sided copying.

EXECUTIVE SUMMARY

PROJECT PURPOSE

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) made major changes in the Medicare Advantage (MA) program that are evident in 2006. In 2006, MA has expanded to include regional Preferred Provider Organization (PPO) plans in addition to such local plans as health maintenance organizations (HMOs) and local PPOs (historically referred to as coordinated care plans (CCPs)) and private fee-for-service plans (PFFS). MA has also been modified to include additional competitive features, such as the new competitive bidding system. Regional and local MA plans provide beneficiaries with access to a comprehensive set of benefits that includes the new and voluntary prescription drug benefit (Part D), which is being implemented in 2006. Beneficiaries wishing to receive the new Medicare prescription drug benefit must decide between enrolling in an MA plan or staying in traditional Medicare and joining a stand-alone prescription drug plan (PDP).

This project provides the Assistant Secretary for Planning and Evaluation (ASPE) with a baseline of timely, policy-relevant information that will help ASPE understand the MA products that are available in 2006, how they compare to past offerings when only local MA options were authorized, initial plan decisions and experiences under the new competitive bidding process, and how well available offers and enrollment meet Congress' overall objectives in enacting the MMA. The project seeks to help ASPE to identify emerging trends and determine whether further analysis or policy refinements may be desirable to address potential problems or opportunities

METHODS

We analyzed publicly available quarterly data from the Centers for Medicare and Medicaid Services (CMS) Geographic Service Area (GSA) Report and other sources in 2005 and 2006. Because CMS has not yet made these data available in 2006, we used the November 2005 release of the Medicare Plan Finder to develop a "pseudo-GSA" file that allowed for analysis of 2006 contracts[1]. We also conducted 14 telephone discussions with a total of 20 diverse firms to learn more about their decision-making process and strategies, and gathered information valuable in "getting beneath the numbers" to learn more about how firms perceive MA now and in the future. These discussions, held primarily during March and April 2006, were confidential so that firms would be more willing to speak freely.

[1] The "pseudo-GSA" file is an MPR created database based on the November 2005 release of the CMS Plan Finder data for 2006; the main differences between this and the GSA file are the that the CMS plan finder file used for the "pseudo GSA" does not include certain contract types (e.g. Health Care Prepayment Plan or HCPP, Program for All Inclusive Care for the Elderly or PACE, and demonstration contracts).

FINDINGS—DESCRIPTIVE ANALYSIS OF TRENDS

National Trends in MA Offerings, 2005-2006

- The total number of MA contracts increased substantially from March 2005 to 2006, leading to a substantial increase in the share of beneficiaries with at least one MA contract available to them in 2006.
- In most cases, firms expanding in 2006 did so before the start of the year. The most extensive number of new entries was between July and September 2005. Regional PPOs were an exception, as they were not authorized until 2006. Only a small number of contracts were withdrawn in 2006 once transitions are taken into account.
- Virtually all Medicare beneficiaries (including 93 percent of rural beneficiaries) had some form of MA choice in 2006. The dominant drivers of increased availability were the growing prevalence of PFFS contracts (reaching 78 percent of beneficiaries in 2006 versus 41 percent in March 2005) and newly available regional PPOs in 2006 (available to 86 percent of beneficiaries).
- Almost all MA contracts in 2006 include at least one plan offering prescription drug benefits (MA-PDs). Although drug coverage is optional under PFFS contracts, 62 percent of PFFS contracts have at least one plan with prescription drugs.

Variation in Choice Across the Nation

- HMOs and local PPOs are available to more beneficiaries nationwide in 2006 than in 2005, with local PPOs growing more rapidly than HMOs. However, HMO and local PPO availability continues to be uneven across geographical areas and much of the expansion in local PPOs is in areas already served by HMOs.
- The introduction of regional PPOs expanded choices but cannot be credited uniquely with driving the increase in MA overall availability in 2006, because PFFS contracts have also grown over this period. States with the most dramatic change in MA availability from 2005 to 2006 typically experienced growth in both types of contracts or, if only one, in PFFS contracts.
- Regions attracting regional PPO entrants appear to have a balance of urban and rural areas and counties with higher and lower payment rates. Entry was less likely in less populated regions with a heavy dominance of rural areas. In contrast, only 109 counties attracted no PFFS plans but many of these were highly populated and located in the Northeast and California. In many areas of the country, options may be offered but may not really be competitive or marketed heavily.
- PFFS is available in all but 109 counties in the United States but these exclude some highly populated counties especially in the Northeast and California. Virtually all beneficiaries in urban or rural floor counties have them available. Beneficiaries in urban and rural floor counties (i.e. counties whose payment rates are enhanced because Medicare has minimum payment levels for counties by type) make up 56 percent of beneficiaries with PFFS but only 3 percent of beneficiaries without it.

- Because regional PPOs and PFFS plans are so prevalent, enrollment data by county and product are essential to analyzing the effect that county-by-county variation in payment rates has had on the way firms are positioning themselves.

MA Contract Sponsors

- A small number of firms and affiliates play a disproportionate role in the MA program in 2006, as they have historically. Almost half (48 percent) of MA contracts are with seven MA firms that MPR has tracked as part of its M+C/MA Monitoring Project since 1999 or with affiliates of Blue Cross and Blue Shield (BCBS). These count for an even larger share of MA enrollment (65 percent in March 2005)[2].

- In the six-month period (March to September 2005) preceding the 2006 MA expansion, MA enrollment grew about five percent. HMOs account for only about half (53) percent of this enrollment growth, although they were 86 percent of MA enrollment at the start of the period. Humana accounted for about a third of the growth in non-HMO MA enrollment.

Enrollment Trends, 2005-2006

- MA enrollment grew from 5.1 million to 5.5 million between March and December 2005. The limited enrollment data for 2006 suggests such growth continued and even accelerated in 2006, reaching 6.8 million in April 2006—a Medicare market penetration rate of 15.5 percent.

- In March 2005, MA enrollment varied substantially across states, with 9 states having less than one percent of their population in MA and another 13 having under 5 percent penetration. In rural counties, penetration was only 2.4 percent on average. CMS has not yet made publicly available data sufficient to examine whether this pattern has changed in 2006. December 2005 shows some growth in enrollment but variability by state.

- While HMOs continue to dominate MA enrollment, their share of the market is declining as newer products are marketed. PFFS plans are the fastest growing segment of MA, with a total enrollment of over half a million members in 2006, twice that of local PPOs. About 1.3 percent of all beneficiaries are now in PFFS plans. Enrollment in regional PPOs, in contrast, remains very limited to date, with fewer than 55,000 enrolled nationwide.

- Three firms account for over two of five enrollees in MA—UnitedHealthcare/PacifiCare, Kaiser, and Humana. Since March 2005, Humana's

[2] MPR's M+C/MA tracking project includes, among other aspects of the work, tracking MA availability, enrollment, and penetration over time. Since 2004, Kaiser Family Foundation has funded the work. From 1999-2004, the work was funded by the Robert Wood Johnson Foundation as part of a broader project to examine the implications of M+C for beneficiaries.

enrollment has grown 61 percent, although the other two firms still have more enrollees.

- Enrollment data for December 2005 show that 88 percent of PFFS enrollment comes from urban or rural floor counties, with urban floor counties contributing over half (53 percent) of PFFS enrollment. This is very different from the distribution of general MA enrollment.

FINDINGS—INSIGHT FROM FIRM DISCUSSIONS

The Environment for MA and Firm Response

- Nationally, three strong forces encouraged firms to consider aggressively pursuing Medicare Advantage program involvement for 2006: (1) the entire Medicare program was in transition, particularly because of the introduction of Part D; (2) MMA introduced more favorable MA payment rates; and (3) the aging of the U.S. population has made senior products demographically attractive to firms.

- Given the breadth of the changes in the Medicare program in 2006, firms had to decide where to focus their resources. Most were also establishing PDPs, which required very large start-up costs. The attraction and demands of the PDP product, combined with the unstable history of the MA/M+C program, limited the resources firms had available for MA.

- In deciding how to position themselves in MA, firms balanced the pressure on their resources in different ways depending on what they perceived would best suit their long-term style and strategy in the marketplace. For example, they:

  - Built on their base
  - Targeted "low-hanging fruit"
  - Favored strategies consistent with their perceived market strength
  - Sought expansions appropriate within the full range of business, including both Medicare and other products
  - Tailored the level of business risk
  - Responded to market preferences
  - Began positioning themselves at least by 2005

- For some firms, the changes in 2006 were relevant mainly because of the threats they generated to their existing book of business rather than the opportunities. This appeared to be particularly true for the most traditional HMO-model firms.

Influence of Rates and Network Requirements on Firm Decisions

- Top leadership from each firm was involved in 2006 MA decisions, with the balance between corporate and local leadership differing across firms. Both MA payment rates and considerations relating to provider network formation were the major factors driving product- and market-specific decisions in 2006.

- Firms took into account how the expected revenues in each county affected the feasible structure and likely market viability of different products. While rates might be regarded favorably in 2006, firms also considered the risks associated with potential future reductions.

- While payment rates were important, a firm's ability to put together a viable provider network had a major influence in shaping 2006 offerings, with the need for on-the-ground resources to establish new networks a major limiting factor. The absence of network requirements was one of the major factors making PFFS products so attractive.

- Providers' requests that MA plans pay them more than Medicare pays them in the traditional Medicare program led to difficult negotiations, particularly with hospitals. MA viability could depend on being able to negotiate rates below Medicare for in-network services in a PPO; Medicare-based rates are typical in PFFS. Provider acceptance was an issue that extended beyond rural areas.

- Two factors helped firms address network issues, particularly for regional PPOs: (1) their expectation that CMS might allow them to use in-network payments for out-of-network providers if access problems in some counties might preclude the firm from offering a product; and (2) the expectation that CMS might approve a product even if its network was weaker than ideal in selected areas.

Product-Specific Considerations

- In 2006, firms were most likely to expand more loosely managed products that were easier and faster to implement.

- Firms did not invest heavily in establishing new HMOs because of the start-up demands, and because they often felt their existing placement of products generally spanned the geographical market for this type of product. Firms were also more likely to favor local PPO to HMO expansion in 2006, if they considered either.

- Interest in offering a regional PPO product was constrained by (1) the need to establish provider networks across broad areas of the country; (2) uncertainty about its viability and its financial mechanisms; and (3) less ability to tailor benefits and premiums to local market conditions compared with a local PPO.

- Firms explained the strong interest some had in PFFS as due to their ease of entry because: (1) they do not require provider networks or provider contracts and have no network adequacy requirements; (2) the business case for PFFS is more national in scope since firms do not need to create a local base to form or manage the network;

and (3) marketing is easier because these products are more like traditional indemnity insurance and can be sold through insurance brokers nationwide.

- Despite the advantages of PFFS, firms said they still had to put resources into provider education, particularly when market experience with such products was limited. While PFFS sponsors were optimistic, competitors said provider acceptance could be an issue, as is long-term economic viability.

BENEFITS, MARKETING, AND PRODUCT POSITIONING

- Firms often designed multiple benefit packages and/or a family of products to appeal to diverse subgroups of beneficiaries. They took into account what they expected their competitors to do; as might be expected, entry with very low-priced products drew their special attention and concern and firms were paying particular attention to Humana's aggressive approach.

- Drug coverage was often included in PFFS plan offerings, even though firms were not required to do so. Those firms not doing so typically offered an independent PDP to complement their PFFS plan.

- Traditional HMOs with in-house pharmacies and well-established formulary development processes found integrating Part D challenging for a variety of reasons discussed in the report.

- Beneficiary education and marketing was an important focus in 2006. The concentration of efforts over a brief period in 2005-2006 was a concern for all firms, consuming a large amount of resources. This included both efforts to educate existing enrollees about changes and efforts to reach new enrollees.

- Firms used a variety of channels to reach beneficiaries. Brokers and agents appear much more involved in selling MA in 2006 than they were perceived to be in prior years. Reasons include: their current role in Medigap and geographic scope; their established channels for reaching beneficiaries not accessible through other firm channels; and the fact that the way they are paid provides them an incentive to enroll beneficiaries.

Experience in 2006 and Plans for 2007

- Firms were appreciative of the pressures on CMS and the agency's efforts to collaborate. However, they also said it had been a very demanding year for them. They said that demands of the new drug benefit detracted from the energy both the firms and CMS had to devote to the MA sector. Part D issues affected both PDPs and MA, even if they were more acute for PDPs. Firms were especially concerned that it has been so difficult to reconcile their MA enrollment with CMS. This slowed revenue and generated fears that some current enrollees were being disenrolled. Firms hoped for more support than they have received from CMS in addressing this problem.

- Firms were hesitant to share their upcoming 2007 plans fully, noting concerns over what the 2007 payment rates may mean. The discussions suggest the following for 2007:
  - Substantial continued growth of PFFS unless firms are dissuaded by concerns over 2007 payment rates
  - Refinements in benefit structures and pricing for existing products
  - Modest, if any, growth in regional PPOs
  - Potential introduction of MSA products
  - No expansion in local PPOs because of the moratorium and limited, if any, expansion in HMOs for the general population
  - Continued development of SNPs and other specialized products

Firm Perspectives and Concerns for the Long Term

- Most firms were clear that program stability was important to them, as were predictable MA payment with stable increases. Firms provided mixed feedback on their commitment to the MA market. While they say they are committed to the market, they also typically indicated that they would need to make decisions should experience prove unfavorable over time.
- Aside from stability, firms also wanted to have some advance notice of changes. They said, for example, that Special Needs Plans (SNPs) interested them but that they might be reluctant to offer new plans in 2008 without timely action on reauthorization (which runs out after 2008). Firms wanted a partnership with CMS and had various additional suggestions for MA program improvement.

CONCLUSIONS

The growth in MA contracts in 2006 has made MA more available across the country, including in areas where such contracts were previously absent or limited. Beneficiaries also have more contracts to choose from in 2006. To the extent that the MMA sought to enhance the availability of more coordinated care options for a greater number of beneficiaries, the results are mixed. HMOs and local PPOs are available to more beneficiaries in 2006 than 2005, but geographical concentration persists and there has been less activity in this sector than others in MA. For the most part, the availability of regional PPOs and PFFS contracts is responsible most for the increase in MA availability nationwide, especially in rural areas. Because of the growth of PFFS contracts, regional PPOs cannot be credited, at least directly, as the sole or even predominant driver of expanded choice.

Although many firms participate in the MA market, a small number dominate. The decisions of these firms have a major influence on the MA marketplace. Regional PPOs, for example, would be far less available had Humana not decided to enter 14 of the 26 MA regions. Decisions by Humana and PacifiCare in 2006 also had a disproportionate influence on the PFFS market.

HMOs still account for most MA enrollment. However, while HMO enrollment continues to grow, other products—especially PFFS—are driving much of the current growth in MA enrollment. Preliminary indications are that PFFS enrollment will exceed PPO enrollment in 2006. In contrast, regional PPOs, although available, have not yet proven their viability in the market and current enrollment is very limited. PFFS enrollment is particularly strong in counties benefiting from urban or rural floor payments, which raise rates above what they would otherwise be in the traditional Medicare program.

Although we focused on MA, we heard from firms that they devoted more attention to developing free-standing drug plans than MA in 2006. Such plans are more popular than MA plans that integrate prescription drug coverage, at least in 2006. Yet the analysis also shows that firms are actively pursuing MA in 2006 and are likely to continue to do so in 2007. Much of this appears driven by the opportunities created by the MMA, which both increased MA payments and made it more likely beneficiaries would consider MA by making them have to consider a private plan option if they desired a drug benefit. The MMA positioned MA firms to compete well in this marketplace by paying rates that exceed traditional Medicare program costs and allowing firms to use these funds—to the extent they have savings in delivering the Part A/B benefit—to expand Part D benefits and/or offset the beneficiary premium for such plans, as well as to support other attractive benefits. Floor payments sought to provide a cushion for firms in markets where MA has historically had the most difficulty thriving.

What these trends mean for Medicare is unclear. While beneficiaries have more choice, it appears the main expansions have given them more choice of essentially fee-for-service options—either directly through PFFS or indirectly through regional PPOs that use the same techniques in parts of their service area. This trend may provide limited opportunity for government to capitalize on private plan's ability to offer health plans with more care management potential than the traditional Medicare program. In many cases, these products take advantage of Medicare's negotiated rates. They therefore may not improve Medicare's rates or utilization, and if they grow they could reduce the current market ability Medicare has to negotiate rates. In addition, to the extent MA enrollment grows disproportionately in floor counties, the outcome also could be expensive for Medicare because such payments are higher than what Medicare would otherwise pay in the traditional program.

It also is not clear that expanded choice will be stable over time. Regional PPOs have not yet proven themselves and may not prove to be viable in the marketplace. Local plans, particularly those with less management potential, may only be attractive because Medicare is paying above market rates to support them. Firms are likely to either exit or substantially reduce their benefits if payment levels erode. Lacking networks, PFFS plans are particularly easy to drop. To the extent firms in MA respond by raising premiums and reducing benefits, MA expansion could lead to an integrated MA/supplement package but may not make such coverage more affordable than the current combination of Medicare and Medigap.

In sum, the Medicare market has changed in 2006 but whether such changes are fundamental and, if so, how, remains to be seen.

I. PROJECT PURPOSE, SCOPE, AND METHODS

A. PROJECT PURPOSE

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) made major changes in the Medicare Advantage (MA) program that are evident in 2006. In 2006, MA has expanded to include regional Preferred Provider Organization (PPO) plans as well as local MA plans—such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs) (historically referred to as coordinated care plans (CCPs)) and private fee-for-service plans (PFFS). (See Box on page 2.) MA also have been modified to include additional competitive features, such as the new competitive bidding system. Regional and local MA plans provide beneficiaries with access to a comprehensive set of benefits that includes the new and voluntary prescription drug benefit (Part D), which is being implemented in 2006. Beneficiaries wishing to receive the new Medicare prescription drug benefit must decide between enrolling in an MA plan or staying in traditional Medicare and joining a stand-alone prescription drug plan (PDP).

This project provides the Assistant Secretary for Planning and Evaluation (ASPE) with a baseline of timely, policy-relevant information that will help ASPE understand the MA products that are available in 2006, how they compare to past offerings when only local MA options were authorized, initial plan decisions and experiences under the new competitive bidding process, and how well available offers and enrollment meet Congress' overall objectives in enacting the MMA. The work includes analysis of quantitative data from available public sources and qualitative discussions with executives in MA plans and their parent organizations. The project seeks to help ASPE to identify emerging trends and determine whether further analysis or policy refinements may be desirable to address potential emerging problems or opportunities.

B. OVERVIEW OF MEDICARE ADVANTAGE IN THE MMA CONTEXT

The MMA is the latest in a series of steps designed to provide Medicare beneficiaries with access to emerging commercial products. In 1982, the Tax Equity and Fiscal Responsibility Act (TEFRA) created the Medicare risk contracting program, which provided authority for beneficiaries to contract with private health maintenance organizations (HMOs) and similar organizations. In 1997, the Balanced Budget Act (BBA) authorized the M+C program, enabling contracting with a broader range of private plans. Although the intent was to increase private plan options under Medicare, the reality, for a variety of reasons that included restrictions on annual payment rate increases, was that the opposite occurred. Plan choices and enrollment declined rather than expanded between 1999 and 2003 (Table I.1).

Under MA, existing HMO, PPO, and PFFS options were referred to as "local plans" because their service areas were established on a county-by-county basis, most serving geographically defined markets. The MMA made immediate changes in payment rates for local plans effective March 1, 2004, in order to stabilize the market. The most obvious changes were to set a minimum payment of 100 percent of the traditional FFS payments in that county and to mandate that the minimum increase in the annual payment percentage be either 2 percent (previous policy) or the National Gross Percentage, which was 6.3 in 2004 and 6.6 percent in 2005.

Major Types of Medicare Advantage Plans

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 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, which 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 PSOs that are offered
- ***Private Fee for Service (PFFS*****).** 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.)

Regional Preferred Provider Organizations (rPPOs). These are PPOs that serve large areas in the 26 defined regions that include one or more states. Regional 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.

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 but may also be offered 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).

Effective 2004, those with certain special needs may also obtain benefits through a Special Needs Plan (SNP), developed for dually eligible, institutionalized, or other defined populations with severe chronic or disabling conditions.

The MMA authorized more extensive changes starting January 1, 2006. This included a new regional PPO option, for which the Centers for Medicare & Medicaid Services (CMS) defined 26 regions nationally. In contrast to local plans, regional plans must be available to beneficiaries throughout the region and premiums and benefits must be uniform across the region. (Although beneficiaries pay the same amount, CMS will vary its contribution based on a beneficiary's county of residence.) Local MA plans were able to integrate traditional cost sharing for Medicare Part A and B services, and most made some modification to Medicare's benefit structure. Regional PPOs, however, are required to do so, and must also include a set limit on out-of-pocket cost sharing for Part A and B benefits—an important feature for beneficiaries that is lacking in traditional Medicare and some local MA plans. The MMA also modifies the former method of payment by introducing an element of competitive bidding into the administered pricing system previously in place for MA (Berenson 2005; MedPAC 2005).[3] The changes apply to both regional and local MA offerings, although details differ between the two types of plans.

Table I.1 Trends in MA Contracts, Enrollment, and Availability, 1999-2005

	1999	2003	2004	2005
Contracts				
All	412	235	234	273
CCP	303	143	143	182
PPO demonstration	0	35	35	34
PFFS	0	4	4	8
Enrollment				
All	6,573,435	5, 40,293	5,120,966	5,498,113
CCP	6,065,575	4,560,459	4,535,422	4,817,083
PPO Demonstration	0	56,156	89,408	118,497
PFFS	0	18,331	26,932	79,372
Percent of Beneficiaries in MA	16.8%	12.2%	12.1%	12.7%
Percent of Beneficiaries with MA Available				
Any	72	82	77	85
CCP	71	63	62	68

Source: See Table 1 in Gold (2005); based on MPR Analysis of CMS Geographic Service Area Reports for March of each year.

[3] Plans submit separate bids for basic Medicare Part A and B benefits, Part D pharmacy benefits, and supplemental benefits, with prices compared to benchmarks established using traditional fee-for-service experience/ payments and/or average bids (depending on the type of plan or benefit). When bids are below the benchmark, plans can use 75 percent of the difference available to expand benefits or reduce premiums. When bids are above the benchmark, the difference is added to the cost of the premium that a beneficiary must pay to enroll in that plan.

In 2006, Medicare introduced the new, voluntary Part D prescription drug benefit. In contrast to traditional Medicare (Parts A and B), drug benefits offered in Part D are available through private plans only. Those who wish to continue receiving traditional Medicare benefits through the original fee-for-service program—which serves more than 85 percent of beneficiaries—and also access Medicare's coverage for prescription drugs must enroll in a stand-alone private drug plan (PDP). Alternatively, they can enroll in a private local or regional Medicare MA plan that integrates drug coverage with Parts A and B, and supplemental benefits. Exceptions apply to PFFS plans that need not offer a drug benefit option, and medical saving account plans (MSAs), which are prohibited from doing so. Special provisions affecting enrollment also apply to Medicaid beneficiaries or to those with low income and assets who are eligible for a subsidy, as well as to those already enrolled in a qualified group retiree plan.

Marketing for the new prescription drug benefit—both through stand-alone PDP and MA plans—began on October 1, 2005, and beneficiaries were allowed to begin enrolling on November 15, 2005. CMS collaborated with a large number of diverse organizations to educate beneficiaries on the benefits and plans available and encourage those who would benefit to enroll in a plan that meets their needs. Plan sponsors also are marketing their own plans, and some of these efforts are fairly intensive. Beneficiaries had until May 15, 2006 to enroll in Part D without a penalty, but those wishing benefits to begin January 1, 2006 had to enroll by year-end 2005. Auto-enrollment for dual eligibles also occurred in late 2005, to enable these individuals to have uninterrupted prescription drugs coverage as they transition to receipt of this coverage via Medicare as opposed to Medicaid. Others eligible for a subsidy were auto-assigned in May 2006 if they had not made a choice on their own. With limited exceptions, auto-assignment is to PDP plans only, so its influence on MA will be limited. (The exceptions apply to dual eligibles in particular circumstances who reside in areas where an SNP is available.)

CMS has released only limited information on enrollment in the new prescription drug benefit. As of May 7, 2006, CMS indicates that 8.9 million beneficiaries are enrolled in stand-alone PDPs nationally, 5.9 million are enrolled in such plans as dual-eligibles and that 5.9 million are enrolled in prescription drug plans associated with Medicare Advantage contracts (MA-PDs) (http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp, accessed 6/7/2006). A small share of MA-PD enrollees are dually eligible for Medicare and Medicaid. There also are some beneficiaries enrolled in MA only plans without prescription drugs (Other CMS data for April 2006 shows about 910,000 such enrollees).

C. RESEARCH QUESTIONS

The quantitative portion of this project provides baseline data on MA in 2005 and how it has changed in early 2006. The main questions of interest include:

1. How many MA contracts of each type are available nationwide, and what share of beneficiaries have access to them?

2. How are contracts distributed nationally, and how does availability vary across MA regions?

3. What are the major companies that sponsor MA plans, and what role do they play nationally and for different types of contracts?

4. How are payment rates associated with diverse offerings?
5. How many beneficiaries are enrolled in MA, what is the market penetration, and how does this differ across the country and by type of contract?

The qualitative portion of this project complements the descriptive analysis and provides more insight into firm strategies, how various types of products are designed, and future implications. The main questions of interest include:

1. What are the main factors that led firms to change (or not change) their offerings in 2006 in the ways they have?
2. To what extent are the factors of influence similar across types of contracts or markets, and how do they differ?
3. How do firms view their contract types in juxtaposition to one another, particularly when they offer multiple types of contracts in the same markets?
4. What role did network formation play in developing new offerings in 2006, and what influence did selected Medicare policies have on this development?
5. What considerations were important in designing benefits and targeting premium levels, and in what ways are decisions made across contracts of diverse types that may be offered in the same market?
6. How actively are firms marketing MA, and through which vehicles are they doing so?
7. What is initial experience with enrollment for 2006?
8. To what extent have firms made decisions about 2007, and what are their long-term interests in the program?

The report presents findings from the quantitative analysis first (Chapters II-V) and then the findings from the firm discussions (Chapter VI.)

D. METHODS AND DATA SOURCES

1. Quantitative Analysis

The quantitative analysis is based on a file we have created through publicly available CMS data and builds on our historical work for the Kaiser Family Foundation (KFF), the Robert Wood Johnson Foundation, and others. The basic data file is a SAS-ready file that employs the "contract-county combination" as the main unit of analysis. This provides flexibility to analyze offerings at different geographical units of analysis as well as for contracts as a whole. The file includes quarterly data for each contract-county unit starting March 2005 through March 2006—the latter are estimated using data on available January 2006 offerings, which change little between January and March.

Analysis Period. We used the March 2005 through March 2006 period for analysis because ASPE asked us to given their interests in learning about changes in 2006. As indicated in Section B of this chapter, what are now called MA offerings reached a high around 1999 and then declined through 2003. The MMA changed rating rules and other aspects of the program effective March 2004 but the industry response probably lagged, given that the legislation was not enacted until late 2003. Hence, March 2005 data probably reflect the initial industry response to the MMA rather than a "pure" baseline for MMA effects.

Data Sources. CMS's quarterly Geographic Service Area Report (GSA file) is the main source of information on MA contracts by type, service area, and enrollment. Because CMS has not released this file in 2006, we created a "pseudo-GSA file" based on the November 2005 release of the CMS Plan Finder data for 2006; the main differences are that the CMS plan finder file does not include certain contract types (e.g., Health Care Prepayment Plan or HCPP, Program for All Inclusive Care for the Elderly or PACE, and demonstration contracts).

We merged other sources of information with the core file created from the GSA file on a contract-county combination. Beneficiary counts for each county are from the market penetration state/county file; CMS has not yet released 2006 data on Medicare eligibles, so we use December 2005 data in analyzing the share of beneficiaries with access to plans in 2006. Rate information comes from the Medicare Advantage Rate book annual files. Counties are identified as urban/rural using the Area Resource File. Firm codes reflect historical MPR coding using InterStudy and other sources of data. Because enrollment tends to be unstable at the early part of the year, we intended to wait until March 2006 enrollment data are available to analyze enrollment and market penetration. However, CMS has not yet released public files that include 2006 enrollment data in the traditional ways the support flexible analysis. Our analysis of 2006 enrollment trends is thus limited to those topics that can be addressed via the limited data CMS has released. In general, the data provide some insight at the national level but less understanding of how enrollment is shifted geographically or by MA contract type or firm across the country.

Analysis File. Table I.2 provides a record layout showing the main elements in the analysis file used in the project. The file is limited to MA plans in the 26 MA regions, excluding U.S. territories and Puerto Rico. (See Appendix for a summary of MA in Puerto Rico.)

Limitations on SNP Analysis. Readers should note that the analysis file has limitations in terms of analyzing SNPs. This is partly because SNPs are defined by population rather than type of contract. As a result, many SNPs are not authorized by a separate number and distinct contract type but instead as one of several plans offered under a given contract. Such an SNP may be available in only a subset of counties in which the contract service area. CMS did not separately distinguish SNPs until late 2005. Furthermore, the November release of the 2006 Medicare Plan Finder data used to construct the pseudo-GSA does not include all SNPs available in 2006 because some were approved later. We used a separate file on SNPs that CMS released in 2006 to identify whether or not contracts included in the regular database included no SNP plans, a mix of general and SNP plans, or SNP plans only. This allows for constructing non-duplicated counts of total contracts at the national level. Because county service areas for SNPs are lacking and the project database excludes late-approved SNPs, they are excluded from other general analyses.

Table I.2. Main Elements in The File for the ASPE Project

Variable	Source	Timeframe
Contract code	GSA	Update quarterly
Contract type	GSA	Update quarterly
County code	GSA	Fixed
Urban/rural flag (4 category)	Area Resource File	Fixed
State code	GSA	Fixed
MA region code (with flag for PR/Territories)	CMS publication	Fixed
Contract-county enrollment	GSA code	Update quarterly
Contract firm code	MPR coded using various data sources	Fixed
County payment category 2004 (rural floor, urban floor, blend, minimum update)	MA Rate Book	Fixed
County MA benchmark	MA Rate Book	2006 only
Statutory component Regional MA Benchmark	CMS publication	2006 only
Payment as percent of FFS	MA Rate Book	Annually
Medicare beneficiaries	Market penetration File	Quarterly
Contract effective date	13-month trend report	Fixed (new contracts and terminations updated from GSA)

2. Qualitative Analysis

We arranged and conducted telephone discussions of about 45 to 60 minutes with executives from the full spectrum of MA plans. The original plan called for 15-20 calls. We aimed for individual calls with the 10 largest national and multi-regional MA firms: Aetna, Cigna, Health Net, Heritage, Kaiser-Permanente, Sierra, United Healthcare/PacifiCare,[4] Sterling, and Wellpoint. We also sought to organize about six other group interviews including three with diversely situated Blue Cross and Blue Shield (BCBS) plans, one with traditional prepaid group practices, and two with new entrants to Medicare. This design aimed to balance open reporting on proprietary topics with reach that addressed the diversity of firms in Medicare. In each case we sought participation from the senior-most executive responsible for the Medicare product for the firm. We asked national firms to invite a few individuals from specific localities to join in the interviews. Firms responded well to the request for interviews, but appeared to be trying to

[4] We planned to interview them separately since they offer distinctive plans in 2006. However, the firms have now merged and we interviewed them together.

limit the burden on operational staff by including mainly top executives in the interviews. In an effort to encourage firms to be open, we indicated that their comments would be confidential and that the analysis would not identify specific firms. Table I.3 shows the topics we discussed with each firm.

Firms Involved in the Discussions. In total, we succeeded in completing 14 discussions with a total of 20 firms that in total had 2.7 million of the 5.5 million MA enrollees in December 2005. In some cases, firms were interviewed separately rather than as a group, either because of scheduling constraints or firm preferences. Table I.4 lists the discussions convened and the firms that were involved in each. While we were generally successful in reaching our targets, we were only able to arrange to interview six of the 10 national and multi-regional firms targeted. However, the six included all of the largest firms now in MA.

Timing and Status of Discussions. We delayed scheduling the firm discussion until March 2006 to reduce the burden on firms at the start of 2006, and because the date made it more likely we could learn about 2006 experience. While firms varied in how completely they were willing to answer questions (especially about strategy and upcoming plans), they were typically relatively candid and cooperative in the discussions. Their comments provided insight into firm decision-making and generated information useful in "getting behind the numbers" and understanding how firms perceive the future of the MA product. Our commitment to confidentiality at the firm level was essential to firm participation, although even that was not sufficient for some firms to provide details in what they view is not the public domain—this is particularly true for some publicly traded firms that face Securities and Exchange Commission constraints on the kinds of forward-looking comments they can make.

Table I.3. Discussion Topics

2006 Strategy

Review what we understand the key changes to be in 2006.

- Have firms clarify, as necessary, whether they stayed in existing markets, went back to markets they had left, or entered new markets, and why.
- Have firms clarify why they selected to offer specific products over others. What are their expectations/positions for specific products? What are the perceived tradeoffs in expanding markets via Local PPOs versus HMOs? Viability of regional PPOs?
- Clarify how decisions were influenced by payment levels overall and by area, by anticipated competitor behavior, broader business concerns, etc.

  If national firm: which decisions are made centrally versus locally?

  If traditional HMO firm: what concerns do they have about the changes in 2006, new products, competition, etc.?

  If local or BCBS firm: how have MA and PDP regions influenced their decisions and what are their related concerns?

  If new to Medicare: was it a difficult or major decision to start to offer MA products?

- What considerations affected firm decisions to enter? Any reservations and concerns?

Network Structure and Development

- How did the need to develop new or revised provider networks affect firm decisions on product offerings in 2006, especially in entering new areas? Did network issues preclude firms from offering any products?
- What problems, if any, did firms encounter in creating the provider networks needed for their MA work? Did providers (physicians and hospitals) expect them to pay in excess of Medicare rates? To what extent did MMA policies (essential hospitals, network adequacy) facilitate or hinder network formation?

  For those offering PFFS: how are firms handling the issue of provider participation in PFFS products which are open access? Payment rates? Available providers?

Product Benefits and Positioning

- What strategic considerations underlie the basic structure of firms' MA plan benefits and premiums in 2006? Probe in terms of whether there was a target premium level and if so any relationship to PDPs (if offered), trade-offs in premiums, and cost sharing between Part D and other benefits.
- Are contracts of each type expected to be equally profitable?

Table I.3 ***(continued)***

Marketing

- What overall business strategies across MA products guided firms and were they appealing to different beneficiaries with each type of product (geographically, by income, or by risk aversion)?
- How aggressively are firms marketing diverse products, and through which routes? Any geographic variation in this?
- How do firms handle enrollment—role of plan staff in marketing/enrollment versus captive agents versus brokers with exclusive arrangements versus others?

Enrollment

- What were firm enrollment objectives for year 1 (2006)?
- What is the minimum enrollment a firm needs to make 2006 successful?
- So far, how does beneficiary response and enrollment compare to expectations?
- Have there been administrative issues with CMS systems that firms use to identify new enrollees, or to help with corrections or changes in enrollment?

Commitment and Concerns

- What assumptions have firms made about time horizon; how likely are they to stay in the market if experience proves unfavorable?
- Have firms made specific decisions now with respect to any changes in 2007?
- To what extent is timing an issue in 2007 bid submissions? To what extent will changes occur in 2008 versus 2007 because of these and what kinds of changes are being considered?
- What are firms' most pressing concerns with respect to MA policy?

Table I.4. Interviews and Firms Participating in Discussions

National and Multi-Regional Firms

- Cigna
- Heritage Health Plans
- Humana
- Kaiser-Permanente
- Sierra Health Services
- UnitedHealthcare/PacifiCare

Blue Cross and Blue Shield Affiliates

- Affiliates with boundaries co-terminous with regional PPOs (Horizon (NJ), BCBS of Michigan, BSBS of Texas)
- Affiliates with boundaries co-terminous with regional PPOs (BCBS of Florida)
- Affiliates with boundaries in conflict with regional PPOs (Excellus (parts of NY), Highmark (Western PA)
- Affiliates with boundaries in conflict with regional PPOs (Regence BCBS, NW)
- Multi-regional collaboration (Medicare Blue Solution)

Other, Largely Local Plans

- Traditional prepaid group practices (Health Alliance Plan, Harvard Pilgrim, Group Health Cooperative of Puget Sound, Health Partners)
- New entrant: Blue Cross and Blue Shield of Alabama
- New entrant: Instill Health Insurance Company

This page has been intentionally left blank for double-sided copying.

II. NATIONAL TRENDS IN MA OFFERINGS, 2005-2006

In this chapter, we review trends in the MA contract offerings by type. We begin by reporting on the number of contracts, a traditional measure CMS has used to describe the size of the MA program. We then discuss changes in the availability of different contracts to beneficiaries nationally and within urban and rural areas. We end by analyzing the dynamics of change, including characteristics of new entrants and transitions across contract type.

A. NUMBER OF CONTRACTS BY TYPE

Contracts are at best a crude indicator of availability because their number can vary as firms consolidate or change their service areas. In addition, some newer types of contracts—for example, regional PPO contracts, and PFFS contracts—can cover large areas of the United States with numerous MA plans that have different benefit structures in diverse parts of the country. However, while counts of contracts may become less meaningful in the future, they remain a common measure of change in the size and interest in the MA program over time.

Total Contracts. The number of MA contracts increased substantially between March 2005 and 2006 (Table II.1). The total number of contracts increased by 149 over this period (60 percent) from 249 to 398, excluding HCPP, PACE and other specialized contract types not reported in available 2006 data. Table II.1 understates the expansion since the 2006 data exclude some SNPs approved late in 2005. Many new contracts were effective by September 2005 in anticipation of 2006. (The only contract type not authorized before 2006 were regional PPOs). For this reason, changes from March 2005 to March 2006 are most meaningful in portraying the firm response to 2006 policy changes under the MMA. From 2005 to 2006, the number of contracts grew for each contract type for which data are available, with the exception of cost contracts, which declined in 2006 (see below).

Coordinated Care Contracts. Coordinated care contracts—local HMOs, PPOs, and PSOs under the MMA—have historically dominated contracts in the MA program and this remains the case in 2006. The total number of such contracts increased from 212 to 314 between 2005 and 2006. The 2006 HMO and local PPO numbers include only contracts with at least one plan available to all Medicare beneficiaries. (Such contracts also may include SNPs for specific subgroups of beneficiaries who are dually eligible, institutionalized, or who have specific serious chronic and disabling conditions.) The adjustment allows more consistent trending of available offerings over time. While it appears that HMO contracts declined between December 2005 and March 2006 after a rapid expansion in 2005, this is an artifact of measurement. September and December 2005 HMO counts include HMOs approved solely to offer SNPs; with available data in 2006, we have been able to separately categorize such offerings.

Table II.1. MA and Related Private Plan Contracts by Type, United States 2005-2006

Contracts by Type	March 2005	June 2005	September 2005	December 2005	March 2006[a]	Net Change 3/05 to 3/06
Total Contracts[b, c]	306	326	444	440	NA	NA
Total excluding HCPP, PACE, and other	249	268	381	376	398	+149
Local HMO, PSO, or PPO (formerly CCPs)[d]	212	228	327	327	314	+102
Local HMO	148	156	195	194	198	+50
Local PPO or PSO[d]	64	72	132	133	116	+52
Cost	29	29	34	29	18	-11
SNP	NA	NA	NA	NA	127[g]	NA
PFFS	8	11	16	16	21	+13
Regional PPO[e]	0	0	0	0	11	NA
HCPP[f]	5	5	6	6	NA	NA
PACE[f]	32	33	33	34	NA	NA
Other[f]	20	20	24	24	NA	NA

Source: MPR analysis of files developed from publicly available CMS data. 2005 data are from the Geographical Service Area Report for March, September, and December 2005. 2006 data are from a file created from the November 2005 release of the 2006 Medicare Personal Plan Finder.

NA= Data not available.

[a]Based on January 2006 data, as March 2006 data were not yet available and new contracts are generally approved in January of each year.

[b]Counts exclude employer-only contracts which are not available for individual enrollment. CMS data for 2005 includes HCPP, PACE, and other (largely demonstration) contracts, which are not included in the data available for 2006.

[c]The totals may not match the sum of the rows because SNP plans are not necessarily approved as unique contracts. Many SNPs are plans that are offered under contracts approved for the general population (e.g., HMOs). Contracts which have an SNP plan were identified through an indicator developed using January 2006 SNP data. Total contract numbers reflect unique contract numbers (i.e., total contracts only count SNP contracts if they are not already counted through contracts included in other contract types.)

[d]2005 data include those in the PPO demonstration.

[e]Regional PPOs were not authorized until 2006.

[f]HCPP, PACE and other contracts (e.g., demonstrations) are not included in the Medicare Personal Plan Finder which was used to create the file on which 2006 statistics are computed.

[g]Excludes SNPs that are not affiliated with contracts included in the November 2006 Medicare plan finder. CMS' February 14, 2006 Fact Sheet on SNPs indicates that on January 1, 2006, there were 164 MA contracts that offered one or more special needs plans in 42 states and Puerto Rico including 20 demonstrations, 23 local PPOs and 3 regional PPOs.

Local HMOs Versus PPOs. There was a net increase of 102 local HMO, PPO, and other coordinated care contracts between March 2005 and March 2006. The increase is substantial and about equally divided between HMOs, and PPO/others. Because there were more HMOs to begin with, the equal absolute growth of both contract types means the rate of growth for PPO contracts was greater than for HMO contracts. There were 64 PPO contracts in March 2005, including those authorized under PPO demonstration authority.[5] In 2006, there are 116 such contracts. Firms had an incentive to get approval for new local PPO contracts in 2005 because there was a two-year moratorium on adding these contracts or expanding service areas in 2006 and 2007. (The moratorium is designed to encourage firms to offer regional PPOs which are newly authorized in 2006.)

Cost Contracts. After remaining relatively stable in 2005, the number of cost contracts declined substantially in 2006 when there were only 18 such contracts, compared to 29 the year earlier. Congress has a history of interest in reducing the role of these contracts as the number of risk-based contracts expands. The Balanced Budget Act of 1997 stipulated the phasing out of cost contracts, although the date was delayed (from 2002 to 2004) when the withdrawal of contracts in the late 1990s-early 2000s highlighted concerns about access to MA. Under the MMA, these contracts continue to be authorized. However, starting in 2008, they can only be offered in areas without adequate access to other MA types (using criteria defined in the statute). Cost contracts also are much more restricted in their prescription drug plan offerings.[6] Both of these considerations could have influenced the reduction in cost contracts in 2006.

PFFS Contracts. The number of PFFS contracts more than doubled between March 2005 and 2006 (from 8 to 21). Authorized in the late 1999, the first PFFS contract (with Sterling) was approved in 2001 (Gold 2001) but growth has been relatively recent, with only 4 contracts in March 2004. Over 2005, the number of PFFS contracts increased steadily from 8 in March, to 11 in June, and to 16 in September and December. The number increased again in 2006 to 21. Many PFFS contracts cover extensive geographical areas, so their availability in the program is understated by contract counts.

Regional PPOs. Regional PPOs were first authorized in 2006. There are 11 separate PPO contracts, although some contracts cover more than one of the 26 regions. As discussed later, regional PPOs are available in 21 of the 26 regions, a fact heavily influenced by Humana's decision to enter the market in 14 regions. Humana accounts for only 3 of the 11 contracts however.

SNP Contracts. While the other types of contracts involve unique rules in how care is organized—for example, whether a provider network is used, or coverage is available outside the network—SNPs are distinguished instead by the population they serve. CMS may enter into unique contracts for SNPs. It may also authorize SNP plans under existing contracts that serve

[5] Future analysis will indicate the share of PPO demonstrations that transitioned to regular program status.

[6] Part D coverage is optional for cost contracts, and firms electing to do so in their cost contracts may do so only as an optional benefit. Cost contractors also may apply to be a free-standing PDP sponsor. (Sections 417.400 and 417.534 of the Part D regulations)

the general population as well (such as HMOs). While SNPs have been authorized since 2004, they only gained popularity in 2005 and data before 2006 do not distinguish them.

The Medicare Personal Plan Finder we used to construct the 2006 data shows 127 contracts that offer SNPs. In 2005, CMS approved most new contracts by September but SNP approvals lagged so many of the 127, 93 were in contracts for MA types available to the general population. They 93 included 78 in HMO contracts, 10 in local PPO contracts, 3 that were regional PPO contracts, and 2 that were PSO contracts.[7] Contracts approved after that date and not included in the September MA data made available to beneficiaries initially to support 2006 choice. In its February 14, 2006, Fact Sheet, CMS indicates that there were 164 such contracts including 19 demonstration plans. Of the 164 SNP contracts, 140 were for dually eligible enrollees, 32 were for enrollees in or eligible for institutionalization, and 12 were for other beneficiaries with severe chronic or disabling conditions.

B. AVAILABILITY BY CONTRACT TYPE NATIONALLY

Availability of MA contracts increased from 2005 so that in 2006 nearly all Medicare beneficiaries had a choice of at least one MA contract in each area (Table II.2). Growth was particularly marked with respect to available local PPOs and PFFS plans. It also reflects the first time availability of regional PPOs in 2006 and the fact that 2006 contracts made this option available to 86 percent of all beneficiaries. We are unable to calculate SNP availability because data defining specific offerings at the county level are not available consistently for all contracts. This information is critical, since we know from other sources that many of these plans are not offered statewide (CMS 2006).

Overall Availability. In 2006, 97 percent of Medicare beneficiaries had at least one contract approved for their geographic area, up from 91 percent in March 2005, 95 percent in June 2005, and 96 percent in September and December 2005. The share of beneficiaries with an available contract increased for each contract type for whom we have data, except for cost contracts whose availability declined from 23 percent of all beneficiaries to 9 percent between March 2005 and March 2006.

Local HMO or PPO (Coordinated Care Plans). Between March 2005 and March 2006, the percentage of beneficiaries with an available HMO, local PPO or similar plan increased from 64 percent to 77 percent (a net change of 12.3 percentage points). Availability was most pronounced outside of the HMO sector. More than twice as many beneficiaries had a local PPO available to them in March 2006 than March 2005 (62 percent versus 38 percent). The increase in HMO availability was more modest (70 percent from 61 percent.) Many of the new PPOs apparently serve areas with existing HMOs, which explains why the overall availability of at least one of these options did not increase more dramatically with the greater availability of local PPOs.

[7] UnitedHealthcare accounts for 42 of the 127 contracts, including all 3 of the regional PPO contracts. Chapter IV describes more generally the role of diverse firms in the market.

Table II.2. Selected Measures of Availability of MA and Related Private Plan Contracts to Medicare Beneficiaries by Type, United States, 2005-2006

Percentage of Beneficiaries with:	March 2005	June 2005	September 2005	December 2005	March 2006[a]	Net Change 3/05 to 3/06
Any Available Plan[b]	91.4	95.0	96.1	96.0	97.1	+5.7
Local HMO, PSO, or PPO (formerly CCP)	64.3	71.0	78.0	78.0	76.6	+5.7
Local HMO	61.6	67.6	70.3	70.3	70.3	+8.7
Local PPO or PSO[c]	38.3	45.9	64.3	64.2	61.9	+23.6
Cost contracts	22.9	22.9	25.0	23.0	9.4	-13.4
PFFS	40.5	71.5	74.9	74.9	78.4	+37.9
Regional PPO[d]	0	0	0	0	86.2	NA
Other (HCPP, Demo, PACE)	61.9	61.9	56.7	56.7	NA[e]	NA
Number of all available HMO, PSO, or PPOs (including regional PPOs)						
None	36%	29%	23%	23%	4%	
One	2	1	1	1	1	
Two	6	3	2	2	4	
3-5	29	28	20	20	29	
6+	28	40	55	54	61	

Source: MPR Analysis of files created from publicly available CMS data, selected months, Geographic Area Service Area Report (for March 2005–December 2005) as well as the MPR created pseudo-GSA file using CMS' publicly available data from the November 2005 release of the 2006 Medicare Personal Plan Finder.

NA = Data not available.

[a]Based on January 2006 data, as March 2006 data were not yet available and new contracts generally are approved in January of each year.

[b]Counts exclude employer-only contracts, which are not available for individual enrollment. CMS data for 2005 includes HCPP, PACE, and other (largely demonstration) contracts, which are not included in the data available for 2006. SNP availability is not reported separately because service areas aren't consistently available and these plans are not available to the general population.

[c]Includes PPO demonstration plan in 2005.

[d]Regional plans were not authorized in 2005.

[e]HCPP, PACE and other contracts (e.g. demonstrations) are not included in the Medicare Personal Plan Finder which was used to create the file on which 2006 statistics are computed.

PFFS. The share of beneficiaries with access to a PFFS contract almost doubled between March 2005 and March 2006—from 41 percent to 78 percent of beneficiaries. PFFS availability increased relatively evenly over the period.

Regional PPOs and the Overall Availability of Network-Based Offerings. Regional PPOs are located in many of the more populated states and 86 percent of beneficiaries have such an option available to them. Because network-based plans may be better situated to enhance care management, there has historically been interest in encouraging HMOs and PPOs locally. The MMA sought to make HMOs and PPOs more universally available through regional PPOs. While over one-third of beneficiaries (36 percent) had no network-based plan available to them in March 2005, this figure declined to 23 percent by December 2005 with the expansion of local PPO (and HMO offerings) and then fell markedly to 4 percent with the introduction of regional PPOs in 2006. Further, the number of HMO and PPO (local or regional) choices increased. While at least three such choices were available to 57 percent of beneficiaries in March 2005, that number rose to 90 percent of beneficiaries in March 2006. During the same period, percentage of beneficiaries with six or more such contracts operating in their area also increased—from 28 percent to 61 percent.

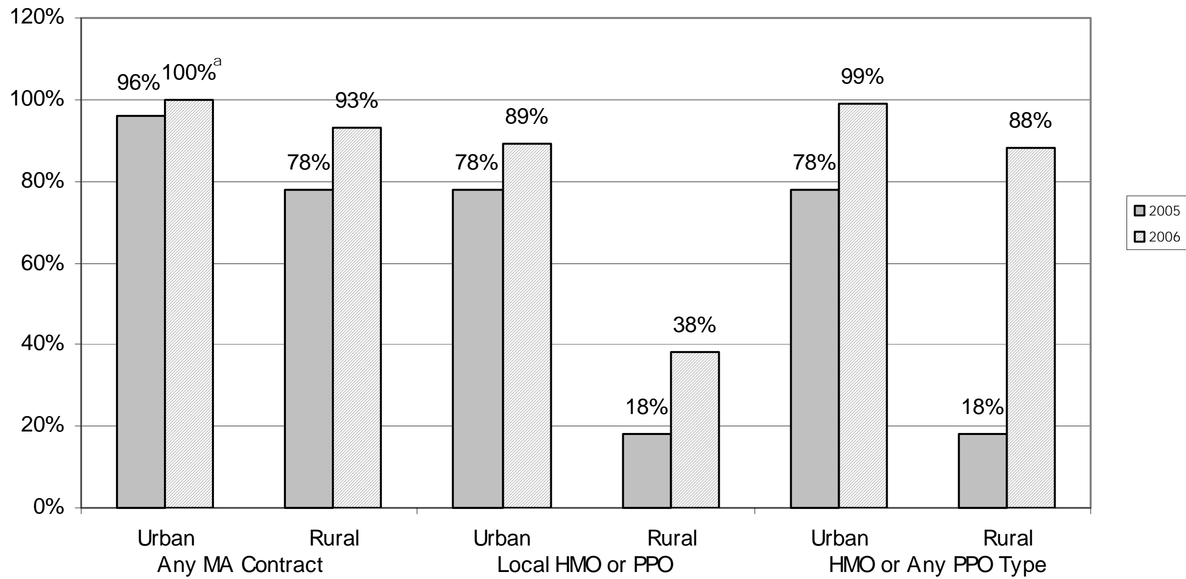
C. AVAILABLE CHOICE: URBAN AND RURAL COUNTIES

Historically, MA has been more available in urban areas than in rural areas of the country (Gold 2004; MedPAC 2001). While this continues to be true in 2006, the gap has narrowed (Figure II. 1). Virtually all urban and 93 percent of rural beneficiaries are likely to have some form of MA contract available in 2006, up from 96 percent and 78 percent respectively in March 2005. While the share of rural beneficiaries with an available local HMO or PPO virtually doubled from 2005 to 2006, the availability of regional PPOs and PFFS plans is most responsible for the growth in availability in rural areas. Below, we describe availability in urban and in rural counties in the United States in 2005 and 2006.

1. Beneficiaries in Urban Areas

In March 2005, almost all (96 percent) of Medicare beneficiaries living in urban areas had access to an MA plan, including 76 percent with at least one available HMO serving their county of residence (Table II.3). In 2006, all but 0.4 percent of Medicare beneficiaries in urban areas have some form of MA plan available to them—including 84 percent with an available HMO, 89 percent with an available HMO or local PPO, and 99 percent with an available HMO, local PPO or regional PPO. Almost three-quarters (74 percent) of urban beneficiaries nationally have six or more choices of the last kind available to them in 2006, more than double that in March 2005 (37 percent). PFFS plan availability increased from 38 percent to 76 percent over the period. Cost contracts, in contrast, declined in availability, with only 10 percent of urban beneficiaries having at least one such contract in their area in March 2006 as compared to 27 percent in March 2005.

Figure II.1. Percentage of Urban and Rural Beneficiaries with at Least One Available MA Contract by Type, March 2005-2006



Source: MPR Analysis of files created from publicly available CMS data, selected months, Geographic Area Service Area Report (for March 2005–December 2005) as well as the MPR created pseudo-GSA file using CMS' publicly available data from the November 2005 release of the 2006 Medicare Personal Plan Finder.

Note: 2006 availability is estimated from the November 2005 release of the Medicare Personal Plan Finder using December 2005 data on eligibility.

[a]Because of rounding – true figure is 99.6 percent.

Table II.3. Selected Measures of Availability of MA and Related Private Plan Contracts to Medicare Beneficiaries by Type, Urban Counties Only, United States, 2005-2006

Percentage of Beneficiaries with	March 2005	June 2005	September 2005	December 2005	March 2006[a]	Net Change 3/05 to 3/06
Any Available Plan[b]	96.1	98.5	99.2	99.2	99.6	+3.5
Local HMO, PSO, or PPO (formerly CCPs)	78.3	83.8	89.6	89.6	89.4	+11.1
Local HMO	75.7	80.5	83.3	83.2	84.2	+8.5
Local PPO or PSO[c]	47.3	55.4	76.4	76.4	73.7	+26.4
Cost	27.1	27.2	29.5	27.2	10.1	-17.0
PFFS	38.0	69.2	72.6	72.6	76.0	+38.0
Regional PPO[d]	0	0	0	0	88.1	NA
Other (HCPP, PACE or other demo)	67.9	67.9	62.0	62.0	NA[e]	NA
With available HMO, PSO, or PPOs (including regional PPOs)						
None	22%	16%	10%	10%	1%	
One	1	1	1	1	1	
Two	6	3	2	2	2	
3-5	34	30	19	20	23	
6+	37	50	68	67	74	

Source: MPR Analysis of files created from publicly available CMS data, selected months, Geographic Area Service Area Report (for March 2005–December 2005) as well as the MPR created pseudo-GSA file using CMS' publicly available data from the November 2005 release of the 2006 Medicare Personal Plan Finder.

NA = Data not available.

[a]Based on January 2006 data, as March 2006 data were not yet available and new contracts generally are approved in January of each year.

[b]Counts exclude employer-only contracts which are not available for individual enrollment. CMS data for 2005 includes HCPP, PACE, and other (largely demonstration) contracts, which are not included in the data available for 2006. SNP availability is not reported separately because service areas aren't consistently available and these plans are not available to the general population.

[c]Includes PPO demonstration plans in 2005.

[d]Regional plans were not authorized in 2005.

[e]HCPP, PACE, and other contracts (e.g. demonstrations) are not included in the Medicare Personal Plan Finder which was used to create the file on which 2006 statistics are computed.

2. Beneficiaries in Rural Areas

MA offerings are more limited in rural than in urban areas, but the availability of such options grew substantially between 2005-2006, reflecting to a considerable extent the influence of the introduction of regional PPOs and expansion of PFFS plans (Table II.4). Regional PPOs, not available in 2005, were available to 84 percent of rural beneficiaries in 2006. PFFS contracts grew from serving 51 percent of rural beneficiaries in March 2005 to 83 percent in June 2005, 86 percent in September and December 2005, and 91 percent in March 2006, not quite doubling but reflecting an absolute net change of 37 percentage points. HMOs and local PPOs remain much less prominent in rural areas than urban ones, although the share of beneficiaries with one or more of them available has increased from 18 percent to 36 percent, including 25 percent with an HMO and 24 percent with a local PPO in 2006.

With the additions particularly in regional PPOs, only 12 percent of rural beneficiaries have no HMO or PPO (local or regional) available to them in March 2006, compared to 82 percent in March 2005. Further, 74 percent have at least three such contracts in March 2006, up from 13 percent in March 2005.

D. AVAILABILITY OF PRESCRIPTION DRUG PLANS

Virtually all MA contracts in 2006—except for PFFS and cost contracts—include at least one MA plan with the new prescription drug benefit (Table II.5). Exceptions may reflect unique circumstances or errors in the Personal Plan Finder that were corrected after the release of the file used here. The MMA made offering an MA-PD optional for PFFS contracts, but 62 percent of such contracts have elected to offer the product anyway. We are exploring these decisions more fully in our interviews.

E. ENTRY, EXIT, AND CONVERSION

The number of MA contracts grew substantially from March 2005 to the start of 2006 (Table II.6). Altogether, we identified 198 new contracts over that time period, with growth particularly heavy in the July-September 2005 period (104 new contracts). Plans newly approved only in 2006 were more likely to be regional PPOs (first authorized in 2006) or contract types that may represent a conversion from demonstration status (such as PPOs or SNPs).

In most cases, firms expanding in 2006 had entered the marketplace before the start of the year. Because of the two-year moratorium on establishment of new local PPOs, effective January 2006, firms had to obtain CMS approval of new PPOs or PPO expansions in 2005 or they would have to wait until 2008. In addition, CMS's monthly reports showed a lengthy backlog of potential new applicants for much of 2005. Hence, it could be that firms had planned for a more extensive enrollment push in local plans earlier in 2005 than had proved feasible, with many of these new plans being approved late in the year.

Table II.4. Selected Measures of Availability of MA and Related Private Plan Contracts to Medicare Beneficiaries by Type, Rural Counties Only, United States, 2005-2006

Percentage of Beneficiaries with	March 2005	June 2005	September 2005	December 2005	March 2006[a]	Net Change 3/05 to 3/06
Any Available Plan[b]	77.8%	87.1%	89.2%	89.1%	92.9%	+15.1
Local HMO, PSO, or PPO (formerly CCPs)	18.4	29.6	39.3	39.3	37.8	+19.4
Local HMO	15.3	23.7	27.2	27.2	25.4	+10.1
Local PPO or PSO[c]	8.2	13.5	27.0	27.1	24.1	+15.9
Cost	9.3	9.3	10.4	9.5	7.7	+1.6
PFFS	51.0	82.6	86.2	86.2	90.5	+36.5
Regional PPO[d]	0	0	0	0	83.6	0
HCPP, PACE or Other	43.8	43.8	41.0	40.9	NA[e]	NA
Distribution of available HMO, PSO, or PPOs (including regional PPOs)						
None	82%	70%	61%	61%	12%	
One	0	1	1	1	1	
Two	5	4	3	3	13	
3-5	12	20	24	24	52	
6+	1	5	12	11	22	

Source: MPR Analysis of files created from publicly available CMS data, selected months, Geographic Area Service Area Report (for March 2005–December 2005) as well as the MPR created pseudo-GSA file using CMS' publicly available data based on the November 2005 release of the January 2006 Medicare Personal Plan Finder.

NA = Data not available.

[a]Based on January 2006 data since March 2006 data were not yet available and new contracts generally are approved in January of each year.

[b]Counts exclude employer-only contracts which are not available for individual enrollment. CMS data for 2005 includes HCPP, PACE, and other (largely demonstration) contracts, which are not included in the data available for 2006. SNP availability is not reported separately because service areas aren't consistently available and these plans are not available to the general population.

[c]Includes PPO demonstration plans in 2005.

[d]Regional plans were not authorized in 2005.

[e]HCPP, PACE, and other contracts (e.g. demonstrations) are not included in the Medicare Personal Plan Finder which was used to create the file on which 2006 statistics are computed.

Table II.5. Availability of Plans with Prescription Drug Coverage Under Medicare Advantage Contracts, 2006

United States	Total Number of Contracts	Number of Contracts with One or More MA-PD Plans	Percentage with MA-PD
All Contracts[a]	398	376	94%
HMO	198	195	98%
Local PPO	116	115	99%
PFFS	21	13	62%
Regional PPOs	11	11	100%
Cost	18	8	44%
SNP[b]	127	127	100%

Source: MPR analysis of a file created from the November 2005 release of the 2006 Personal Plan Finder. Availability of MA-PDs is separately calculated from that source for contracts of that type.

[a]Excludes HCPP, PACE, and other (demonstration) contracts not included in the Personal Plan Finder.

[b]Excludes SNP contracts approved after the release of the November 2005 version of the 2006 Personal Plan Finder.

Table II.6. Characteristics of Selected New Contracts by Type, 2005-2006

	Total New Contracts Over Period	New Local PPO or PSO	New Local HMO	Local SNP[a]	Local PFFS	Regional PPO
Total (excluding PACE, HCPP, and other)	198	95	65	14	13	11
Tracked national or affiliate firm, existing area[b]	60	39	11	0	3	7
Tracked national or affiliate firm, new area	40	21	12	0	4	3
Other firms[c]	98	35	42	14	6	1
Timing of Entry						
March-June 2005	19	8	8	0	3	0
July-September 2005[d]	104	60	39	0	5	0
For 2006	75	27	18	14	5	11

Source: MPR analysis of files created from publicly available CMS data, selected months, and Geographic Service Area Report (for March 2005-December 2005) as well as the MPR created pseudo-GSA file using CMS's publicly available data from the January 2006 Medicare Personal Plan Finder (for March 2006). Firm coding by MPR Staff

[a]SNP only contract

[b]These firms include: Aetna, Cigna, Health Net, Humana, Kaiser, PacifiCare, United Health Care; BCBS Affiliates.

[c]Other firms include new firms in new areas. Some existing firms coded as 'other' in the database may be included in this count since they are not coded by name for in the database.

[d]No new 2005 contracts were approved after September 2005

More than half of the new MA contracts over the 2005-2006 period were initiated by major national firms or Blue Cross and Blue Shield affiliates already in the MA market, which we track by name. Of the 198, 60 were such firms or affiliates introducing new products (most commonly a local PPO) in areas that included at least part of an area they already served, and 40 were contracts that involved those same firms expanding into new areas. The remaining 98 new contracts were a mix of other firm expansions and firms new to Medicare.

Our analysis indicates that 62 contracts were withdrawn in 2006. About half (34) were PPO demonstrations, 19 of which converted to regular authority plans and remained as market options. PacifiCare, in particular, had a number of withdrawals of what appear to be local firms, accounting for a majority of the withdrawn demonstrations. Of the remaining 28 contract withdrawals, 11 were cost contracts and 17 were HMOs or PSO plans, which either decided to terminate or converted in ways we did not track. No PFFS or SNP contracts terminated in 2006.

III. VARIATION IN CHOICE ACROSS MA REGIONS AND STATES

In this chapter, we analyze how the number of MA contracts and availability of choice in 2006, measured as in Chapter II for the nation, differs in 2006 across the 26 MA regions and the states they encompass. Next, we use these data to assess whether the introduction of MA regional PPOs in 2006 expanded MA availability more widely across the country. This question is important because a major goal behind the introduction of regional MA PPOs was to make coordinated care options—HMOs and PPOs—available to beneficiaries in more parts of the country, including areas previously with little or no choice. We then analyze how availability varies by county payment rates.

A. NUMBER OF CONTRACTS BY TYPE

The number of MA contracts in 2006 differs substantially across regions and states (Table III.1). For this purpose, we define a contract to exist in a state or region if its service area includes one or more counties in the state or region—a common practice which obviously overstates the contracts available to beneficiaries since they can access only options that serve their county of residence, not those only available elsewhere in the state or region. (An exception is with regional PPOs, which must serve the entire region and all states within it.) Geographic variation has been an important feature of the MA market over time (Gold et al. 2004). MA choice is more available across the country in 2006 but there remains significant variation.

At the lowest end in 2006, there is only 1 MA contract serving Alaska (Region 26), 4 serving Maine or New Hampshire (Region 1), and 6 serving Hawaii (Region 25). In contrast, there are 39 contracts in Florida (Region 9), 34 in Washington, Oregon, Idaho, and Utah (Region 23), and 32 in New York (Region 3). The number of contracts varies within regions as well as across them. For example, in the previously mentioned four-state Region 23 in the upper Northwestern United States, there are 14 contracts that serve at least a single county of Washington and 19 that serve the same in Oregon, but only 8 to 10 each in Idaho and Utah.

HMO contracts are most numerous nationally, a factor driving many of the differences in MA across states. The range of geographic variation in availability for PFFS plans is more limited. We review variation by each type of contract below.

Local HMO Contracts. In 2006, Florida (Region 9) has 25 HMO contracts serving one or more counties in the state, the national high, followed by New York (Region 3) which has 18. Eight states have 10 or more HMOs in one or more counties: Florida and New York, as mentioned, California (16), Illinois (11), Pennsylvania (11), Ohio (10), Texas (11), Massachusetts (10), and Oregon (10). In contrast, there are 7 states with no HMOs: Maine, Vermont, Delaware, Montana, South Dakota, Wyoming, and Alaska.

Table III.1. MA Contracts by MA Region and State, 2006

MA Region	PDP Region	State	Number of Medicare Beneficiaries	Number of Regional PPO Contracts	Number of HMO Contracts Serving 1 or More Counties	Number of Local PPO Contracts Serving 1 or More Counties	Number of PFFS Contracts Serving 1 or More Counties	Cost
Region 1			**437,553**	**0**	**1**	**1**	**2**	**0**
	1	Maine	243,190	0	0	1	2	0
	1	New Hampshire	194,363	0	1	0	2	0
Region 2			**1,825,841**	**0**	**10**	**5**	**2**	**0**
	2	Connecticut	540,699	0	3	1	1	0
	2	Massachusetts	1,007,212	0	7	3	0	0
	2	Rhode Island	177,579	0	2	1	1	0
	2	Vermont	100,351	0	0	0	2	0
Region 3			**2,879,429**	**1**	**18**	**11**	**1**	**1**
	3	New York	2,879,429	1	18	11	1	1
Region 4			**1,270,110**	**1**	**5**	**1**	**2**	**0**
	4	New Jersey	1,270,110	1	5	1	2	0
Region 5			**928,255**	**1**	**3**	**2**	**2**	**1**
	5	Delaware	132,269	1	0	0	2	0
	5	District of Columbia	77,597	1	2	1	1	1
	5	Maryland	718,389	1	2	1	1	1
Region 6			**2,556,932**	**1**	**12**	**10**	**7**	**1**
	6	Pennsylvania	2,189,492	1	11	8	7	0
	6	West Virginia	367,440	1	1	2	2	1
Region 7			**2,342,182**	**1**	**4**	**6**	**6**	**1**
	7	Virginia	1,023,400	1	2	3	6	1
	8	North Carolina	1,318,782	1	2	3	6	0
Region 8			**1,750,864**	**2**	**6**	**5**	**7**	**0**
	9	South Carolina	673,878	2	1	2	6	0
	10	Georgia	1,076,986	2	5	3	5	0
Region 9			**3,135,438**	**2**	**25**	**9**	**3**	**0**
	11	Florida	3,135,438	2	25	9	3	0
Region 10			**1,736,672**	**1**	**8**	**5**	**5**	**0**
	12	Alabama	781,601	1	3	2	2	0
	12	Tennessee	955,071	1	5	3	5	0
Region 11			**1,537,840**	**1**	**5**	**1**	**4**	**0**
	13	Michigan	1,537,840	1	5	1	4	0
Region 12			**1,811,669**	**2**	**10**	**9**	**3**	**2**
	14	Ohio	1,811,669	2	10	9	3	2
Region 13			**1,639,637**	**2**	**2**	**7**	**6**	**3**
	15	Indiana	934,910	2	1	5	6	3
	15	Kentucky	704,727	2	1	3	4	0
Region 14			**2,603,836**	**1**	**14**	**8**	**8**	**5**
	16	Wisconsin	854,772	1	3	2	6	4
	17	Illinois	1,749,064	1	11	6	6	1
Region 15			**1,432,182**	**1**	**8**	**5**	**6**	**0**
	19	Arkansas	489,388	1	2	0	5	0
	20	Missouri	942,794	1	6	5	4	0

Table III.1 ***(continued)***

MA Region	PDP Region	State	Number of Medicare Beneficiaries	Number of Regional PPO Contracts	Number of HMO Contracts Serving 1 or More Counties	Number of Local PPO Contracts Serving 1 or More Counties	Number of PFFS Contracts Serving 1 or More Counties	Cost
Region 16			**1,114,558**	**1**	**4**	**2**	**4**	**0**
	20	Mississippi	471,940	1	1	0	2	2
	21	Louisiana	642,618	1	3	2	3	0
Region 17			**2,641,789**	**1**	**11**	**5**	**3**	**1**
	22	Texas	2,641,789	1	11	5	3	1
Region 18			**971,888**	**1**	**5**	**4**	**3**	**0**
	23	Oklahoma	559,862	1	3	1	3	0
	24	Kansas	412,026	1	2	3	3	0
Region 19			**1,953,686**	**1**	**7**	**2**	**8**	**5**
	25	Iowa	502,547	1	4	1	6	1
	25	Minnesota	721,521	1	3	0	6	3
	25	Montana	153,286	1	0	1	4	0
	25	Nebraska	267,836	1	2	0	5	0
	25	North Dakota	106,313	1	0	0	3	1
	25	South Dakota	128,623	1	0	0	4	1
	25	Wyoming	73,560	1	0	0	2	1
Region 20			**819,885**	**0**	**5**	**5**	**4**	**1**
	26	New Mexico	277,591	0	2	4	4	0
	27	Colorado	542,294	0	3	1	3	1
Region 21			**818,639**	**2**	**9**	**4**	**5**	**0**
	28	Arizona	818,639	2	9	4	5	0
Region 22			**308,802**	**1**	**4**	**2**	**3**	**0**
	29	Nevada	308,802	1	4	2	3	0
Region 23			**1,853,090**	**0**	**15**	**12**	**6**	**1**
	30	Washington	851,609	0	7	4	3	0
	30	Oregon	557,661	0	10	4	4	1
	31	Idaho	198,714	0	1	3	4	0
	31	Utah	245,106	0	1	3	6	0
Region 24			**4,386,037**	**1**	**16**	**3**	**2**	**0**
	32	California	4,386,037	1	16	3	2	0
Region 25			**189,271**	**1**	**2**	**1**	**1**	**1**
	33	Hawaii	189,271	1	2	1	1	1
Region 26			**55,058**	**0**	**0**	**0**	**1**	**0**
	34	Alaska	55,058	0	0	0	1	0

Source: MPR analysis of files constructed from publicly available CMS data. 2006 information on available contracts is from a file created from the November 2005 release of the 2006 Medicare Personal Plan Finder. Beneficiary data are for December 2005 from the Market Penetration Report.

To some extent, the fact that eight states have more HMOs than others is not surprising. States vary dramatically in population, which influences the capacity of an area to support HMOs. Seven of the eight states with 10 or more HMOs rank highest in number of Medicare beneficiaries, with the exception of Oregon, which ranks 27th (KFF State Health Facts 2006). At the other extreme, the seven states with no HMOs also rank lowest (among states) in Medicare beneficiaries (Maine ranks #38th). But size cannot explain why Florida—which has 3.1 million Medicare beneficiaries—has 25 MA HMOs, whereas California, with 4.4 million beneficiaries, has only 16; New York, with 2.9 million beneficiaries, has only 18; or Texas, with 2.6 million beneficiaries, has only 11 HMOs.

Local PPO Contracts. There is at least one local PPO operating in at least one county in each of the 26 regions in the United States except Alaska. However, at the state level, 11 states have no local PPOs: New Hampshire, Vermont, Delaware, Arkansas, Mississippi, Minnesota, Nebraska, North Dakota, South Dakota, Wyoming, and Alaska. In some cases, states with no PPOs do have at least a single HMO (New Hampshire, Arkansas, Mississippi, Minnesota, and Nebraska). At the upper end, there are fewer local PPOs per state than there are HMOs—such contracts are most relevant in New York (11), Ohio and Florida (both 9) and Illinois (6).

Regional PPO Contracts. Regional PPOs are offered in 21 of the 26 MA regions (Regions 1, 2, 20, 23, and 26 are the exceptions). Unlike the previous kinds of plans, regional PPOs are available uniformly across all states and counties in the region. The location of 21 regional PPOs means that there are 13 states with no regional PPOs: Maine, New Hampshire, Connecticut, Massachusetts, Rhode Island, Vermont, New Mexico, Colorado, Washington, Oregon, Idaho, Utah, and Alaska. Most regions have only one regional PPO; five regions have two regional PPOs: Region 8 with South Carolina and Georgia, Region 9 with Florida, Region 12 with Ohio, Region 13 with Indiana and Kentucky, and Region 21 with Arizona.

PFFS Contracts. Each of the 26 MA regions has at least one PFFS contract operating in at least one county in the region in 2006 and such contracts also exist in all states except for Massachusetts. PFFS are most numerous mainly in states in the middle of the country, with 7 in Pennsylvania, and 6 each in 10 other states: Illinois, Indiana, both North and South Carolina, Virginia, Wisconsin, Illinois, Iowa, Minnesota, and Utah. (There also are 5 PFFS contracts operating in Georgia, Arkansas, Nebraska, and Arizona.)

Cost Contracts. Cost contracts have an historical base so it perhaps is not surprising that they are unique to a small number of states, especially Wisconsin (4), Indiana (3) and Minnesota (3). There are 30 states with no such contracts operating in any county in the state in 2006.

B. TRENDS AND DRIVERS IN OVERALL AVAILABILITY 2005-2006

Trends in Overall MA Availability. In Table III.2, above, we examine the share of beneficiaries with MA choice, and patterns of plan choice, in 2006.[8] In most states, all beneficiaries have access to at least one MA plan of any type (local HMO, PPO or PFFS,

[8] For this purpose, we ignore cost contracts because the legislation calls for their phase-out in 2008 if there are sufficient other MA plans operating in the same market.

Table III.2. Selected Measures of MA Plan Availability by Region and State, 2006

MA Region	PDP Region	State	Percent of Beneficiaries with Any MA Choice (HMO, PPO, PFFS, Regional PPO)	Percent of Beneficiaries with 1+ HMO Choice	Percent of Beneficiaries with 1+ Local PPO Choice	Percent of Beneficiaries with 1+ Regional PPO Choice	Percent with 1+ PFFS Choice
Region 1			**81.6**	**12.0**	**24.6**	**0.0**	**81.6**
	1	Maine	86.1	0.0	44.3	0.0	86.1
	1	New Hampshire	75.9	26.9	0.0	0.0	75.9
Region 2			**96.8**	**92.8**	**84.2**	**0.0**	**17.5**
	2	Connecticut	100.0	100.0	75.4	0.0	10.5
	2	Massachusetts	97.1	96.9	96.9	0.0	1.5
	2	Rhode Island	100.0	100.0	86.4	0.0	100.0
	2	Vermont	70.0	0.0	0.0	0.0	70.0
Region 3			**100.0**	**92.9**	**99.3**	**100.0**	**34.0**
	3	New York	100.0	92.9	99.3	100.0	34.0
Region 4			**100.0**	**100.0**	**86.6**	**100.0**	**34.7**
	4	New Jersey	100.0	100.0	86.6	100.0	34.7
Region 5			**100.0**	**69.6**	**69.6**	**100.0**	**26.0**
	5	Delaware	100.0	0.0	0.0	100.0	100.0
	5	District of Columbia	100.0	100.0	100.0	100.0	100.0
	5	Maryland	100.0	79.2	79.2	100.0	4.4
Region 6			**100.0**	**85.4**	**96.1**	**100.0**	**100.0**
	6	Pennsylvania	100.0	95.0	95.5	100.0	100.0
	6	West Virginia	100.0	27.9	100.0	100.0	100.0
Region 7			**99.6**	**85.4**	**96.4**	**100.0**	**100.0**
	7	Virginia	99.1	16.1	56.6	99.1	99.1
	8	North Carolina	100.0	56.0	40.5	100.0	100.0
Region 8			**100.0**	**34.0**	**45.7**	**100.0**	**100.0**
	9	South Carolina	100.0	23.1	47.4	100.0	100.0
	10	Georgia	100.0	40.8	44.6	100.0	100.0
Region 9			**99.8**	**90.3**	**78.1**	**99.8**	**99.8**
	11	Florida	99.8	90.3	78.1	99.8	99.8
Region 10			**100.0**	**78.2**	**6.4**	**100.0**	**100.0**
	12	Alabama	100.0	74.1	57.1	100.0	100.0
	12	Tennessee	100.0	81.6	68.5	100.0	100.0
Region 11			**100.0**	**72.6**	**50.1**	**100.0**	**100.0**
	13	Michigan	100.0	72.6	50.1	100.0	100.0
Region 12			**100.0**	**88.1**	**88.6**	**100.0**	**100.0**
	14	Ohio	100.0	88.1	88.6	100.0	100.0
Region 13			**100.0**	**17.2**	**38.6**	**100.0**	**100.0**
	15	Indiana	100.0	3.6	39.4	100.0	100.0
	15	Kentucky	100.0	35.2	37.6	100.0	100.0
Region 14			**100.0**	**74.3**	**74.7**	**100.0**	**100.0**
	16	Wisconsin	100.0	71.2	48.4	100.0	100.0
	17	Illinois	100.0	75.8	87.5	100.0	100.0
Region 15			**100.0**	**51.9**	**43.0**	**100.0**	**100.0**
	19	Arkansas	100.0	29.9	0.0	100.0	100.0
	20	Missouri	100.0	63.3	65.3	100.0	100.0

Table III.2 ***(continued)***

MA Region	PDP Region	State	Percent of Beneficiaries with Any MA Choice (HMO, PPO, PFFS, Regional PPO)	Percent of Beneficiaries with 1+ HMO Choice	Percent of Beneficiaries with 1+ Local PPO Choice	Percent of Beneficiaries with 1+ Regional PPO Choice	Percent with 1+ PFFS Choice
Region 16			**100.0**	**35.7**	**26.4**	**100.0**	**100.0**
	20	Mississippi	100.0	18.3	0.0	100.0	100.0
	21	Louisiana	100.0	48.5	45.9	100.0	100.0
Region 17			**100.0**	**66.9**	**54.8**	**100.0**	**100.0**
	22	Texas	100.0	66.9	54.8	100.0	100.0
Region 18			**100.0**	**45.0**	**48.9**	**100.0**	**100.0**
	23	Oklahoma	100.0	52.1	62.7	100.0	100.0
	24	Kansas	100.0	35.3	30.1	100.0	100.0
Region 19			**100.0**	**54.5**	**11.1**	**100.0**	**100.0**
	25	Iowa	100.0	68.3	21.6	100.0	100.0
	25	Minnesota	100.0	88.1	0.0	100.0	100.0
	25	Montana	100.0	0.0	71.2	100.0	100.0
	25	Nebraska	100.0	31.9	0.0	100.0	100.0
	25	North Dakota	100.0	0.0	0.0	100.0	100.0
	25	South Dakota	99.9	0.0	0.0	99.9	99.9
	25	Wyoming	100.0	0.0	0.0	100.0	100.0
Region 20			**99.9**	**72.2**	**75.1**	**0.0**	**99.9**
	26	New Mexico	100.0	48.8	100.0	0.0	100.0
	27	Colorado	99.8	84.2	62.4	0.0	99.8
Region 21			**100.0**	**92.2**	**80.7**	**100.0**	**100.0**
	28	Arizona	100.0	92.2	80.7	100.0	100.0
Region 22			**100.0**	**89.2**	**100.0**	**100.0**	**100.0**
	29	Nevada	100.0	89.2	100.0	100.0	100.0
Region 23			**100.0**	**82.2**	**84.8**	**0.0**	**95.7**
	30	Washington	100.0	86.9	77.6	0.0	100.0
	30	Oregon	100.0	93.4	100.0	0.0	85.9
	31	Idaho	100.0	56.4	70.3	0.0	100.0
	31	Utah	100.0	61.4	87.4	0.00	100.0
Region 24			**100.0**	**93.2**	**41.1**	**100.0**	**24.7**
	32	California	100.0	93.2	41.1	100.0	24.7
Region 25			**100.0**	**100.0**	**77.3**	**100.0**	**100.0**
	33	Hawaii	100.0	100.0	77.3	100.0	100.0
Region 26			**13.9**	**0.0**	**0.0**	**0.0**	**13.9**
	34	Alaska	13.9	0.0	0.0	0.0	13.9

Source: MPR analysis of files constructed from publicly available CMS data. 2006 information on available contracts is from a file created from the November 2005 release of the 2006 Medicare Personal Plan Finder. Beneficiary data are for December 2005 from the Market Penetration Report.

regional PPO), or virtually all do (97 percent or more in Massachusetts, Virginia, Florida, South Dakota, and Colorado). Availability is less widespread in the rural New England states of Maine (86 percent), New Hampshire (76 percent), and Vermont (70 percent), and Alaska, where only 13.9 percent of beneficiaries have an MA choice and only because a PFFS option is available in some counties.

There are many more states where all beneficiaries have at least one MA choice in 2006 than 2005 (Table III.3). States wherein fewer than half of beneficiaries had any MA choice in 2005 but at least 75 percent have such a choice in 2006 are: Maine (0 to 86 percent), New Hampshire (27 percent to 76 percent), Vermont (0 percent to 76 percent), West Virginia (10 percent to 100 percent) Alabama (43 percent to 100 percent), Indiana (33 percent to 100 percent), Arkansas (32 percent to 100 percent), Mississippi (0 to 100 percent), and Wyoming (0 to 100 percent).[9]

Drivers of Change. Regional PPOs expanded choices but they cannot be solely credited with driving the increase in overall availability of MA contracts in 2006, because PFFS contracts—which appear to have significant influence on MA availability—have also grown since 2005. In 2006, PFFS contracts serve all or virtually all counties in every state but nine: Maine, New Hampshire, Connecticut, Massachusetts, Vermont, New York, New Jersey, Maryland, California, and Alaska. With one exception, these are states where beneficiaries either typically also have access to local HMOs or PPOs already (Massachusetts, New York, New Jersey, California) or are in regions that do not have a regional PPO (the New England states, Alaska). The exception is Maryland, where local HMO options are available but not very extensive, and where the entry of a regional PPO in 2006 has raised the share of beneficiaries with an available choice to 100 percent.

States with dramatic growth in availability between 2005 and 2006 typically benefited both from growth in PFFS and regional PPOs or, if only one, from PFFS expansion. Of the nine states where availability increased from under half to at least 75 percent in 2006, three did so without a regional PPO, and the rest had both regional PPOs and PFFS contracts available in 2006.

The obvious question, which we can't answer with these data, is whether PFFS growth would have been as extensive as it was without the entry of regional PPOs in 2006.

C. AVAILABILITY OF LOCAL COORDINATED CARE (HMO AND PPO) OPTIONS

HMOs, originally the sole private plan option in Medicare, have dominated MA enrollment from the program's inception and still did so in 2005 (Gold 2005). In recent years, there has been growth in local PPO contracts, and policymakers hoped that more open provider access (albeit for additional cost sharing) would attract beneficiaries to private plans whose incentives

[9] Other states with sizeable gains in availability (of at least 20 percent) are Virginia (54 percent to 99 percent), Michigan (57 percent to 100 percent), Missouri (74 percent to 100 percent), Texas (76 percent to 100 percent), Oklahoma (80 percent to 100 percent), Colorado (80 percent to 100 percent), and Oregon (79 percent to 100 percent).

Table III.3. Selected Measures of Change in MA Plan Availability by Region and State, 2005-2006

MA Region	PDP Region	State	March 2005: Percent of Beneficiaries with Any Local MA Choice (HMO, PPO, PFFS)	March 2005: Percent of Beneficiaries with Any Local HMO or PPO Choice	March 2005: Percentage with 1+ PFFS Choice	March 2006[a]: Percent of Beneficiaries with Any MA Choice (HMO, PPO, PFFS, Regional PPO)	March 2006[a]: Percent of Beneficiaries with Any HMO or PPO Choice (include regional)	March 2006[a]: Percent with any Local HMO or PPO Choice	March 2006[a]: Percent with 1+ PFFS Choice
Region 1			**12.0**	**12.0**	**0.0**	**81.6**	**36.6**	**36.6**	**81.6**
		Maine	0.0	0.0	0.0	86.1	44.3	44.3	86.1
		New Hampshire	27.0	27.0	0.0	75.9	26.9	26.9	75.9
Region 2			**85.6**	**85.6**	**0.0**	**96.8**	**92.8**	**92.8**	**17.5**
1		Connecticut	75.6	75.6	0.0	100.0	100.0	100.0	10.5
1		Massachusetts	96.9	96.9	0.0	97.1	96.9	96.9	1.5
		Rhode Island	100.0	100.0	0.0	100.0	100.0	100.0	100.0
		Vermont	0.0	0.0	0.0	70.0	0.0	0.0	70.0
Region 3 2			**100.0**	**99.1**	**20.4**	**100.0**	**100.0**	**99.8**	**34.0**
2		New York	100.0	99.1	20.4	100.0	100.0	99.8	34.0
2 **Region 4** 2			**100.0**	**100.0**	**0.0**	**100.0**	**100.0**	**100.0**	**34.7**
		New Jersey	100.0	100.0	0.0	100.0	100.0	100.0	34.7
Region 5 3			**86.5**	**72.4**	**14.1**	**100.0**	**100.0**	**69.6**	**26.0**
		Delaware	100.0	0.0	100.0	100.0	100.0	0.0	100.0
4		District of Columbia	100.0	100.0	0.0	100.0	100.0	100.0	100.0
	5	Maryland	82.6	82.6	0.0	100.0	100.0	79.2	4.4
Region 6 5			**87.1**	**85.1**	**85.7**	**100.0**	**100.0**	**98.0**	**100.0**
5		Pennsylvania	100.0	97.7	100.0	100.0	100.0	97.7	100.0
		West Virginia	9.6	9.6	0.0	100.0	100.0	100.0	100.0
Region 7			**80.1**	**27.0**	**78.9**	**99.6**	**99.6**	**98.0**	**99.6**
		Virginia	54.4	5.5	51.8	99.1	99.1	62.0	99.1
6		North Carolina	100.0	43.8	100.0	100.0	100.0	56.0	100.0
6 **Region 8**			**100.0**	**23.9**	**100.0**	**100.0**	**100.0**	**49.3**	**100.0**
		South Carolina	100.0	0.0	100.0	100.0	100.0	47.4	100.0
7		Georgia	100.0	38.8	100.0	100.0	100.0	50.5	100.0
8 **Region 9**			**85.7**	**85.7**	**0.0**	**99.8**	**99.8**	**93.5**	**99.8**
		Florida	85.7	85.7	0.0	99.8	99.8	93.5	99.8
9									
10									
11									

Table III.3 *(continued)*

MA Region	PDP Region	State	March 2005: Percent of Beneficiaries with Any Local MA Choice (HMO, PPO, PFFS)	March 2005: Percent of Beneficiaries with Any Local HMO or PPO Choice	March 2005: Percentage with 1+ PFFS Choice	March 2006[a]: Percent of Beneficiaries with Any MA Choice (HMO, PPO, PFFS, Regional PPO)	March 2006[a]: Percent of Beneficiaries with Any HMO or PPO Choice (include regional)	March 2006[a]: Percent with any Local HMO or PPO Choice	March 2006[a]: Percent with 1+ PFFS Choice
Region 10			**74.4**	**64.3**	**54.9**	**100.0**	**100.0**	**81.3**	**100.0**
	12	Alabama	43.2	43.2	0.0	100.0	100.0	80.9	100.0
		Tennessee	100.0	81.6	100.0	100.0	100.0	81.6	100.0
Region 11			**56.9**	**48.3**	**8.6**	**100.0**	**100.0**	**72.6**	**100.0**
	13	Michigan	56.9	48.3	8.6	100.0	100.0	72.6	100.0
Region 12			**84.5**	**80.5**	**4.8**	**100.0**	**100.0**	**89.7**	**100.0**
	14	Ohio	84.5	80.5	4.8	100.0	100.0	89.7	100.0
Region 13			**61.7**	**12.4**	**60.0**	**100.0**	**100.0**	**38.6**	**100.0**
		Indiana	33.0	3.0	30.1	100.0	100.0	39.4	100.0
		Kentucky	100.0	25.0	100.0	100.0	100.0	37.6	100.0
Region 14			**100.0**	**75.6**	**100.0**	**100.0**	**100.0**	**86.0**	**100.0**
		Wisconsin	100.0	72.1	100.0	100.0	100.0	76.7	100.0
		Illinois	100.0	77.2	100.0	100.0	100.0	90.5	100.0
Region 15			**59.7**	**48.8**	**10.9**	**100.0**	**100.0**	**54.1**	**100.0**
		Arkansas	32.0	0.0	32.0	100.0	100.0	29.9	100.0
	20	Missouri	74.0	74.0	0.0	100.0	100.0	66.6	100.0
Region 16			**47.9**	**24.1**	**31.5**	**100.0**	**100.0**	**35.7**	**100.0**
		Mississippi	0.0	0.0	0.0	100.0	100.0	18.3	100.0
		Louisiana	81.8	41.1	53.8	100.0	100.0	48.5	100.0
Region 17			**75.6**	**55.9**	**27.9**	**100.0**	**100.0**	**69.3**	**100.0**
		Texas	75.6	55.9	27.9	100.0	100.0	69.3	100.0
Region 18			**88.4**	**50.4**	**88.0**	**100.0**	**100.0**	**51.1**	**100.0**
		Oklahoma	79.8	50.2	79.1	100.0	100.0	62.7	100.0
		Kansas	100.0	50.6	100.0	100.0	100.0	35.3	100.0

Table III.3 *(continued)*

MA Region	PDP Region	State	March 2005: Percent of Beneficiaries with Any Local MA Choice (HMO, PPO, PFFS)	March 2005: Percent of Beneficiaries with Any Local HMO or PPO Choice	March 2005: Percentage with 1+ PFFS Choice	March 2006[a]: Percent of Beneficiaries with Any MA Choice (HMO, PPO, PFFS, Regional PPO)	March 2006[a]: Percent of Beneficiaries with Any HMO or PPO Choice (include regional)	March 2006[a]: Percent with any Local HMO or PPO Choice	March 2006[a]: Percent with 1+ PFFS Choice
Region 19			**95.5**	**28.2**	**95.5**	**100.0**	**100.0**	**60.0**	**100.0**
		Iowa	100.0	4.9	100.0	100.0	100.0	68.3	100.0
		Minnesota	100.0	61.4	100.0	100.0	100.0	88.1	100.0
		Montana	90.7	0.0	90.7	100.0	100.0	71.2	100.0
		Nebraska	100.0	31.7	100.0	100.0	100.0	31.9	100.0
25		North Dakota	100.0	0.0	100.0	100.0	100.0	0.0	100.0
25		South Dakota	100.0	0.0	100.0	99.9	99.9	0.0	99.9
25		Wyoming	0.0	0.0	0.0	100.0	100.0	0.0	100.0
Region 20 25			**86.8**	**69.4**	**33.8**	**99.9**	**89.6**	**89.6**	**99.9**
25		New Mexico	100.0	48.6	100.0	100.0	100.0	100.0	100.0
25 25		Colorado	80.0	80.0	0.0	99.8	84.2	84.2	99.8
Region 21			**100.0**	**83.1**	**100.0**	**100.0**	**100.0**	**92.2**	**100.0**
26		Arizona	100.0	83.1	100.0	100.0	100.0	92.2	100.0
Region 22 27			**95.4**	**89.1**	**97.8**	**100.0**	**100.0**	**100.0**	**100.0**
		Nevada	95.4	89.1	91.8	100.0	100.0	100.0	100.0
Region 23 28			**93.5**	**72.1**	**90.8**	**100.0**	**90.1**	**90.1**	**95.7**
		Washington	100.0	80.3	100.0	100.0	89.1	89.1	100.0
		Oregon	78.5	72.1	69.4	100.0	100.0	100.0	85.9
29		Idaho	100.0	49.4	100.0	100.0	70.3	73.3	100.0
		Utah	100.0	61.6	100.0	100.0	87.4	87.4	100.0
Region 24 30			**93.2**	**93.2**	**8.1**	**100.0**	**100.0**	**93.2**	**24.7**
30 31	32	California	93.2	93.2	8.1	100.0	100.0	93.2	24.7
Region 25 31			**94.9**	**94.9**	**0.0**	**100.0**	**100.0**	**100.0**	**100.0**
		Hawaii	94.9	94.9	0.0	100.0	100.0	100.0	100.0
Region 26			**12.4**	**0.0**	**12.4**	**13.9**	**0.0**	**0.0**	**13.9**
		Alaska	12.4	0.0	12.4	13.9	0.0	0.0	13.9

33

Source: MPR analysis of files constructed from publicly available CMS data. 2006 information on available contracts is from a file created from the November 2005 release of the 2006 Medicare Personal Plan Finder. Beneficiary data are for December 2005 from the Market Penetration Report.

34

[a]Based on January 2006 service.

and structures might be more suited to care management than the traditional Medicare program (and PFFS).

In 2006, half the states (26) have a local HMO or PPO available to 75 percent of Medicare beneficiaries, including 16 states with such an option available to at least 90 percent (and often all) of their beneficiaries (Table III.4). Another 7 states—bringing the total to 33—have made such options available to 50 percent or more of their beneficiaries. Seven states have no such option for any beneficiary: Vermont, Delaware, Montana, North Carolina, South Dakota, Wyoming, and Alaska. Another, Mississippi, has made it available to under one-quarter of all beneficiaries. The remaining 10 had the 25 to 49 percent of Medicare beneficiaries in their state with a local HMO or PPO option.

The share of beneficiaries with a local HMO or PPO option increased in a number of states in 2006 compared to 2005 and declined in a few. In 19 states the change in the share of beneficiaries for whom a local HMO or PPO option was available was enough to move those states up one or more steps in the classification we have used here, including 3 states that in 2005 had no such choices and another seven with only 1 to 24 percent of their population having such choice. Only in Maine, West Virginia, and Indiana was the change due to local PPO growth. In the others, availability of HMOs in 2006 alone would support the shift in category. This means that while local PPOs expanded in 2006, the main effect in most localities was to expand choice in areas where local HMOs were already present in 2005, or would be in 2006.

D. AVAILABILITY OF MA IN URBAN VERSUS RURAL AREAS

Tables III.5 and III.6 are identical to Table III.3, but they show availability and change from 2005 to 2006 for urban and rural areas, respectively. As discussed in Chapter II, virtually all urban residents nationwide already had a choice on MA plan in 2005, although the share with an available HMO or PPO grew between 2005 and 2006. In contrast, overall availability in rural areas was only 78 percent in 2005. While it expanded to 93 percent in 2006, this mainly reflected expansion in the regional PPO and PFFS sector. In 2006, only 38 percent of rural beneficiaries have access to a local HMO or PPO—a rise from 18 percent in 2005, driven by growth in both kinds of offerings but mainly local PPOs. Because MA availability has been a greater issue in rural than urban areas, we focus on it in the text (Table III.6).

Overall Availability in Rural Areas by State. In 2005, eight states had no MA contracts available to any of their rural residents: Maine, New Hampshire, Connecticut, Massachusetts, Vermont, Maryland, Mississippi and Wyoming. (The District of Columbia, Rhode Island, and New Jersey have no rural counties.) Another four had an MA option available to 10 percent or fewer of rural Medicare beneficiaries (West Virginia, Michigan, Colorado, and Alaska). In 2006, such options were still rare in rural areas of Alaska (7.5 percent of rural beneficiaries). However, at least one MA contract was available to at least 90 percent of rural beneficiaries in each of the other noted states except for Maine (70 percent) and Massachusetts (69 percent). Regional PPOs did not enter the New England regions (1 and 2). The growth in choice there was almost entirely due to expansion in the PFFS sector of MA; the same was true in Colorado. In other areas, both regional PPOs and PFFS growth contributed to the growth in options.

Table III.4. States By Availability of Local HMO or PPO Contract, 2006

Percent of Beneficiaries Instate with Local HMO or PPO	States	Number of States	States in That Category In 2005 That Had Expanded Choice and Were No Longer There in 2006
Zero Percent	Vermont, Delaware, North Dakota, South Dakota, Wyoming, Alaska	6	Maine,* Arkansas, Mississippi, Montana
1-24%	Mississippi	1	New Hampshire, West Virginia,* Iowa, Virginia, Michigan, Indiana,* Kentucky
25-49%	New Hampshire, Maine, South Carolina, Indiana, Kentucky, Kansas, Nebraska, Arkansas, Louisiana	9	New Mexico, Idaho, Utah, Michigan
50-74%	Virginia, North Carolina, Georgia, Oklahoma, Iowa, Texas, Missouri, Montana, Michigan	9	Minnesota
75-89%	Wisconsin, Alabama, Tennessee, Colorado, Washington, Maryland, Minnesota, Idaho, Utah	9	Connecticut, Ohio, Illinois, Nevada, Oregon
90% or more	Arizona, California, Nevada, Oregon, Hawaii, New York, New Jersey, Pennsylvania, Florida, Illinois, Ohio, District of Columbia, West Virginia, New Mexico, Rhode Island, Connecticut, Massachusetts	16	NA

Source: MPR analysis of data from Table III.3 in this report.

*Movement attributable to growth of local PPOs. (Other states would qualify for movement based on HMO availability alone, although local PPOs may also have expanded.)

NA = Not Applicable.

Table III.5. Selected Measures of Change MA Plan Availability in URBAN Areas by Region and State, 2006

			March 2005			March 2006[a]			
MA Region	PDP Region	State	Percent of Urban Beneficiaries with Any MA choice (HMO, PPO, PFFS)	Percent of Urban Beneficiaries with Any HMO or PPO Choice	Percent with 1+ PFFS Choice	Percent of Urban Beneficiaries with Any MA Choice (HMO, PPO, PFFS, Regional PPO)	Percent of Urban Beneficiaries with Any HMO or PPO Choice (include regional)	Percent with any local HMO or PPO Choice	Percent with 1+ PFFS Choice
Region 1			**21.9**	**21.9**	**0.0**	**83.7**	**57.1**	**57.1**	**89.7**
		Maine	0.0	0.0	0.0	100.0	64.0	64.0	100.0
		New Hampshire	48.7	48.7	0.0	63.8	48.5	48.5	63.8
Region 2			**91.9**	**91.9**	**0.0**	**96.8**	**96.8**	**96.8**	**12.7**
	2	Connecticut	82.9	82.9	0.0	100.0	100.0	100.0	5.2
		Massachusetts	97.2	97.2	0.0	97.2	97.2	97.2	1.2
1		Rhode Island	100.0	100.0	0.0	100.0	100.0	100.0	100.0
1		Vermont	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Region 3			**100.0**	**99.3**	**15.5**	**100.0**	**100.0**	**99.8**	**27.4**
		New York	100.0	99.3	15.5	100.0	100.0		27.4
2 **Region 4** 2			**100.0**	**100.0**	**0.0**	**100.0**	**100.0**	**100.0**	**34.7**
2		New Jersey	100.0	100.0	0.0	100.0	100.0	100.0	34.7
Region 5			**91.2**	**80.2**	**11.0**	**100.0**	**100.0**	**94.5**	**24.2**
3		Delaware	100.0	0.0	100.0	100.0	100.0	0.0	100.0
		District of Columbia	100.0	100.0	0.0	100.0	100.0	100.0	100.0
4	5	Maryland	88.9	88.9	0.0	100.0	100.0	85.3	4.8
Region 6			**92.2**	**92.2**	**90.7**	**100.0**	**100.0**	**99.6**	**100.0**
5	6	Pennsylvania	100.0	100.0	100.0	100.0	100.0	99.6	100.0
5	6	West Virginia	15.7	15.7	0.0	100.0	100.0	100.0	100.0
Region 7			**77.0**	**30.5**	**77.0**	**99.4**	**99.4**	**71.2**	**99.4**
	7	Virginia	52.9	2.7	52.9	98.8	98.8	68.6	98.8
		North Carolina	100.0	56.9	100.0	100.0	100.0	73.6	100.0
Region 8			**100.0**	**33.0**	**100.0**	**100.0**	**100.0**	**72.1**	**100.0**
	9	South Carolina	100.0	0.0	100.0	100.0	100.0	61.4	100.0
		Georgia	100.0	53.3	100.0	100.0	100.0	65.8	100.0
Region 9 8			**91.4**	**91.4**	**0.0**	**100.0**	**100.0**	**97.9**	**100.0**
		Florida	91.4	91.4	0.0	100.0	100.0	97.9	100.0

10

11

Table III.5 *(continued)*

MA Region	PDP Region	State	March 2005: Percent of Urban Beneficiaries with Any MA choice (HMO, PPO, PFFS)	March 2005: Percent of Urban Beneficiaries with Any HMO or PPO Choice	March 2005: Percent with 1+ PFFS Choice	March 2006[a]: Percent of Urban Beneficiaries with Any MA Choice (HMO, PPO, PFFS, Regional PPO)	March 2006[a]: Percent of Urban Beneficiaries with Any HMO or PPO Choice (include regional)	March 2006[a]: Percent with any local HMO or PPO Choice	March 2006[a]: Percent with 1+ PFFS Choice
Region 10			**81.2**	**79.2**	**55.0**	**100.0**	**100.0**	**94.8**	**100.0**
		Alabama	58.2	58.2	0.0	100.0	100.0	89.7	100.0
		Tennessee	100.0	96.4	100.0	100.0	100.0	98.9	100.0
Region 11			**71.4**	**61.6**	**9.8**	**100.0**	**100.0**	**92.1**	**100.0**
		Michigan	71.4	61.6	9.8	100.0	100.0	92.1	100.0
Region 12			**95.2**	**93.1**	**3.2**	**100.0**	**100.0**	**96.4**	**100.0**
12		Ohio	95.2	93.1	3.2	100.0	100.0	96.4	100.0
Region 13			**56.3**	**19.4**	**53.7**	**100.0**	**100.0**	**55.9**	**100.0**
13		Indiana	34.2	4.0	30.2	100.0	100.0	50.2	100.0
		Kentucky	100.0	49.6	100.0	100.0	100.0	67.1	100.0
Region 14			**100.0**	**80.7**	**100.0**	**100.0**	**100.0**	**93.1**	**100.0**
		Wisconsin	100.0	70.1	100.0	100.0	100.0	77.0	100.0
15		Illinois	100.0	84.9	100.0	100.0	100.0	96.0	100.0
Region 15			**79.8**	**67.4**	**12.4**	**100.0**	**100.0**	**76.8**	**100.0**
		Arkansas	43.7	0.0	43.7	100.0	100.0	50.8	100.0
16		Missouri	94.0	94.0	0.0	100.0	100.0	87.2	100.0
Region 16			**60.2**	**40.1**	**32.0**	**100.0**	**100.0**	**60.1**	**100.0**
	20	Mississippi	0.0	0.0	0.0	100.0	100.0	43.0	100.0
19		Louisiana	83.0	55.3	44.2	100.0	100.0	67.0	100.0
Region 17			**79.2**	**68.8**	**19.6**	**100.0**	**100.0**	**82.3**	**100.0**
		Texas	79.2	68.8	19.6	100.0	100.0	82.3	100.0
Region 18			**97.4**	**83.9**	**96.6**	**100.0**	**100.0**	**80.2**	**100.0**
21		Oklahoma	95.5	80.2	94.1	100.0	100.0	92.5	100.0
		Kansas	100.0	88.9	100.0	100.0	100.0	63.2	100.0

22

23
24

Table III.5 *(continued)*

MA Region	PDP Region	State	March 2005: Percent of Urban Beneficiaries with Any MA choice (HMO, PPO, PFFS)	March 2005: Percent of Urban Beneficiaries with Any HMO or PPO Choice	March 2005: Percent with 1+ PFFS Choice	March 2006[a]: Percent of Urban Beneficiaries with Any MA Choice (HMO, PPO, PFFS, Regional PPO)	March 2006[a]: Percent of Urban Beneficiaries with Any HMO or PPO Choice (include regional)	March 2006[a]: Percent with any local HMO or PPO Choice	March 2006[a]: Percent with 1+ PFFS Choice
Region 19			**96.2**	**49.7**	**96.2**	**100.0**	**100.0**	**86.3**	**100.0**
	25	Iowa	100.0	6.4	100.0	100.0	100.0	90.7	100.0
		Minnesota	100.0	85.5	100.0	100.0	100.0	98.3	100.0
		Montana	71.7	0.0	71.1	100.0	100.0	100.0	100.0
		Nebraska	100.0	65.5	100.0	100.0	100.0	65.6	100.0
		North Dakota	100.0	0.0	100.0	100.0	100.0	0.0	100.0
		South Dakota	100.0	0.0	100.0	100.0	100.0	0.0	100.0
25		Wyoming	0.0	0.0	0.0	100.0	100.0	0.0	100.0
25 **Region 20** 25			**96.2**	**89.8**	**27.3**	**99.8**	**99.8**	**99.8**	**99.8**
25		New Mexico	100.0	76.6	100.0	100.0	100.0	100.0	100.0
25		Colorado	94.7	99.7	0.0	99.7	99.7	99.7	99.7
25									
Region 21			**100.0**	**91.4**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
26		Arizona	100.0	91.4	100.0	100.0	100.0	96.7	100.0
Region 22 27			**100.0**	**95.7**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
		Nevada	100.0	95.7	100.0	100.0	100.0	100.0	100.0
Region 23			**97.4**	**84.9**	**95.8**	**100.0**	**98.1**	**98.1**	**97.4**
28		Washington	100.0	88.9	100.0	100.0	96.8	96.8	100.0
	30	Oregon	90.4	90.4	84.8	100.0	100.0	100.0	90.5
		Idaho	100.0	70.9	100.0	100.0	96.6	96.6	100.0
29		Utah	100.0	69.0	100.0	100.0	99.5	99.5	100.0
Region 24 30			**96.0**	**96.0**	**8.4**	**100.0**	**100.0**	**95.9**	**24.7**
		California	96.0	96.0	8.4	100.0	8.4	95.9	24.7
Region 25 31			**100.0**	**100.0**	**0.0**	**100.0**	**100.0**	**100.0**	**100.0**
31		Hawaii	100.0	100.0	0.0	100.0	100.0	100.0	100.0
Region 26			**17.2**	**0.0**	**17.2**	**17.7**	**0.0**	**0.0**	**17.7**
32		Alaska	17.2	0.0	17.2	17.7	0.0	0.0	17.7

Source: MPR analysis of a data file constructed from publicly available CMS data.
33

[a]Based on January 2006 offerings.
34

Table III.6. Selected Measures of Change MA Plan Availability in Rural Areas by Region and State, 2006

MA Region	PDP Region	State	March 2005: Percent of Rural Beneficiaries With Any MA Choice (HMO, PPO, PFFS)	March 2005: Percent of Rural Beneficiaries With Any HMO or PPO Choice	March 2005: Percent With 1+ PFFS Choice	March 2006[a]: Percent of Rural Beneficiaries With Any MA Choice (HMO, PPO, PFFS, Regional PPO)	March 2006[a]: Percent of Rural Beneficiaries With Any HMO or PPO Choice (include regional)	March 2006[a]: Percent with any local HMO or PPO Choice	March 2006[a]: Percent With 1+ PFFS Choice
Region 1			**0.0**	**0.0**	**0.0**	**78.9**	**11.7**	**11.7**	**78.9**
	1	Maine	0.0	0.0	0.0	69.6	20.8	20.8	69.6
		New Hampshire	0.0	0.0	0.0	90.9	0.0	0.0	90.9
Region 2			**0.0**	**0.0**	**0.0**	**96.1**	**38.4**	**38.4**	**82.4**
		Connecticut	0.0	0.0	0.0	100.0	100.0	100.0	64.1
		Massachusetts	0.0	0.0	0.0	68.8	0.0	0.0	68.8
		Rhode Island	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1		Vermont	0.0	0.0	0.0	95.1	0.0	0.0	95.1
Region 3			**100.0**	**97.3**	**65.7**	**100.0**	**100.0**	**100.0**	**95.0**
2		New York	100.0	97.3	65.7	100.0	100.0	100.0	95.0
Region 4 2			0.0	0.0	0.0	0.0	0.0	0.0	0.0
2		New Jersey	0.0	0.0	0.0	0.0	0.0	0.0	0.0
2 **Region 5**			**42.8**	**0.0**	**42.8**	**100.0**	**100.0**	**58.0**	**43.2**
	5	Delaware	100.0	0.0	100.0	100.0	100.0	0.0	100.0
3		District of Columbia	0.0	0.0	0.0	0.0	0.0	0.0	0.0
4		Maryland	0.0	0.0	0.0	100.0	100.0	0.0	0.0
Region 6			**69.0**	**59.9**	**67.9**	**100.0**	**100.0**	**92.4**	**100.0**
		Pennsylvania	100.0	86.7	100.0	100.0	100.0	88.8	100.0
5		West Virginia	3.3	3.3	0.0	100.0	100.0	100.0	100.0
Region 7 5			**87.0**	**19.3**	**83.2**	**100.0**	**100.0**	**30.1**	**100.0**
		Virginia	59.8	14.9	48.2	100.0	100.0	39.7	100.0
	8	North Carolina	100.0	21.4	100.0	100.0	100.0	25.6	100.0
6 **Region 8** 6			**100.0**	**0.0**	**100.0**	**100.0**	**100.0**	**11.7**	**100.0**
	9	South Carolina	100.0	0.0	100.0	100.0	100.0	11.5	100.0
		Georgia	100.0	0.0	100.0	100.0	100.0	9.4	100.0
7 **Region 9**			**12.0**	**12.0**	**0.0**	**97.6**	**97.6**	**37.3**	**97.6**
		Florida	12.0	12.0	0.0	97.6	97.6	37.3	97.6

10

11

Table III.6 *(continued)*

MA Region	PDP Region	State	March 2005: Percent of Rural Beneficiaries With Any MA Choice (HMO, PPO, PFFS)	March 2005: Percent of Rural Beneficiaries With Any HMO or PPO Choice	March 2005: Percent With 1+ PFFS Choice	March 2006[a]: Percent of Rural Beneficiaries With Any MA Choice (HMO, PPO, PFFS, Regional PPO)	March 2006[a]: Percent of Rural Beneficiaries With Any HMO or PPO Choice (include regional)	March 2006[a]: Percent with any local HMO or PPO Choice	March 2006[a]: Percent With 1+ PFFS Choice
Region 10			**60.8**	**34.3**	**54.9**	**100.0**	**100.0**	**54.2**	**100.0**
		Alabama	13.1	13.1	0.0	100.0	100.0	63.4	100.0
		Tennessee	100.0	51.8	100.0	100.0	100.0	46.6	100.0
Region 11			**7.9**	**3.4**	**4.5**	**100.0**	**100.0**	**7.3**	**100.0**
		Michigan	7.9	3.4	4.5	100.0	100.0	7.3	100.0
Region 12	12 12		**43.6**	**32.7**	**10.8**	**100.0**	**100.0**	**64.3**	**100.0**
		Ohio	43.6	32.7	10.8	100.0	100.0	64.3	100.0
Region 13			**71.3**	**0.0**	**71.3**	**100.0**	**100.0**	**7.8**	**100.0**
	13	Indiana	29.7	0.0	29.7	100.0	100.0	8.1	100.0
		Kentucky	100.0	0.0	100.0	100.0	100.0	7.6	100.0
Region 14	14		**100.0**	**58.7**	**100.0**	**100.0**	**100.0**	**71.0**	**100.0**
		Wisconsin	100.0	76.1	100.0	100.0	100.0	76.1	100.0
		Illinois	100.0	43.6	100.0	100.0	100.0	66.5	100.0
Region 15	15 15		**27.2**	**18.7**	**8.5**	**100.0**	**100.0**	**17.1**	**100.0**
		Arkansas	19.5	0.0	19.5	100.0	100.0		100.0
		Missouri	33.1	33.1	0.0	100.0	100.0	24.3	100.0
Region 16	16 17		**30.8**	**1.8**	**30.8**	**100.0**	**100.0**	**3.7**	**100.0**
		Mississippi	0.0	0.0	0.0	100.0	100.0	3.1	100.0
		Louisiana	78.5	4.6	78.5	100.0	100.0	4.5	100.0
Region 17	19 20		**61.0**	**4.3**	**61.0**	**100.0**	**100.0**	**16.2**	**100.0**
		Texas	61.0	4.3	61.0	100.0	100.0	16.2	100.0
Region 18	20		**77.1**	**7.8**	**77.1**	**100.0**	**100.0**	**21.2**	**100.0**
	21	Oklahoma	59.8	11.6	59.8	100.0	100.0	24.0	100.0
		Kansas	100.0	2.6	100.0	100.0	100.0	0.0	100.0

22

23
24

Table III.6 *(continued)*

MA Region	PDP Region	State	March 2005: Percent of Rural Beneficiaries With Any MA Choice (HMO, PPO, PFFS)	March 2005: Percent of Rural Beneficiaries With Any HMO or PPO Choice	March 2005: Percent With 1+ PFFS Choice	March 2006[a]: Percent of Rural Beneficiaries With Any MA Choice (HMO, PPO, PFFS, Regional PPO)	March 2006[a]: Percent of Rural Beneficiaries With Any HMO or PPO Choice (include regional)	March 2006[a]: Percent with any local HMO or PPO Choice	March 2006[a]: Percent With 1+ PFFS Choice
Region 19			**94.9**	**7.0**	**94.9**	**100.0**	**100.0**	**47.3**	**100.0**
		Iowa	100.0	3.6	100.0	100.0	100.0	48.5	100.0
		Minnesota	100.0	20.5	100.0	100.0	100.0	70.5	100.0
		Montana	100.0	0.0	100.0	100.0	100.0	57.1	100.0
		Nebraska	100.0	3.3	100.0	100.0	100.0	3.3	100.0
		North Dakota	100.0	0.0	100.0	100.0	100.0	0.0	100.0
	25	South Dakota	100.0	0.0	100.0	99.9	99.9	0.0	99.9
	25	Wyoming	0.0	0.0	0.0	100.0	100.0	0.0	100.0
	25								
	25								
Region 20	25		**58.0**	**7.0**	**53.7**	**100.0**	**58.0**	**58.0**	**100.0**
	25	New Mexico	100.0	5.1	100.0	100.0	100.0	100.0	100.0
	25	Colorado	9.2	9.2	0.0	100.0	9.2	9.2	100.0
Region 21			**100.0**	**33.0**	**100.0**	**100.0**	**100.0**	**84.4**	**100.0**
		Arizona	100.0	33.0	100.0	100.0	100.0	65.0	100.0
Region 22	26		**65.8**	**46.7**	**38.6**	**100.0**	**100.0**	**100.0**	**100.0**
	27	Nevada	65.8	46.7	38.6	100.0	100.0	100.0	100.0
Region 23			**80.6**	**29.5**	**73.9**	**100.0**	**63.7**	**63.7**	**90.2**
	28	Washington	100.0	38.2	100.0	100.0	51.1	51.1	100.0
		Oregon	51.4	30.4	34.4	100.0	100.0	100.0	75.3
		Idaho	100.0	16.0	100.0	100.0	28.6	28.6	100.0
	29	Utah	100.0	20.2	100.0	100.0	20.3	20.3	100.0
Region 24			**19.0**	**19.0**	**0.0**	**100.0**	**100.0**	**19.0**	**26.0**
	30	California	19.0	19.0	0.0	100.0	100.0	19.0	26.0
Region 25	30 31		**81.6**	**81.6**	**0.0**	**99.9**	**99.9**	**99.9**	**99.9**
	31	Hawaii	81.6	81.6	0.0	99.9	99.9	99.9	99.9
Region 26			**4.3**	**0.0**	**4.3**	**7.5**	**0.0**	**0.0**	**7.5**
	32	Alaska	4.3	0.0	4.3	7.5	0.0	0.0	7.5

Source: MPR analysis of a data file constructed from publicly available CMS data.
33

[a]Based on January 2006 offerings.
34

Availability of HMOs and PPOs in Rural Areas Within States. In 2005, all of the New England states (5 have rural areas) and 13 others had no rural beneficiaries with access to a local HMO or PPO. In addition, another 8 had fewer than 10 percent of rural beneficiaries with such options. Although regional PPOs dramatically reduced these figures, states without a regional PPO continue to have many rural beneficiaries without access to a coordinated care product. There continue to be no such options in rural areas of New Hampshire, Massachusetts, and Vermont. Only 9 percent of beneficiaries have these options in Colorado, 20 percent in Utah, and 29 percent in Idaho (although the latter is up from 16 percent in 2005). In Washington, only 51 percent of rural beneficiaries have such an option, despite the fact that 97 percent of urban residents in the state do.

E. ROLE OF PAYMENT RATES AND SELECT PRODUCT OFFERINGS

1. Geography of Regional PPO Entry

Table III.7 analyzes selected characteristics of regions by whether or not a regional PPO was offered, including whether the offer included Humana and whether or not two regional PPOs were offered. Overall, the five regions with no PPOs had smaller Medicare populations than those with at least one regional PPO offering, with a median of about 90,000 beneficiaries versus 1.7 million beneficiaries, respectively. The smallest region with no regional PPO had 55,000 beneficiaries (Alaska) and the largest had 1.9 million beneficiaries in Region 23 (Washington, Oregon, Idaho, Utah). Regions with and without regional PPOs did not differ in the median share of beneficiaries in urban versus rural areas (each having about 75 percent in urban areas). Regions with a regional PPO, however, did have a larger share of beneficiaries with a local choice of PPO compared with those without a regional PPO (a mean of 63 percent versus 54 percent, respectively). In fact, 24 percent of beneficiaries (in aggregate) in the former regions were able to choose between a local and a regional PPO from the same sponsor.

Regions attracting regional PPO entrants appeared to have a balance of urban and rural areas and higher and lower paid counties. Entry by regional PPOs was more limited in heavily rural regions—at least half of all beneficiaries resided in an urban area in regions with a PPO. There also was a difference between regions with and without a regional PPO in the distribution of beneficiaries across the counties by payment rate though the results are hard to interpret without more extensive analysis. Regions with a regional PPO had a higher share of beneficiaries in counties whose rates were increased after the MMA so that they were receiving 100 percent of FFS payment. Thirty-nine percent of beneficiaries in such regions were in these counties versus only 30 percent in regions without regional PPOs. In regions with a regional PPO, the share of beneficiaries in rural floor counties was 17 percent and in urban floor counties 27 percent. This contrasts with 21 percent and 41 percent respectively in regions without a regional PPO. In regions that attracted a regional PPO, 16 percent of beneficiaries were in counties with an MA payment rate of $850 or more in 2006; in regions without a regional PPO, only 4 percent lived in such counties. Humana appears to have offered its regional PPO product in regions with a distribution of lower payment rates than in regions with other regional PPO entry. Regions that attracted two regional PPOs seemed, on balance, to have higher payment rates than single region PPO areas.

Because of the way regional PPOs are paid, it is impossible to analyze the role payment plays in regional PPO entry in the absence of data on enrollment and specific counties experiencing regional PPO enrollment. Unfortunately, those data do not yet exist.

2. PFFS Entry by County Payment Rate

PFF plans were offered in 2,999 of the 3,108 counties in the United States in 2006—or all but around 3.5 percent (Table III.8). The 109 counties without such an option included some populous counties because a PFFS plan was only available to 81 percent of all beneficiaries. That is, 8.3 million beneficiaries lived in the 109 counties without such a plan—an average of 75,649 beneficiaries per county. Findings previously shown in this chapter indicate that only 76 percent of urban beneficiaries have a PFFS plan available versus 91 percent of rural beneficiaries. Except for Massachusetts, all states have a PFFS plan in at least one county. In most states, all beneficiaries have such an option, with the main exceptions being Massachusetts (only 2 percent of beneficiaries have access to a PFFS plan), Maryland (4 percent), Alaska (14 percent), California (25 percent), New York (34 percent), and New Jersey (35 percent). Hence, PFFS plans are available in most areas of the country, with exceptions for the most part in the northeast, California, and parts of Alaska.

While they are widely available, PFFS plans do vary in location with MA payment rate. Beneficiaries in floor counties make up 56 percent of all beneficiaries in counties with such options but only 3 percent in counties without them. Of the 7.5 million beneficiaries in rural floor counties all but a 122,000 have a PFFS plan available. In urban floor counties, all of the 12.1 million beneficiaries in urban floor counties have a PFFS plan available except for about 146,000 beneficiaries. Such offerings are common in counties with other payment rates but the distribution is much less imbalanced.

For PFFS plans, as for regional PPOs, enrollment data are critical to better understanding the role the products are playing in the Medicare marketplace and how payment rates, particularly across counties, are driving firm behavior. Enrollment data do not yet exist for 2006 but are available through December 2005. In Chapter V we review what is known about enrollment in PFFS by payment rates and in Chapter VI we summarize what we learned from firms about why PFFS products have been so attractive, especially in rural and other areas where other MA products have been hard to establish.

Table III.7. Selected Characteristics of MA Regions with and without Regional PPOs, 2006

Selected Characteristics	All Regions	Regions with No Regional PPOs	Regions with Any Regional PPO	Regions with Humana Regional PPOs	Regions with Regional PPOs from Other Sponsors	Regions with Two Regional PPOs
Number of Regions	26	5	21	11	10	5
Number of Beneficiaries	43,001,143	4,991,427	38,009,716	26,094,126	21,071,837	9,156,247
Number of Beneficiaries per Region						
Mean	1,653,890	998,285.	1,809,986	1,863,866	1,755,986	1,831,249
Median	1,688,155	89,885	1,736,672	1,743,768	1,695,251	1,750,864
Low	55,058	55,058	818,639	818,639	189,271	818,639
High	4,386,037	1,853,090	3,135,438	3,135,438	4,386,037	3,135,438
Percent of Beneficiaries in Urban Areas						
All regions	78.4	78.0	78.5	74.7	83.9	80.4
Mean per region	73.2	59.9	76.3	72.6	81.7	78.8
Median per region	76.8	75.3	77.1	74.7	86.1	79.2
Low	11.0	11.0	49.9	56.2	49.9	64.0
High	100.0	90.1	100.0	92.7	100.0	92.7
2006 Statutory Component Payment Rate Used for Benchmark—Share of Beneficiaries in Counties with						
$620 (Rural Floor)	16.9	21.5	16.3	17.4	13.5	13.1
$621-$685	6.6	4.2	6.9	8.4	5.5	8.0
$686 (Urban Floor)	27.7	43.2	25.8	30.3	24.3	35.3
$687-$749	17.6	17.5	17.6	19.1	17.8	22.0
$750-$849	17.0	9.7	17.9	15.7	17.9	11.7
$850 and above	14.2	4.0	15.5	9.2	20.9	10.0
Distribution of Beneficiaries by Type of County Payment (2004)						
Rural floor	17.4	21.4	16.9	18.1	14.0	13.8
Urban floor	28.2	41.2	26.5	31.3	25.0	36.9
Blend	4.1	6.1	3.8	0.8	6.6	1.8
Minimum increase	12.4	1.8	13.8	11.2	17.2	14.5
100 Percent FFS	37.9	29.5	39.0	38.8	37.2	33.0
Percent of Beneficiaries with a Choice of Local PPO, 2006						
Overall	63.3	76.8	61.6	62.5	62.8	67.1
Mean	61.1	53.8	62.8	59.6	68.1	66.3
Median	66.5	75.1	63.4	51.5	77.7	78.1
Low	0.0	0.0	11.1	26.4	11.1	38.6
High	100.0	84.8	100.0	96.1	100.0	88.6
Percent of Beneficiaries with a Choice of Regional PPO by the Same Sponsor, 2006	20.8	0.0	23.6	21.9	28.5	30.4

Table III.8. PFFS Contracts by Selected Characteristics of Payment, 2006

	All Counties	With PFFS	Percent with PFFS	Without PFFS	Percent Without PFFS
Number of Counties	3,108	2,999	100%	109	100%
Number of Beneficiaries	42,797,738	34,552,040	100%	8,245,698	100%
Distribution of Beneficiaries by Type of County Payment (2004)					
Rural floor	7,482,756	7,359,806	21.3%	122,950	1.5%
Urban floor	12,124,160	11,977,924	34.7	146,236	1.8
Blend	1,751,281	910,224	2.6	841,057	10.2
Minimum increase	5,321,927	3,003,902	8.7	2,318,025	28.1
FFS 100 percent	16,117,614	11,300,184	32.7	4,817,430	58.4
2006 Statutory Component Payment Rate Used for Benchmark—Share of Beneficiaries in Counties with					
$620 (rural floor)	7,226,660	7,140,753	20.7%	85,907	1.0%
$621 - $685	2,813,304	2,534,667	7.3	278,637	3.4
$686 (urban floor)	11,875,278	11,729,042	34.0	146,236	1.8
$687 - $749	7,543,832	5,791,119	16.8	1,752,713	21.3
$750 - $849	7,260,706	4,733,719	13.7	2,526,987	30.7
$850 and above	6,077,958	2,622,740	7.6	3,455,218	41.9
Type of Area					
Urban	33,714,099	25,706,775	74.4%	8,007,324	97.1%
Rural	9,083,693	8,845,265	25.6	238,374	2.9

Source: MPR analysis file created from publicly available CMS data.

IV. MA CONTRACT SPONSORS

In this chapter, we analyze the role played by selected major firms in MA, their 2006 contracts, and how they have changed since 2005. The analysis builds on our prior work coding contracts so support analysis of national firms. In particular, we distinguish by name the seven firms that in 1999—when we began analysis—dominated the MA market (Aetna, Cigna, Health Net, Humana, Kaiser, PacifiCare and United HealthCare), affiliates of Blue Cross and Blue Shield organizations, and "others." The latter typically includes smaller firms with offerings in multiple markets—for example Sierra, Heritage, Wellcare and their diversely named affiliated companies—and independent local plans that tend to be more geographically based and influential in particular markets.[10] In our 2006 work for KFF, we updated the coding and revised the Blue Cross and Blue Shield affiliations to reflect recent changes and analysis by Blue Cross and Blue Shield Association (BCBS, 2005).

When we refer to "selected national firms," we mean the seven firms with individually coded offerings and also the affiliates of Blue Cross and Blue Shield organizations. While not necessarily national in scope, each firm has some presence in many markets that are geographically diverse. (Cigna's role in MA has diminished over time but it plays a national role in the commercial market.) Two of the seven national firms (PacifiCare and United Healthcare) have separate contracts in 2006 but officially merged in December 2005. Additional analysis of firms in historical context is included in Draper, McCoy, and Gold (2004) and Gold (2006b).

A. MAJOR SPONSORS IN THE MA MARKET: CHARACTERISTICS AND TRENDS

1. Number of Contracts

A small number of firms and affiliates play a disproportionate role in the MA program in 2006, as they have historically (Gold 2006b).[11] Almost half (48 percent) of MA contracts in 2006 are with the seven identified national firms or with affiliates of Blue Cross and Blue Shield (Table IV.1). United Healthcare, Aetna, and Humana have a particularly large number of contracts—44, 26, and 24 respectively.

[10] When we analyzed the share of the market by a few other smaller firms (like Sierra), we found it to be relatively small (Gold 2006b). While we have not analyzed data on this topic, we believe that most of the "other sponsors" involve contracts with organizations that are geographically focused. In markets where they operate, they could play dominate roles (e.g., Harvard-Pilgrim, Group Health Cooperative).

[11] Many of these same MA firms also play a dominant role in the market for PDPs. Aetna, Cigna, PacifiCare, and United each offer a national PDP and Humana offers a near national one. PDPs also are common in Blue Cross and Blue Shield affiliates, with the largest—Wellpoint—offering a national PDP through UniCare (the product is not "Blue-branded" in all regions). See Gold (2006b) for more information.

Table IV.1. MA Contracts by Sponsor and Type, 2006

Selected Firms or Affiliations	Total Contracts[a, b]	Local HMO	Local PPO	Regional PPO	PFFS	SNP[c]	Cost
All Sponsors	**364**	**198**	**116**	**11**	**21**	**124**	**18**
Selected National Firms	**176**	**81**	**71**	**9**	**9**	**59**	**6**
Aetna	26	13	12	1	0	1	0
Cigna	2	2	0	0	0	1	0
Health Net	9	6	2	1	0	6	0
Humana	24	6	14	1	3	1	0
Kaiser	8	6	0	0	0	0	2
PacifiCare[d]	9	8	0	0	1	3	0
United HealthCare[d]	44	20	20	3	1	42	0
Blue Cross and Blue Shield Affiliates	54	20	23	3	4	5	4
Wellpoint[a]	10	4	4	1	1	2	0
Other	44	16	19	2	3	3	4
All Other Sponsors	**188**	**117**	**45**	**2**	**12**	**65**	**12**

Source: MPR analysis file created from CMS data from the November 2005 release of the 2006 Medicare Personal Plan Finder. Firm coding by MPR staff.

[a]Excludes HCPP, PACE, and other (largely demonstration) contracts that are not included in the 2006 Personal Plan Finder. Also excludes employer-only contracts not available for individual enrollment.

[b]Totals do not match the sum of the columns because SNPs are not necessarily approved as separate contracts. Contracts that have an SNP were identified by matching the data file to the 2006 Personal Plan Finder. The total number of contracts counts each contract only once.

[c]Excludes SNPs not affiliated with contracts in the November 2005 release of the 2006 Personal Plan Finder.

[d]Each firm has separately approved and operated contracts in 2006, but the two are now merged as a company.

The mix of contracts varies by firm. Although HMOs account for over half (54 percent) of all MA contracts, Humana's total number of contracts is driven more by other kinds of contracts (HMOs account for only 6 of the 24 Humana contracts). Cigna's role in the MA market is small in 2006, with only two local HMO contracts, one of which also includes an SNP product.

Once one gets beyond the traditional HMO product, there is considerable variation across firms in their interest (as expressed in contracts) for particular MA product types. For example:

- Kaiser contracts for no products other than the HMO—except for cost contracts, which are a financial arrangement under which HMO-like offerings are provided. (No other national firm uses cost contracts.)
- United Healthcare, Humana, and Aetna (a well as some Blue Cross and Blue Shield affiliates, such as Wellpoint) are the much more likely than other firms to have as many or more local PPO as HMO contracts. These three firms and Health Net, which has some local PPOs, are the only named firms offering a regional PPO.
- United Healthcare dominates individual firm offerings in the SNP market, both through products offered under their HMO contracts and independently. (This is not surprising, as the Evercare product under their Ovations subsidiary has been a leader in model development in this area.)
- Only Humana, PacifiCare, United Healthcare, and some Blue Cross and Blue Shield affiliates, such as Wellpoint, are offering PFFS in 2006.

Because contract counts do not reflect the geographical scope of offerings (especially when they involve offerings other than local HMOs or PPOs), these data understate the role of national firms in overall beneficiary choice in MA.

2. Availability of MA Contracts to Beneficiaries by Firm, 2005-2006

Another way to look at the role of diverse firms in the MA market is to examine their geographical scope and prevalence. We do so in Table IV.2 by measuring the number of regions and share of Medicare beneficiaries that had a contract for any MA product offered by that firm in 2005 and how that changed in 2006.

Although we characterize them as national, major MA firms have different levels of presence across the country, reflecting both their commercial base and the areas in which they have chosen to focus their Medicare activity (Draper, McCoy, and Gold 2004). In 2005, United Healthcare, Humana, and the Blue Cross and Blue Shield affiliates came closest to having some form of national presence, with at least one type of contract in 18, 14, and 11 MA regions respectively.[12] However, while they may be in many regions, these three firms' contracts were

[12] In some cases, presence could reflect only PFFS options, without a network-based product.

Table IV.2. Selected Measures of Scope of MA Plan Offerings Nationally, Selected Firms or Affiliates, 2005-2006

Firm	Number of MA Regions with Any Firm Product		Percent of Beneficiaries with A Choice of At Least One Firm Product		Percent of Beneficiaries in Service Area in 2006, by Selected Contract Type		
	2005	2006	2005	2006	Local HMP/PPO Only	HMO, Local, or Regional PPO	Any Local MA (HMO, PPO, or PFFS
Aetna	6	12	17.1	18.6	17.5	18.6	17.5
Cigna	2	2	1.3	1.4	1.4	1.4	1.4
Health Net	8	7	16.3	17.1	16.7	17.1	16.7
Humana	14	18	26.4	67.2	18.0	60.4	67.2
Kaiser	8	8	14.7	14.7	11.8	11.8	11.8
PacifiCare/ United Healthcare Combined	21	26	41.0	71.0	47.0	49.9	68.8
PacifiCare	7	25	17.2	46.9	15.8	15.8	46.9
United Healthcare	18	21	26.1	40.1	34.8	37.7	37.2
BCBS Affiliates	11	18	28.7	57.2	41.0	53.0	45.1

Source: MPR analysis file created from publicly available CMS data. 2005 data are from the Geographical Service Area Report for March 2005. 2006 data are from a file created from the November release of the 2006 Medicare Personal Plan Finder. Firm coding by MPR staff.

Note: Counts for 2006 exclude HCPP, PACE, and other (largely demonstration) contracts not included in the 2006 file.

available only to about 26 to 29 percent of beneficiaries each. Except for Cigna, all national firms or affiliates, however, were available in six or more regions in 2005 and their products were available in counties where at least 15 percent of beneficiaries reside.

In 2006, the availability of MA contracts to beneficiaries has changed little in three firms—Cigna, Health Net, and Kaiser—whether measured by regions or percentage of beneficiaries with an available contract. A fourth, Aetna, added to its geographical scope, but not many additional beneficiaries had products made available to them. However United Healthcare, PacifiCare, Humana, and the affiliates of Blue Cross and Blue Shield expanded their scope of geographical coverage substantially in 2006 with each having products now available to well over half of all Medicare beneficiaries.

United Healthcare/PacifiCare. As a result of their merger and 2006 expansions, the combined United Healthcare/PacifiCare organization has a national presence, with products in all 26 markets.

- In 2006, what can be viewed as "legacy United Healthcare" has contracts in 21 markets that are available to 40 percent of beneficiaries. They appear to be offering multiple product types in most markets since the share of beneficiaries with a local

HMO or PPO, local HMO or local/regional PPO, or any local contract (HMO, PPO, PFFS) is relatively similar, at 35-38 percent.

- What can be viewed as "legacy PacifiCare" is now in 25 markets, mainly because of a PFFS expansion (PacifiCare offers no regional PPO and its local HMO or PPO contracts are available to only 16 percent of beneficiaries in 2006.)

The combined United Healthcare/PacifiCare organization has MA products available to 71 percent of beneficiaries in 2006 (up from 41 percent in 2005). Just under half have a coordinated care product—47 percent of Medicare beneficiaries have a local HMO or PPO contract from either or both legacy firms available in their county and 50 percent have this when regional PPOs are included. Together, they have PFFS contracts that are available to 69 percent of all beneficiaries. Both also offer national PDP plans. United Healthcare offers the sole AARP-branded PDP nationally to complement the Medicare supplemental products it also sells for AARP. PacifiCare offers a national PDP that it markets via agents alongside its PFFS plan, which excludes drugs (Gold 2006b).

Humana. Humana's contracts were already in 14 MA regions in 2005 and on this measure their availability grew only modestly to 18. However the share of beneficiaries with access to any Humana MA product increased two and a half fold between 2005 and 2006, from 26 percent of beneficiaries in 2005 to 67 percent in 2006. The main force behind the growth appears to be both the expansion of the PFFS product to more counties (in new regions and those they were in already) and Humana's decision to offer regional PPOs in 14 regions. Despite Humana's dominance in the Regional PPO sector, more beneficiaries have access to the firm's PFFS products (67 percent) than coordinated care products (60 percent). Humana's HMO and local PPO contracts are more geographically limited, with only 18 percent of beneficiaries having access to them in 2006.

Blue Cross and Blue Shield Affiliates. Firms affiliated with Blue Cross and Blue Shield have MA contracts in at least one county in 18 MA regions in 2006, up from 11 in 2005. While there has been consolidation—most notably through the merger of Wellpoint with Anthem—the affiliates appear to show considerable independence as reflected in their decisions on whether to enter into MA contracts. In 2006, about 57 percent of Medicare beneficiaries have access to MA products through at least one Blues-branded MA contract, about double that in 2005 (29 percent). Blues affiliates in the MA market have local HMO and/or local PPO products that are available to two fifths (41 percent) of beneficiaries, and such coordinated care availability rises to 53 percent when regional PPOs (which some Blues affiliates offered) are considered. PFFS products appear less relevant to Blues affiliates, perhaps because so many of them are very active already in the Medicare supplemental market.

3. Firm MA Market Share Before 2006

Although availability is a good measure of firm offerings, MA enrollment provides the most practical summary of the role diverse firms played in the MA market prior to 2006. Because firms made changes in their offerings during 2005, March 2005 enrollment totals provide an initial point for measuring change (even though some change in response to the MMA may have predated it). As of March 2005, there were 5.1 million MA enrollees with the selected national

firms or BCBS affiliates we identify accounting for almost two-thirds (65 percent) of them (Table IV.3). Over half of that was from the MA enrollment of BCBS affiliates (18 percent), Kaiser (14 percent) or PacifiCare (12 percent). HMO enrollment still dominated MA, accounting for 86 percent of total enrollment. National firms accounted for 68 percent of HMO enrollment but only 44 percent of enrollment in other contract types.

Between March and September 2005, overall MA enrollment grew from 5.1 million to 5.3 million—a modest increase of about five percent, or 243,711 beneficiaries. The time period is important because it predated the effects of the large number of local MA contracts approved in summer/early fall 2005 as firms positioned themselves for 2006 (Table IV.3). Although small, the number (and nature) of firms contributing to growth over the March-September period provides a reflection of the competitive environment as firms approved 2005.

While HMOs accounted for 83 percent of MA enrollment at the start of the six-month period, this enrollment accounts for only a little more than half (54 percent) of the net growth in enrollment over this period (Table IV.4). The rest of the net growth (46 percent) was in other kinds of contracts. Humana accounts for one-third of the non-HMO growth, surpassed only by non-named "other sponsors" who added a net of around 61,500 over this period. The market share of national firms and BCBS affiliates overall remained relatively stable over the six-month period. However, national firms kept their market share mainly because Humana added around 45,000 new enrollees and the combined PacifiCare/United Healthcare component added around the same amount. (The other named firms and affiliates grew much more slowly, or declined slightly in the case of Cigna.)

This analysis suggests that as 2006 was unfolding, enrollment was becoming more concentrated within a small number of firms that dominate the national firm sector but products were diversifying and that was bringing in additional competitors whose previous role in the program was more limited. We know already that sponsors of MA contracts increased their offerings in 2006 and that PacifiCare/United Healthcare and Humana were very active in this regard. It will be interesting to see, when 2006 enrollment data become available, if and how MA enrollment has shifted, both among firms within the MA sector and between HMO and other types of contracts.

Table IV.3. MA Enrollment & Market Share by Contract Type and Pre-2006 Trend: March-September 2005

	Number of Enrollees			Percent of Enrollees	
	March 2005	September 2005	Difference	March 2005	September 2005
All MA Contracts					
All Sponsors	5,066,067	5,309,778	+243,711	100%	100%
Selected National Sponsors	3,274,852	3,387,138	+112,286	64.6	63.8
Aetna	97,134	98,533	+1,399	1.9	1.9
Cigna	57,357	56,825	-532	1.1	1.1
Health Net	174,709	181,924	+7,215	3.4	3.4
Humana	392,195	437,254	+45,059	7.7	8.2
Kaiser	715,140	725,672	+10,531	14.1	13.7
PacifiCare	618,967	636,213	+17,246	12.2	12.0
United HealthCare	292,576	320,411	+27,835	5.8	6.0
BCBS Affiliates	926,774	930,306	+3,532	18.3	17.5
All Other Sponsors	1,770,561	1,901,968	+131,407	34.9	35.8
HMO Contracts Only					
All Sponsors	4,332,598	4,462,940	+130,342	100%	100%
Selected National Sponsors	2,948,867	3,009,682	+60,815	68.1	67.4
Aetna	81,921	83,131	+1,210	1.9	1.9
Cigna	57,357	56,825	-532	1.3	1.3
Health Net	161,620	165,349	+3,729	3.7	3.7
Humana	357,678	363,346	+7,668	8.3	8.2
Kaiser	644,418	654,873	+10,455	14.9	14.7
PacifiCare	614,868	631,584	+16,716	14.2	14.2
United HealthCare	258,228	279,893	+21,665	6.0	6.3
BCBS Affiliates	772,777	772,681	-96	17.8	17.3
All Other Sponsors	1,370,261	1,440,150	+69,889	31.6	32.3
Non-HMO MA Contracts Only					
All Sponsors	733,469	846,838	+113,369	100%	100%
Selected National Sponsors	325,985	377,456	+51,471	44.4	44.6
Aetna	15,213	15,4021	+189	2.1	1.8
Cigna	0	0	0	0.0	0.0
Health Net	13,089	16,575	+3,486	1.8	2.0
Humana	34,517	71,908	+37,391	4.7	8.5
Kaiser	70,722	70,799	+77	9.6	8.4
PacifiCare	4,099	4,629	+530	0.6	0.5
United HealthCare	34,348	40,518	+6,170	4.7	4.8
BCBS Affiliates	153,997	157,625	+3,628	21.0	18.6
All Other Sponsors	400,300	461,818	+61,518	54.6	54.5

Source: MPR analysis of files created from publicly available CMS data, primarily the Geographic Service Area File for March and September 2005. Firm codes by MPR.

Table IV.4. Growth in MA Enrollment, Various Sectors, March-September 2005

	March 2005		Net Growth	
Sector	Enrollment	Market Share	March-September 2005	Percent Contribution to Growth
All Firms	**5,066,067**	**100%**	**243,711**	**100%**
HMO				
National Firm	2,948,867	56%	60,815	25%
United/PacifiCare	873,096	15	38,381	16
Other	2,075,771	41	22,434	9
HMO Other	1,370,261	27%	69,889	29%
Non-HMO				
National Firm	325,469	6%	51,471	21%
Humana	34,517	1	37,391	15
Other	290,952	6	14,080	6
Non-HMO Other	400,300	8%	61,518	25%

Source: MPR analysis and firm codes of CMS Data from the March and September GSA file (See Table III.3).

V. 2006 ENROLLMENT AND PENETRATION TRENDS

Because CMS has released only limited enrollment data for 2006, the analysis of MA enrollment trends from 2006 is similarly limited. Because the data available for 2006 comes from sources that are different from, and may not be consistent, with 2005, we separately analyze the trends in enrollment through December 2005 and then consider what is known about enrollment in 2006 from publicly available data. We end the Chapter with some early analysis of the relationship between payment rates and where firms draw MA enrollment, focusing specifically on PFFS because these are the fastest growing products

A. ENROLLMENT TRENDS IN 2005

Enrollment in MA grew from 5.1 million to 5.5 million between March and December 2005 (Table V.1), an increase of 7.9 percent. With this growth, MA penetration across all contract types was 12.4 percent, up from 11.7 percent at the start of the period. The largest growth in enrollment occurred in the second half of the year—from July to December 2005. This likely reflects a response to the introduction of new MA plans late in 2005, and enrollment shifts associated with the anticipation of 2006. Because many new 2006 plans were already available for enrollment in 2005, beneficiaries were not restricted from making changes before the start of the new year.

HMOs dominated MA enrollment throughout 2005 but HMO enrollment grew more slowly than did enrollment in other MA products and the HMO share of the Medicare market declined. In March 2005, 86 percent of MA enrollees were in HMOs, decreasing to 83 percent by the end of the year. HMOs still had a net gain of about 185,000 beneficiaries over the period examined, accounting for 46 percent of the growth in MA enrollment.

Outside of HMOs, the largest growth in MA enrollment in 2005 was in PFFS contracts. With just under 80,000 enrollees in March 2005, PFFS enrollment rose by a factor of 150 percent (around 120,000 new enrollees) by the end of the year. Thirty percent of the net increase in MA enrollment in 2005 was due to growth in PFFS plans. Local PPO enrollment grew over the period but at a much slower rate (about 64,000 new enrollees). However, total enrollment in local PPOs still exceeded that of PFFS plans by 60 percent at the end of the year. (There also was a 30,000 gain in enrollment in "other" plans. We cannot tell whether these are new demonstration plans or early indications of SNP enrollment that include conversions of dual eligible individuals.)[13]

Table V.2 shows how MA enrollment varied by region and state in March and December 2005. While overall market penetration averaged 11.7 percent in March 2005, it varied substantially across the country. In March 2005, there were no MA enrollees in Alaska, and

[13] Although dual eligibles were assigned to PDPs but not MA plans, dual eligibles who already were in a Medicaid managed care plan that participated in MA (e.g., as a dual eligible SNP) were auto- assigned to that MA contract and then given the opportunity to switch.

Table V.1. MA Enrollment Trends by Contract Type, United States by Quarter 2005

Contracts by Type	Enrollment						Distribution of Enrollment (in percentages)			
	March 2005	June 2005	September 2005	December 2005	Net Change	Percent Change	March 2005	June 2005	September 2005	December 2005
Total Enrollees	5,066,067	5,154,230	5,309,778	5,466,247	+400,180	+7.8%	100.0	100.0	100.0	100.0
Local HMO, PSO, or PPO (formerly CCPs)	4,508,188	4,563,479	4,670,716	4,757,955	+249,767	+5.5	89.0	88.5	88.0	87.0
Local HMO or PSO	4,361,672	4,410,071	4,504,544	4,547,311	+185,639	+4.3	86.0	85.6	84.8	83.2
Local PPO (including PPO Demo)	146,516	153,408	166,172	210,644	+64,128	+43.8	2.9	3.0	3.1	3.9
Cost	317,932	317,267	318,673	317,749	-183	0.0	6.3	6.2	6.0	5.8
PFFS	79,372	106,291	161,921	199,062	+119,690	150.8	1.6	2.1	2.7	3.6
HCPP	20,779	20,631	20,539	20,756	-23	-0.1	0.4	0.4	0.4	0.4
PACE	9,618	9,984	10,247	10,612	+994	+10.3	0.2	0.2	0.2	0.2
Other	130,178	136,578	147,682	160,113	+29,935	+23.0	2.6	2.7	2.8	2.9
MA Penetration Overall	11.7	11.9	12.1	12.40	+30,000		--	--	--	--
Local HMO/PPO Penetration	10.4	10.5	10.7	10.8			--	--	--	--
Private FFS Penetration	0.2	0.2	0.3	0.5			--	--	--	--

Source: MPR Analysis of files created from publicly available CMS data, selected months, and Geographic Service Area Report.

NA = Some SNPs were authorized in 2005, but they are not identified on the files. Regional PPOs also were not authorized in 2005.

Table V.2. MA Enrollment and Penetration by Region and State, March and December 2005

MA Region	PDP Region	State	Total Enrollment March 2005	Total Enrollment December 2005	MA Penetration March 2005	MA Penetration December 2005	Rural Penetration March 2005	Rural Penetration December 2005
United States			5,066,067	5,466,247	11.7%	12.4%	2.4%	3.1%
Region 1			**1,073**	**1,241**	**0.3%**	**0.3%**	**0.0%**	**0.0%**
	1	Maine	0	155	0.0%	0.1%	0.0%	0.0%
	1	New Hampshire	1,073	1,086	0.6%	0.6%	0.0%	0.0%
Region 2			**246,705**	**248,597**	**13.6%**	**13.6%**	**0.0%**	**0.0%**
	2	Connecticut	28,576	29,367	5.3%	5.4%	0.0%	0.0%
	2	Massachusetts	160,166	160,616	16.0%	16.0%	NA	NA
	2	Rhode Island	57,963	58,614	32.8%	33.0%	0.0%	0.0%
	2	Vermont						
Region 3			**518,065**	**555,456**	**18.1%**	**19.3%**	**7.1%**	**8.1%**
	3	New York	518,065	555,456	18.1%	19.3%	7.1%	8.1%
Region 4			**95,877**	**100,497**	**7.6%**	**7.9%**	**NA**	**NA**
	4	New Jersey	95,877	100,497	7.6	7.9%	NA	NA
Region 5			**33,861**	**37,003**	**3.7%**	**4.0%**	**0.1%**	**0.44%**
	5	Delaware	437	752	0.3%	0.6%	0.1%	0.22%
	5	District of Columbia	4,812	5,465	6.2%	7.0%	NA	NA
	5	Maryland	28,612	30,786	4.0%	4.3%	0.0%	0.0%
Region 6			**524,163**	**524,163**	**20.7%**	**21.2%**	**8.2%**	**8.7%**
	6	Pennsylvania	516,230	516,230	23.7%	24.4%	11.2%	12.5%
	6	West Virginia	7,933	8,173	2.2%	2.2%	0.3%	0.4%
Region 7			**81,996**	**110,072**	**3.6%**	**4.7%**	**2.1%**	**3.9%**
	7	Virginia	15,360	20,476	1.5%	2.0%	0.8%	1.2%
	8	North Carolina	66,636	89,596	5.2%	6.8%	2.7%	4.0%
Region 8			**22,175**	**46,045**	**1.3%**	**2.6%**	**0.2%**	**1.3%**
	9	South Carolina	3,386	16,851	0.5%	2.5%	0.2%	1.5%
	10	Georgia	17,789	29,194	1.8%	2.7	0.2%	1.1%
Region 9			**578,172**	**631,686**	**18.7%**	**20.2%**	**2.4%**	**2.5%**
	11	Florida	578,172	631,686	18.7%	20.2%	2.4%	2.5%
Region 10			**136,879**	**170,438**	**8.1%**	**9.8%**	**3.4%**	**6.0%**
	12	Alabama	60,334	75,200	7.9%	9.6%	5.8%	24.0%
	12	Tennessee	76,565	95,238	8.2%	10.0%	3.2%	4.1%
Region 11			**21,726**	**28,759**	**1.4%**	**1.9**	**0.5%**	**4.5%**
	13	Michigan	21,726	28,759	1.4%	1.9	0.5%	4.5%
Region 12			**222,677**	**233,778**	**12.4%**	**12.9%**	**2.0%**	**2.2%**
	14	Ohio	222,677	233,787	12.4%	12.9%	2.0%	2.2%
Region 13			**31,461**	**38,039**	**1.9%**	**2.3%**	**0.4%**	**0.7%**
	15	Indiana	19684	24,635	2.1%	2.6%	0.9%	1.4%
	15	Kentucky	11,777	13,404	1.7%	1.9%	0.1%	0.2%
Region 14			**139,588**	**169,964**	**5.4%**	**6.5%**	**4.3%**	**5.8%**
	16	Wisconsin	59,442	82,342	7.0%	9.6%	7.3%	10.0%
	17	Illinois	80,146	87,622	4.6%	5.0%	1.7%	2.2%
Region 15			**110,017**	**115,105**	**7.8%**	**8.0%**	**1.5%**	**1.7%**
	19	Arkansas	483	1,553	0.1%	0.3%	0.2%	0.6%
	20	Missouri	109,534	113,552	11.8%	12.0%	1.7%	1.8%

Table V.2 *(continued)*

MA Region	PDP Region	State	Total Enrollment March 2005	Total Enrollment December 2005	MA Penetration March 2005	MA Penetration December 2005	Rural Penetration March 2005	Rural Penetration December 2005
Region 16			**73,931**	**71,953**	**6.6%**	**6.5%**	**0.7%**	**1.0%**
	20	Mississippi	0	312	0.0%	0.1%	0.0%	0.0%
	21	Louisiana	73,931	71,641	11.2%	11.2%	0.7%	1.0%
Region 17			**194,781**	**227,611**	**7.6%**	**8.6%**	**1.3%**	**1.5%**
	22	Texas	194,781	227,611	7.6%	8.6%	1.3%	1.5%
Region 18			**53,860**	**59,640**	**5.6%**	**6.1%**	**0.4%**	**0.6%**
	23	Oklahoma	42,490	46,283	7.7%	8.3%	0.8%	1.1
	24	Kansas	11,370	13,357	2.8%	3.2%	0.1%	0.2%
Region 19			**143,799**	**174,621**	**7.4%**	**8.9%**	**2.1%**	**3.4%**
	25	Iowa	22,285	27,998	4.5%	5.6%	1.9%	2.6
	25	Minnesota	108,100	128,920	15.2%	17.9%	4.9%	8.4%
	25	Montana	543	2,259	0.4%	1.5%	0.3%	1.1%
	25	Nebraska	10,929	12,682	4.1%	4.7%	0.9%	1.8%
	25	North Dakota	938	1,347	0.9%	1.3%	1.0%	1.3%
	25	South Dakota	176	583	0.1%	0.5%	0.0%	0.2%
	25	Wyoming	828	832	1.1%	1.1%	0.7%	0.7%
Region 20			**179,399**	**184,845**	**22.4%**	**22.8%**	**3.7%**	**4.0%**
	26	New Mexico	41,845	44,047	15.5%	15.9%	0.2%	0.6%
	27	Colorado	137,554	142,798	26.0%	26.3%	7.7%	7.8%
Region 21			**207,435**	**222,787**	**26.0%**	**27.2%**	**2.3%**	**5.8%**
	28	Arizona	207,435	222,787	26.0%	27.2%	2.3%	5.8%
Region 22			**83,493**	**85,487**	**27.6%**	**27.7%**	**12.6%**	**13.1%**
	29	Nevada	83,493	85,487	27.6%	27.7%	12.6%	13.1%
Region 23			**321,571**	**345,182**	**17.8%**	**18.6%**	**7.7%**	**9.0%**
	30	Washington	123,208	127,056	14.8%	14.9%	5.6%	5.9%
	30	Oregon	171,365	179,320	31.3%	32.2%	12.8%	14.9%
	31	Idaho	19,162	21,859	9.9%	11.0%	3.7%	4.4%
	31	Utah	7,836	16,947	3.3%	6.9%	0.7%	3.1%
Region 24			**983,366**	**1,001,908**	**22.7%**	**22.8%**	**1.3%**	**1.5%**
	32	California	983,366	1,001,908	22.7%	22.8%	1.3%	1.5%
Region 25			**59,997**	**60,976**	**32.2%**	**32.2%**	**32.6%**	**32.2%**
	33	Hawaii	59,997	60,976	32.2%	32.2%	32.6%	32.2%
Region 26			**0**	**0**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	34	Alaska	0	0	0.0%	0.0%	0.0%	0.0%

Source: MPR analysis of a data file constructed from publicly available CMS data. Enrollment is from the March Geographic Services Area Report.

NA = Not Applicable (no rural areas)

fewer than one percent of Medicare beneficiaries were enrolled in eight other states: Arkansas, Delaware, Maine, Montana, New Hampshire, North Dakota, South Carolina, and South Dakota. Thirteen others had less than five percent of beneficiaries enrolled in an MA plan (Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Michigan, Nebraska, Virginia, Utah, West Virginia, and Wyoming.) Hence, at the beginning of 2005, almost half the states (22) had very limited MA enrollment. Across states, penetration also was very low (2.4 percent) in rural areas of the country.

Medicare beneficiaries are distributed unevenly across different parts of the country and MA itself is more attractive in some markets than others. Hence, the MA program tends to be disproportionately driven by the experience of some large, highly populated states. Ten states accounted for 72 percent of all enrollees in March 2005 (Table V.3) and four—California, Florida, New York, and Pennsylvania—accounted for over half (51 percent). The role of MA in the marketplace varies, however, even across these states. At the high end, almost one in three Medicare beneficiaries living in Oregon was enrolled in an MA contract; but fewer than one in ten living in Texas was in MA. In most of the large states, MA penetration ranges from the high teens to the mid-20s, but substantial diversity still exists.

Beyond these states, there are a few others where MA enrollment is low in absolute terms (because the beneficiary population is small relative to some other states) but high in relative terms (market penetration). In particular, Rhode Island and Hawaii had even higher penetration than Oregon in March 2005, with 33 percent, 32 percent and 31 percent of each state's beneficiaries, respectively, enrolled in MA.

When CMS releases its 2006 MA enrollment figures, it will be important to assess whether these patterns and trends have changed since 2005. The December 2005 data show an increase in enrollment of around 400,000 from March to December with penetration to 12.4 percent (3.1 percent in rural areas). States that appear to have particularly rapid growth rates are New York, North Carolina, Florida, Texas, and Minnesota. They each added 20,000 or enrollees over the period and raised their penetration rates by at least one percent. There also was rapid growth (5,000 or more) in some states that previously had few MA enrollees: Virginia, South Carolina, Georgia, and Utah.

B. EARLY INDICATIONS OF 2006 MA ENROLLMENT

The only public source of data on 2006 MA enrollment by plan type of which we are aware is the information CMS made available to *Medical Advantage News* (May 25, 2006) and has not yet posted (as of mid-June 2006) on the CMS web site. That information shows a total MA enrollment in April 2006 of 6.8 million beneficiaries of which 5.9 million were in MA plans with prescription drugs and 0.9 million were in MA-only plans. Though the figures do not indicate a date, other information CMS has released for that time period suggests that the enrollment is for late April 2006. (In contrast to prior years, the actual date is important because of the rapid changes in enrollment associated with the close of the MA open-enrollment period on May 15, 2006.)

In Table V.4 we compare enrollment in the major types of contracts in all MA plans in April 2006 to the same data previously presented for March 2005. Because of consistency concerns,

Table V.3. MA Enrollment in Top 10 versus Other States, March 2005

	Enrollment	Penetration
All MA	5,066,067	11.7%
Top 10 states	3,652,853	
California	983,366	22.7%
Florida	578,172	18.7%
New York	518,065	18.2%
Pennsylvania	516,230	23.7%
Ohio	222,677	12.4%
Arizona	207,435	26.0%
Texas	194,781	7.6%
Oregon	171,365	31.3%
Colorado	137,554	26.0%
Washington	123,208	14.8%

Source: MPR analysis of a data file constructed from available CMS data (see Table V1.2).

Table V.4. MA Enrollment by Selected Contract Types, 2005-2006

	March 2005	April 2006
Coordinated Care Plan	4,838,080	5,679,600
Local HMO	--	5,335,225[a]
Local PPO	--	267,429
Local PSO	--	76,946
PFFS	88,131	579,041
Regional PPO	0	54,378
1879 Cost	325,836	313,312

Note: Excludes HCPP, Demonstrations and National PACE to market easier to compare statistics comparably.

[a]Includes 263,061 in point of service HMO products.

we do not present a breakdown by local coordinated care plans (e.g. HMO, PPO) by type and suggest readers be cautious using even the 2005-2006 comparisons we present. While the 2006 data provides what we believe to be good insight on overall trends, the specific figures may be unreliable both because the data sources (and hence definitions of enrollment) may not be the same from year to year, and because 2006 enrollment statistics tend to be unstable as CMS works with plans to reconcile enrollment in a period of transition and rapid growth.

Given these caveats, the figures confirm that the MA program is continuing to grow in 2006, returning to a market penetration rate of 15.5 percent by April 2006. Though HMOs continue to dominate enrollment, the fastest rate of growth now is in PFFS contracts. April 2006 enrollment in these contracts stood at 579,041, more than double that in December 2005 (199,690), and a seven-fold increase from March 2005. These figures, before the end of the 2006 open-enrollment period, show that PFFS now has over half a million beneficiaries enrolled, more than any other contract type except HMOs. About 1.3 percent of all Medicare beneficiaries were enrolled in a PFFS plan in April 2006. Regional PPOs, in contrast, have not proven very popular to date. Less than 55,000 enrollees were in such plans in April 2006. Enrollment in local PPOs also remains relatively limited though it continues to grow. (There also has been a decline in cost contract enrollment in 2006, which probably is consistent with the reduction in offerings as firms anticipate the potential phase-out of cost plans in 2008.)

In 2005, a small set of firms dominated MA enrollment (Table V.5). This continues to be the case in 2006, and concentration has increased further by the merger of UnitedHealthcare/Pacificare. This firm, together with Kaiser and Humana, enrolls more than 2 of every 5 MA enrollees, a share that appears to have grown in 2006. Humana's MA enrollment has grown particularly rapidly over the period, with April 2006 enrollment of just over a quarter of a million beneficiaries--61 percent higher than in March 2005.

While MA enrollment grew rapidly in 2006, many more beneficiaries receive their prescription drug coverage through free-standing PDP plans than through an MA-PD plan. There were about 13.9 million enrollees in PDP plans in April 2006, including 8.1 million enrolling on their own and 5.8 million dual eligibles who were automatically enrolled in these plans as a result of conversion of drug coverage for dual eligibles from Medicaid to Medicare in 2006.

Table V.5. MA Enrollment in Largest Three Firms, 2005-2006

	March 2005	April 2006	Percent Change
Top Three	2,200,579	2,887,238	+31.2%
United Healthcare/PacifiCare[a]	998,944	1,258,381	+26.0
Kaiser	730,198	870,203	+19.2
Humana	471,455	758,654	+60.9
Top Three as Percent of Total MA	40.3%	42.3%	--

Source: MPR analysis of CMS' GSA file for March 2005; 2006 is based on data on leading MA firms that CMS released to the press.

Note: Both MA-PD and MA enrollment is included.

[a]Includes Oxford enrollment in both years

C. ENROLLMENT BY COUNTY PAYMENT RATE

In Chapter III we described what could be learned about the relationship between payment rates and MA availability, particularly for regional PPO and PFFS plans which have contributed most to the fact that MA now is available to beneficiaries in most parts of the country in 2006. While 2006 enrollment data are not yet available, it is possible to examine enrollment by payment rates for products offered in 2005.

Table V.6 show the distribution of enrollment by MA contract type and county payment rate as of December 2005, the latest date for which enrollment data exists. As previous research has shown, MA enrollment tends to be concentrated in higher payment counties and is more limited in rural areas where fewer offerings have historically existed. In December 2005, 41 percent of beneficiaries in MA were in counties with payment rates of $750 or more; only 11 percent were in counties receiving less than $686, the urban floor. PFFS is widely available but it appears to enroll disproportionately from rural areas (most of which benefit from rural floor payments) and urban floor counties. In December 2005, 81 percent of PFFS enrollment was from floor counties, including 48 percent from urban floor counties and 39 percent from rural floor counties. Only about 3 percent of total PFFS enrollment came from counties with payment rates of $750 or more.

Current PFFS enrollment reflects enrollment in plans offered since 2001 when Sterling entered the market, the 2003-4 period when Humana and UnitedHealthcare joined them, and 2005, when products were expanded and new entrants arrived. Humana, the market leader at the end of 2006, had 91 percent of its PFFS enrollment in floor counties with urban floor counties contributing over half (53 percent) (Table V.7). Sterling, the early leader, had 62 percent of its enrollment from floor counties in December 2005, with about an even split between urban and rural floors. PacifiCare, a newcomer in 2005, had 66 percent of its initial enrollment in urban floor counties.

In the next chapter we summarize findings from our discussions with firms regarding their views of the MA market in 2006 and the rationale for the decisions driving the trends previously discussed.

Table V.6. Distribution of December 2005 Enrollment by Product and 2006 County Payment Rates

	Total MA Enrollees		HMO		PPO		PFFS		Other	
	N	%	N	%	N	%	N	%	N	%
Total	5,466,247	100.0	4,547,311	100.0	210,644	100.0	199,062	100.0	509,230	100.0
$620 (rural floor)	528,939	9.7	156,847	3.4	130,465	62.0	77,221	38.8	164,406	32.3
$621-$685	61,173	1.1	31,502	0.7	1,264	0.6	7,019	3.5	21,388	4.2
$686 (urban floor)	1,544,682	28.3	1,291,599	28.4	27,518	13.1	96,325	48.4	129,240	25.4
$687-$749	1,094,368	20.0	1,009,058	22.2	13,484	6.4	11,941	6.0	59,885	11.8
$750-$849	1,295,010	23.7	1,154,676	25.4	23,063	11.0	5,242	2.6	112,029	22.0
$850 and above	942,075	17.2	903,629	19.9	14,850	7.0	1,314	0.7	22,282	4.4

Table V.7. Distribution of December 2005 PFFS Enrollment by Selected Firm or Affiliate and 2006 County Payment Rates

	Total PFFS Enrollees		Humana		Sterling		PacifiCare		Other	
	N	%	N	%	N	%	N	%	N	%
Total	199,062	100.00	99,462	100.0	31,647	100.0	5,423	100.0	62,530	100.0
$620 (rural floor)	77,221	38.8	35,218	35.4	9,794	31.0	1,089	20.1	31,120	50.0
$621-$685	7,019	3.5	3,145	3.2	3,384	10.7	63	1.2	427	0.7
$686 (urban floor)	96,325	48.4	52,542	52.8	9,970	31.5	3,561	65.7	30,252	48.4
$687-$749	11,941	6.0	6,881	7.0	4,128	13.0	394	7.3	538	0.9
$750-$849	5,242	2.6	1,510	1.5	3,451	11.0	209	3.9	72	0.1
$850 and above	1,314	0.7	166	0.2	920	3.0	107	2.0	121	0.2

This page has been intentionally left blank for double-sided copying.

VI. INSIGHTS FROM FIRM DISCUSSIONS

Our interviews with firms provide insight into the dynamics and processes behind the trends discussed in the previous chapters. As discussed in Chapter I, the analysis is based on 14 telephone sessions with a total of 20 diverse firms in MA. These included the three largest firms in MA and several other national or multi-regional firms, as well as diversely situated Blue Cross and Blue Shield organizations, traditional delivery-based HMO MA sponsors, and a few new entrants to the MA program. For the most part, discussions were in March and April 2006 and lasted about one hour. We talked with senior executives in each firm responsible for the MA product and decisions about it. Firms were assured that their comments would not be attributed to them and would be confidential. Firms were particularly sensitive about not revealing proprietary information or plans on the horizon.

In this chapter, we summarize what we have learned. The analysis is organized to limit the need for repetition. Hence, we discuss together topics that firm responses indicated were jointly considered. These topics include:

- The general national environment entering 2006 and its implications for firm interest in MA, along with the role of markets in influencing firm decision-making. The latter are factors that our own—and earlier—research shows to be important in a marketplace characterized by diversity, in which firms react to national policy within the context of their specific goals, market niches, and the characteristics of relevant markets.
- The specific factors driving interest or disinterest in particular types of MA products, particularly as these relate to payment rates, network formation requirements, and beneficiary acceptance of certain plan characteristics.
- Firm structuring of specific premiums and benefits, alignment of diverse offerings, and marketing of products within the context of the current competitiveness of the marketplace.
- Firms' initial experiences working with CMS on implementation, enrollment, and payment in 2006.
- Changes planned for 2007.
- Firm commitments and future concerns related to MA.

Given the chapter's length, we provide a summary at the start of each section with the major findings.

A. GENERAL ENVIRONMENT ENTERING 2006 AND FIRM RESPONSE

Nationally, three strong forces encouraged firms to seriously consider aggressively pursuing Medicare Advantage program involvement in 2006: (1) the entire Medicare program was in transition, particularly because of the introduction of Part D; (2) MMA introduced more favorable MA payment rates; and (3) the aging of the U.S. population has made senior products demographically attractive to firms. Given the breadth of the changes in the Medicare program in 2006, firms had to decide where to focus their resources. Most were also establishing PDPs, which required very large start-up costs. The attraction and demands of the PDP product, combined with the unstable history of the MA/M+C program, limited the resources firms had available for MA.

In deciding how to position themselves in MA, firms balanced the pressure on their resources in different ways, depending on what they perceived would best suit their long-term style and strategy in the marketplace. For example, they:

- Built on their base
- Targeted "low-hanging fruit"
- Favored strategies consistent with their perceived market strength
- Sought expansions appropriate within the full range of business
- Tailored the level of business risk
- Responded to market preferences
- Began positioning themselves at least by 2005

For some firms, the changes in 2006 were relevant mainly because of the threats they generated to their existing book of business rather than the opportunities. This appeared to be particularly the case for the most traditional HMO-model firms.

1. Environmental Factors

Nationally, three strong forces encouraged firms to seriously consider aggressively pursuing Medicare Advantage program involvement in 2006. First, the entire Medicare program—43 million beneficiaries nationally that account for 17 percent of health care spending (from 2005 Medicare Chart Book)—was in transition. Because of the introduction of the Part D drug benefit, CMS was giving each beneficiary the message that he or she should review their supplemental drug coverage (or lack thereof). Each of the firms we spoke with said aspects of their business strategies had been affected by Part D since it impinged on the employer market (group retiree benefits), Medicare supplements (Medigap), Medicaid (the transition to Part D), and specialized plans (for example, prescription drug management). Additionally, the structure of the MMA created a new and very large market for prescription drug coverage for Medicare beneficiaries, as well as the potential for restructuring the configuration of current coverage and beneficiary demand. Depending on their perspective, firms described both new opportunities (new business, more business) and new threats (loss of the current business base) in response to this new benefit. Furthermore—as one large firm has repeatedly noted publicly—past experience has shown that the initial ability to capture market share in 2006 is important to firms

seeking to aggressively tap the new market, because movements by beneficiaries could become permanent and drive long-term configurations. Hence, firms carefully considered how to position themselves in 2006.

Second, certain features in the MMA made it more attractive for firms to consider the MA market than in the past—in particular, modified payment rates starting in 2004 that were viewed favorably by industry. The change in methods for defining minimum updates to rates meant that beginning in March 2004, increases in payment rates were much higher than in earlier years (see Chapter I). Rates were guaranteed to be at least equal to 100 percent of the local FFS rate, based on adjusted per capita Medicare FFS costs in each county. Moreover, floor rates for rural and urban counties meant that in some counties they were much higher than that. Hold harmless features of risk adjustment also increased the funds available to the MA sector as a whole relative to the traditional Medicare program. While rate floors were not new with the MMA, the legislation created a new opportunity to leverage these rates to offer MA-PDs that might be substantially more attractive than free-standing PDPs in the same counties. This is because 75 percent of any savings from the higher rates could be used to enhance MA plan benefits or premiums. This option was not available in the PDP sector and gave MA firms a real advantage, particularly in counties where rates were considerably above 100 percent of FFS. The MMA was also structured to allow firms the potential to take advantage of geographical variation in payments to create regional PPOs that might be especially attractive in establishing MA options in less-populated, poorly served areas. As discussed below, however, the opportunity to offer regional PPOs appears to be less a driver in the 2006 marketplace than other factors.

Third, the demography of the population supported greater interest in Medicare products. As one discussant observed, "the sheer demographics are a compelling element" in all industries as baby boomers age. The logic for focusing business opportunities on those age 50 and older (or however this population is variously defined by different groups) is strong. Although we did not hear much in our discussions about declining demand in the commercial market, previous ASPE discussions suggest that this is a related consideration behind the increased interest in the senior market.

2. Firm Response

While all the firms we talked with were affected by the national environment, the amount of resources spent in responding—and the focus on MA versus Medicare more generally or other product lines—varied by firm. Because of the breadth of the changes in the Medicare program in 2006, firms had to decide where to focus their resources. For many of them, developing new products or expanding existing MA products competed with resources they might devote to establishing free-standing PDPs either for the general population or for specific markets they already served (for example, reaching dual eligibles if the firms was already extensively involved in Medicaid, or retaining group accounts by revising retiree products to suit purchaser response to Part D).

The sheer breadth and rapidity of the changes created large demands for resources that firms had to balance in ways they felt would best meet their long-range goals. Trade-offs were particularly critical for smaller firms, which had fewer discretionary or flexible resources to allocate. But even the largest firms were limited in what they could do by the sheer work involved in executing a strategy (as discussed below). In deciding how many resources to use in

expanding MA, firms also considered the history of Medicare+Choice and how much risk they were willing to take should government payments for MA continue to be unstable or unpredictable over time.

Almost all the firms we talked with were also establishing PDPs, often across broad areas of the country. Doing so meant they had to devote considerable resources to developing provider networks, designing drug plans, and lining up their distribution and marketing strategies for these new products. Once Part D open enrollment began, the sheer scale of implementation consumed most firms. While some of these activities were jointly relevant to MA, they were sufficiently different and demanding to limit the amount of attention many firms were able to devote to MA in 2006. Hence, firms had to pick and choose carefully where to focus. Equally critical, many firms perceived that the introduction of the drug benefit itself has competed for, and dominated, CMS's attention so far in 2006.

The firms we talked to balanced these competing pressures in different ways in deciding how to position themselves in MA, depending on what they perceived would best suit their long-term style and strategy in the marketplace. For example, they:

- ***Built on their base.*** Entering new markets was more demanding than expanding in those in which firms already had some presence, marketplace knowledge, and existing relationships with providers. They picked and chose carefully, seeking to leverage the experience and relationships built not just for Medicare but for the firm's entire product line. For example, one large firm was geographically aggressive but decided not to initiate new products in a large and well-populated state where it had no presence and faced substantial competition.

- ***First pursued the "low-hanging fruit."*** Firms typically expanded in ways that seemed easiest and most important to them first and then elsewhere only to the extent additional resources allowed. For instance, PDP expansion might have been a priority because the financial risks and administrative burden were lower. Alternatively, a firm with an existing local PPO might expand that first because the geographic scope and resulting burden could be controlled, whereas there was more uncertainty with a regional PPO. Smaller firms told us they were concerned that expansion would detract attention from maintenance of a strong existing product base.

- ***Favored strategies consistent with their perceived market strength.*** In our discussions, it was clear that firms had different "styles" that informed their substantive strategies. A number of Blue Cross and Blue Shield companies cited, for example, that they perceived their major assets to be their community roots and historical stability, and their well-formed provider networks. They were not necessarily focused on providing the lowest-price product, but rather on one consistent with the Blue Cross and Blue Shield brand—that is, acceptable to their providers, with sufficient benefits that beneficiaries would not be surprised or complain, and one they could sustain over time to allow stable offerings. One company that viewed care management as a strength sought ways to introduce it in more loosely managed products. Another that viewed its strength to be in competitively priced products stressed this feature across all of its product lines.

Others sought to create a diverse set of products that would appeal to a broad spectrum of beneficiaries.

- ***Sought expansions appropriate within the full range of business.*** Firms said they generally tried to avoid cannibalizing their existing products for new ones. But they might do so if they thought this was the best strategy for the health of the company overall. For example, firms active in the Medicare supplement business typically told us that current Medigap customers (at least of their firms) were not their target for MA. But they also said they would prefer to keep a customer within the firm's family of products rather than lose that customer overall. So a firm that viewed its Medicare supplement business as stagnant or declining might look to new MA products to strengthen its market position. One traditional managed care firm that had been acquired by a larger company decided to expand beyond its historical HMO products to develop PFFS in a broader set of markets that its parent company found appealing.[14]

- ***Tailored the level of business risk.*** Some of the firms we talked to were consciously aggressive, seeing 2006 as a unique opportunity to enlarge their market substantially in ways that they could build on over time. They sought geographic scope and a range of products to carry out this strategy. Others were more cautious. Some straddled the middle, with aggressive but more measured plans. They experimented with new products in a few markets versus going nationwide or merged with firms whose core competences complemented their own. In general, publicly traded firms with broad geographic scope appeared more likely to be concerned with growth and those with strong local roots seemed more concerned about avoiding the long-term risk associated with unstable offerings.

- ***Responded to market preferences.*** Firms said that the markets they serve vary, with some markets preferring PPOs and others preferring more tightly structured HMO products. Firms observed that in general, it was hard to grow MA in many isolated rural markets because neither providers nor consumers were familiar with the managed care concept. Although they said that firm preferences among products and long-term strategies might influence how aggressively they marketed a specific product, they also indicated that they accommodated local preferences and considered market demand in structuring individual geographic offerings. This meant they might continue to offer certain products even as they devised alternatives that they hoped might eventually replace them.

- ***Began positioning themselves in 2005.*** With the exception of regional PPOs, MA plans had authority to proceed with new and expanded offerings any time before 2006. Firms considering new or expanded local PPO products had to have them in place before 2006 to avoid the two-year moratorium on such products. In many cases, firms described new local MA offerings they consciously introduced prior to 2006. In some cases, firms were attempting to get "a leg up on the competition." For

[14] The parent company had benefited from the previous economic reversals in Medicare+Choice because this allowed it to increase its Medicare supplement enrollment. The company was reportedly concerned that these gains could be threatened by the resurgence of MA, and found PFFS a valuable hedge strategy.

example, one national firm described how it began a phased roll-out of a major PFFS expansion in mid-2005 to "get out ahead of the 2006 environment and cut our teeth." In at least one case, a firm told us it was planning an MA expansion before the MMA was even passed, anticipating the change in climate. Some described expansions that would have made sense to them under the MMA because of the increased payments, even without Part D or authority for new kinds of plans. In other cases, firms were aiming to pre-empt or discourage entry among firms that might seek to capture their market.

For some firms, the changes in 2006 were relevant mainly because of the threats they generated to their existing book of business rather than the opportunities. This appeared to be particularly the case for the most traditional HMO-model firms. In most instances, such firms had little interest in moving beyond their core business to offer alternative MA plans or free-standing PDPs. Their main concerns involved responding to the way in which Medicare's prescription drug requirements differed from their existing practices and educating their existing members about the forthcoming changes. Their main goals—universally, it appeared from our interviews—was to maintain current products and the enrollment in them, or to continue to grow at the same rate and for the same reasons as before. Often this required working with employer group accounts that generated a steady stream of "age-ins" to the plan, and educating individual members who might not understand that signing up with a PDP would mean they were automatically disenrolled from the MA plan.

B. THE INFLUENCE OF MA RATES AND THE DEMANDS OF NETWORK FORMATION

Top leadership from each firm was involved in 2006 MA decisions, with the balance between corporate and local leadership differing across firms. Both MA payment rates and considerations relating to provider network formation were the major factors driving product and market-specific decisions in 2006. Firms took into account how the expected revenues in each county affected the feasible structure and likely market viability of different products. While rates might be regarded favorably in 2006, firms also considered the risks associated with potential future reductions.

While rates were important, firm's ability to put together a viable provider network had a major influence in shaping 2006 offerings; the need for on-the-ground resources to establish new networks was a major limiting factor. The absence of network requirements was one of the major factors making PFFS products so attractive.

Some providers desire for higher payments than provided by the traditional Medicare program led to difficult negotiations, particularly with hospitals. MA viablility could depend on being able to negotiate rates below Medicare for in network services in PPO; Medicare-based rates are typical in PFFS. Provider acceptance was an issue that extended beyond rural areas.

Two factors helped firms address network issues, particularly for regional PPOs: (1) their expectation that CMS might allow them to use in-network payments for out-of-network providers if access problems in some counties might preclude the firm from offering a product, and (2) the expectation that CMS might approve a product even if its network was weaker than ideal in selected areas.

1. Process of Decision-Making

Top leadership in each of the firms was involved in the major decisions on the products to be offered and geographic strategies. In national firms, the corporate leadership generally made the ultimate decisions but with regional input from local affiliates that were more familiar with particular markets. The role and balance of national versus regional authority and input varied across firms, reflecting differences in the way the organizations work. One firm, for example, said that "decisions were made on a corporate level with participation from the market level by staff involved in running products on the ground in particular regions or markets." In another firm, regional offices led the decision-making because they were best positioned to integrate such decisions across commercial and Medicare business so that overall delivery system targets were made. However, the national office provided expertise in rate-setting and gave other input to "make sure that regions understood their decisions and consequences." In one merged organization, executives were clear that decisions were being made after considering the full portfolio of products across the combined organization. Fortunately, the two previously separate organizations' product lines were relatively complementary.

2. The Influence of County-by-County Rate Variation

Although some firms were more explicit on the point than others, the fact that payment rates for the MA product have been high and are growing annually was said to be an important consideration in all firms' decision-making. Discussants, however, remarked on the historical problems with rates and resulting plan withdrawals, hoping that would not occur again. In choosing specific locations for their products, firms explicitly said that they looked first to the payment rate in that locale to compare the expected revenue generation with estimated costs of the MA product. They, as one firm noted, "followed the money."

As discussed more fully later in the report, the same rate might be assessed differently depending on the product's target market. For example, MA products targeted at beneficiaries with Medicare supplements could be offered with higher premiums than those aimed at individuals already in or historically targeted by the MA market. (The latter include a higher proportion of price-sensitive beneficiaries with generally lower incomes.) In some cases, particularly for PFFS plans, firms were quite explicit in describing how a county-by-county rate analysis was a critical part of defining a geographic service area. We heard, for example, that a service area for a PFFS plan might be defined strictly by the favorability of each county's rate, even if that meant the PFFS' service area ultimately excluded a contiguous (or wholly contained) county. In other cases, discussants simply said that PFFS expansion was based on "financial and actuarial analysis," with rates important but not the only element, or that in some markets PFFS just made sense given the reimbursement rates. We were also told—typically by competitors in given markets—that in addition to expansion into markets with the most favorable rate profile for a specific product, marketing resources might be invested more heavily in these markets. This was especially the case with regional PPOs, which require uniform offerings. For example, one firm said that a competitor was offering a regional PPO in their state, but was in fact marketing it only heavily in 8 to 10 counties where the product was well-positioned.

Discussants also commented on the influence of risk adjustment on reimbursement rates. In many cases, they appeared to view the issue mainly as a matter of recordkeeping. One firm, for

example, was a strong supporter of risk adjustment, saying it creates better incentives to treat patients. But the firm also perceived that "it had taken three years…for plans to get good at funding, auditing, and getting paid the rate they should." Firms were concerned that planned changes to CMS's risk adjustment methodology in 2007 would penalize them for this effort. One large firm said that one of the reasons it was not more involved in MA was its concern that—outside a captive delivery system—it would be hard to get providers to properly document care in their private offices, resulting in plan payments that were too low for high-cost beneficiaries.

3. The Demands of Network Formation

While rates might dominate decision-making, firms told us that their ability to put together a viable provider network had a major influence in shaping the extent and nature of new products or product expansions in 2006. In particular, firms said that the need for on-the-ground resources required to establish new networks was a major limiting factor in what they offered. This is because firm staff needed to be familiar with provider communities and able to negotiate contracts within the limited time frame available in 2006. Further, new products typically require new or at least amended provider contracts, even with providers already under contract for other products the firm offered. So even if firms had existing networks, they saw the demands of renegotiating contracts as limiting the scope of new product development in 2006.

Firms actively involved in pursuing regional PPOs, for example, said that their strategy sessions were consumed with reports of progress in signing up "hundreds and thousands" of providers, each needing to be *individually* assigned to a network. For instance, in one large state, the firm would start by establishing new contracts with its existing providers in core counties. However, it might find it had 20,000 of the 50,000 state physicians already in its network, but that there were major gaps across other parts of the state, all of which needed to be filled. The ultimate network proposed to meet CMS's network adequacy requirements for regional PPOs could be as many as 30,000 physicians, or a network 50 percent larger than the one it started with. Firms told us that the absence of the need to form a network was one of the major factors making PFFS products so attractive.

Smaller firms thought they were disadvantaged relative to larger ones in negotiating new provider contracts. Their smaller size made it easier for providers to ignore them, and they lacked the resources needed to support the scale of contracting required to develop new products and still maintain existing business. Providers know that firms have deadlines with CMS, and, as one firm said, they use it to their advantage in negotiation.

Firms said that the willingness of a provider to contract with them depended both on reimbursement rates and on how each provider perceived it would be positioned in the marketplace without such a contract. Firms generally said providers wanted to be paid more than Medicare paid, often leading to difficult negotiations, particularly with hospitals. Firms did not say what they paid providers, but their comments did not indicate that many were paying more than Medicare in their typical provider contract, although there may be exceptions. In previous years, some firms expanding their PFFS business seem to have used payment rates slightly higher than those of Medicare—for example, 102 percent of FFS—as a way to gain the cooperation of physicians. However, such payments were not described for hospitals and many said that doing so in 2006 would not be economically viable. Indeed, one firm said it had to

withdraw their PPO in 2006 from markets where they could not negotiate in-network rates lower than those paid by Medicare.

Providers' willingness to negotiate seemed to vary with their opportunity costs, from what firms said. In one market, providers had a long history of participation as a financial risk-sharing partner with an HMO. They did not want to contract with the same firm for a PPO that might compete with that arrangement. In another state, hospitals were said to be actively opposing new MA products that might lessen their ability to benefit from traditional Medicare FFS payments. Aside from the level of their rates, Medicare FFS payments were also attractive to providers because hospitals could gain from retrospective settlements, a practice that risk-based MA plans do not favor.

For some providers, administrative burden was an issue independent of rates. Firms described examples of providers wanting to limit the number of distinct contract and administrative arrangements to reduce the demands on them or their administrative staff. Although the difficulty of establishing provider networks in rural areas is well known, firms said the constraints they experienced in negotiating contracts with providers for regional PPOs (and sometimes other new products) were not limited just to rural areas.

4. Particular Issues of Network Formation in Rural Areas

In some ways, firms appeared to anticipate the potential obstacles to network formation in rural areas and to take that into account in deciding which markets to enter or which products to develop. For example, regionall PPOs might only be pursued when firms anticipated that developing networks for those products might be feasible (even within rural areas of the region). Sometimes, these evolved after experience with the local PPO in a narrower set of largely urban counties. PFFS plans, instead, might be offered in rural counties but it sometimes seemed as though firms did not expect to gain large enrollments in specific locales, especially if providers or beneficiaries had limited prior experience with Medicare alternatives. One regional PPO sponsor said that the PPO structure made benefits more attractive in less urbanized areas, but also said that the product would not be viable unless it could achieve a scale that depended on enrollment from more populated (although not necessarily heavily urbanized) parts of the region with more experience with MA.

We asked whether the "essential hospital payments" provisions of the MMA were helpful, and were generally told that they were of little help. (These provisions are designed to make it easier for firms to include these hospitals in their network because they authorize CMS to pay a small number of hospitals additional payments if the hospitals can prove they qualify.) The provisions have a limited geographic focus and the financial incentives are not viewed as persuasive for a hospital that can otherwise expect Medicare FFS rates. One firm said that the value of the essential hospital provision was diminished after CMS reneged (according to the firm) on allowing firms to invoke this provision rather than having hospitals agree to it. In addition, another firm told us that it was hesitant to use networks that include reluctant providers, perceiving that this results in unsatisfactory relationships. The one exception was a large firm that said it helped providers gain designation as an "essential hospital."

From what firms said, it appears that two factors made it more possible for firms to offer a product that included extensive rural areas. First was the expectation that CMS might allow

them to use in-network payments for out-of-network providers if access problems in some counties might preclude the firm from offering a product, particularly a regional PPO. We were told that MA included pre-MMA provisions that expedited doing so to achieve network adequacy, especially in areas where a single hospital or two might dominate and create gaps in the network by refusing to join. Second was the expectation that CMS might approve a product even if its network was weaker than ideal in selected areas. The firm could then avoid problems by not marketing the product in those areas, anticipating that beneficiaries in those counties would not enroll, or improving the network over time and paying in-network (Medicare) rates for out-of-network providers in the interim.

C. PRODUCT-SPECIFIC CONSIDERATIONS

In 2006, firms were most likely to expand more loosely managed products that were easier to implement. Although local HMOs dominate the current MA product, these take the most resources to establish and firms typically felt they had exhausted the market. They were more likely to favor local PPO to HMO expansion in 2006, if they considered either. PPOs were typically perceived as less expensive to establish with a broader target audience, but some firms found them not very profitable and had little interest in them.

Firms generally said that their interest in offering a regional PPO product was constrained by (1) the need to establish provider networks across broad areas of the country; (2) uncertainty about its viability and its financial mechanisms; and (3) less ability to tailor benefits and premiums to local markets compared with a local PPO. Each of the five firms in this market that we talked with appeared to have different rationales for entering the market, as well as limited business expectations. Although the geographical base of local Blue Cross and Blue Shield organizations might make them an obvious sponsor of regional PPOs, many we talked with had decided not to pursue this route because of both practical problems and the perception that other strategies might have a higher payoff.

Some firms had strong interest in PFFS, for which they credited the ease of entry because (1) PFFS does not require provider networks or provider contracts and has no network adequacy requirements; (2) the economics of PFFS is more national in scope, as firms need not create a local base to form or manage the network; and (3) marketing is easier because these products are more like traditional indemnity insurance and can be sold through insurance brokers nationwide. Some firms were targeting the PFFS to the Medigap market rather than the traditional MA market. Despite the advantages of PFFS, firms said they still had to put resources into provider education, particularly when market experience with such products was limited. While PFFS sponsors were optimistic, competitors said provider acceptance could be an issue.

1. Local HMOs

In general, firms said they made only minor changes in their local MA HMO products other than adding the new prescription drug benefit and making those changes needed to accommodate it. They may have added a few counties to their existing geographic service area, but only rarely added new markets. If they expanded into other markets, it was often to take advantage of a particularly promising opportunity for an SNP, a high payment area, and/or a provider opportunity. They noted that HMOs take the most resources and time to establish. While HMO sponsors in multi-product firms indicated that their current HMO products may be among the more profitable of their MA products, we had the sense that many firms felt that they already had products in the geographic locales that were most promising to them and that further geographic

expansion within the HMO sector was less likely to pay off than introducing other kinds of products that might attract different subgroups of the Medicare population. With fewer competing demands in 2007, firms' calculus could shift, but we anticipate that any expansion of local MA HMO products will be modest overall. For now at least, most traditional HMOs have stuck with their products, although some diversification was underway in some organizations.

2. Local PPOs

The firms we talked with tended to favor local PPO to HMO expansion in 2006, if they considered either. Several suggested that while local PPO products are demanding to establish, their provider networks are somewhat less expensive to set up than HMOs because of the flexibility of the PPOs' out–of-network provisions. Firms' interest in the PPO product varies: some have little interest in local PPOs because they perceive them hard to run on a financially attractive basis. The PPO model allows the firm less power to direct patient volume, limiting its ability to negotiate favorable rates with providers. Others, however, prefer local PPOs, perhaps because they perceive the PPOs to have a broader target audience. Only a few firms mentioned their experience with the PPO demonstration as important to new product launches, but we did not directly query each about this.

The pending moratorium on local PPO expansions in 2006 and 2007 was a factor in firms' decisions—unless they added such products in 2005, they would otherwise have to wait until 2008. When asked, firms indicated that their local PPO expansion products were real, not just "placeholders." They said CMS required that products be real—in other words, to have enrollment—and also described marketing strategies that suggested that they perceived that the local PPO had potential to draw in a number of beneficiaries not currently in MA. Some firms described local PPOs as the basis of what could be an expanded local PPO presence once the moratorium lifts in 2008. A few also indicated that they might consider building a regional PPO around their local PPO base.

3. Regional PPOs

Firms generally said that their interest in offering a regional PPO product was constrained by the need to establish provider networks across broad areas of the country. One firm that did offer such a product said it did so only in a few areas where it already had networks upon which it could build quickly. It also said that these areas had limited and "manageable" rural sections. Firms also were cool in their initial response to the regional PPO for other reasons. As a new product, there was uncertainty about its viability and financial mechanisms. Firms also noted that because regional PPOs are required to cover broad areas, the plans' benefits and premiums are inherently more "generic and less competitive in urban areas where there are local plans tailored to the market and its unique features and payment levels." All firms agreed that, in most cases, a local PPO was likely to be more attractive to beneficiaries who were offered both a local and a regional PPO option. Regional PPOs are viewed as more likely to attract suburban or rural residents with fewer choices. However, firms' ability to offer regional PPOs in these areas depended upon the willingness of providers there to accept their payment rates, as well as the level of interest of potential enrollees.

Five of the firms we talked with had at least one regional PPO, although not all were willing to be very open about their motivation for this. We did not learn, for example, why one large national plan had chosen to offer regional PPOs in so many parts of the country (other than that it already had a fairly large geographic scope) or why it did so while actively pursuing PFFS expansion. But we did learn of some important motivating factors from the other four firms. In one case, the product was described as a way of generating higher payments in the rural areas of one region the firm already served. The regional PPO was viewed less as an opportunity for growth than a vehicle to generate better financing. This firm did not anticipate that the enrollment in the regional product would be large, at least in 2006. It also expected a lot of enrollment would come through conversion of enrollees currently in its existing local HMO product that had less attractive benefits than the new regional PPO. In a second case, a firm offered alternative products in most parts of its regional PPO's service area but appeared to see the regional PPO as an effective way to provide a competitive product for a part of a state where these products had not been historically viable but where a regional PPO might be feasible due to its higher MA payment rates. In a third case, the firm consciously piloted the regional PPO concept in a few diverse regions where it was well-positioned, none heavily dominated by rural areas. The firm did not anticipate a large initial enrollment; instead, it used the pilot to gain experience that would help it learn more about the product for future decisions.

Few firms shared with us their specific enrollment targets for regional PPOs. Those that did had reasonably low targets; others talked as if they had similarly done so. If regional PPOs were to grow in importance in the market, their executives saw this as a longer-range evolution, not something that would happen in 2006. This appears consistent with the initial enrollment figures available (see Chapter V).

Although the geographical base of local Blue Cross and Blue Shield organizations might make them an obvious sponsor of regional PPOs, many we talked with had decided not to pursue this route. Blue Cross and Blue Shield's branding requirements mean that firms seeking to offer a "Blues' branded product" could not do so on their own unless their service area coincided with the MA region. Otherwise, they had to develop a joint venture with other Blues plans in the region if they wanted to offer a Blues-branded product; this was often viewed as infeasible within the time parameters.

Equally important, the regional structure made it difficult to develop equitable sharing of financial risks and gains among joint-venture Blue Cross and Blue Shield organizations over areas with large variation in costs (and local MA payment rates). One firm said it might have offered such a product but was discouraged by the fact that CMS initially said it would reconcile payments retroactively based on the enrollee's county of residence, essentially nullifying a PPO's ability to spread risk and gains across its entire service area. However, the firm said that if it had known that CMS would later change its implementation of this policy, it might have been able to negotiate agreements sufficient to support regional PPO product development.

Even when a particular Blue Cross and Blue Shield firm service area matched an MA region, such firms typically decided not to pursue a regional PPO. We did not fully learn the rationale for these decisions, although we speculate that it is because the regional PPO is a more unknown product, introduces more risks due to uncertainty about how payments would be reconciled, and has more requirements than a local PPO. In one case, a firm decided to pursue a statewide local PPO with uniform benefits rather than a regional PPO in what would have been

the same counties. Although it would compete with a regional PPO from another company, the firm perceived that beneficiaries would not distinguish or care about the differences in the two products. In another state, the firm said that the region was too diverse to support a consistent benefit package or statewide provider network.

Despite such reservations, six separate Blue Cross and Blue Shield organizations did form a regional PPO in 2006 to serve a seven-state region, along with a regional PDP which to date has achieved a much larger enrollment that has the regional PPO (*Medicare Advantage News,* March 23, 2006). The region covers a large geographical area that, for the most part, has limited prior MA experience. The six organizations are engaged in a joint venture.

4. Local PFFS Plans

Firms described more new PFFS offerings than any other product in 2006. Firms were quite open in saying that these products were much easier and less expensive to set up because they did not require provider networks or provider contracts and had no network adequacy requirements. In contrast to other MA products, we were told that the business case for PFFS is more national in scope, as firms need not create a local base to form or manage the network. Marketing is also easier because these products are more like traditional indemnity insurance and can be sold through existing or newly formed relationships with insurance brokers nationwide.

Firms differed in how they described the focus of their PFFS product. One large firm said that its PFFS product was targeted to the "Medigap market," whereas another said it was more an extension of its MA business that targeted HMO members or those without existing supplemental coverage. The latter firm has structured its PFFS products with relatively low premiums to attract beneficiaries drawn to the MA sector's financial advantages but who also want greater provider choice. Those targeting current Medigap enrollees have structured their products to attract beneficiaries who want to retain broad provider choice but who also are looking for savings over historically high Medicare supplemental premiums. Products targeted at this audience can have a higher premium.

In the end, the way PFFS plans will work on the ground remains unknown, particularly if they attract large numbers of enrollees. Firms said that the absence of a provider network requirement is a major attraction of these products. Indeed, retaining this advantage is one reason that they do not more actively pursue some of the more flexible provider payment policies allowed under this option, which might cause providers to not accept their payment rates. (They said initiating the more flexible payment policies would require provider contracting, if indeed it would be acceptable at all to providers). Yet while the PFFS product has no network, firms also said they have learned that establishing such a product still requires a need for provider education and sensitivity to market-specific provider preferences. Firms also said they need to assess the likelihood that providers will see patients who sign up for their PFFS plans. Some do this education or market assessment in advance, particularly by gathering informal feedback on the likely participation of major hospitals. Many of the firms interviewed said that PFFS also requires extensive work with providers after enrollment. One large firm, for example, said it identifies the providers of new enrollees signing up and contacts them within 30 days to educate them, resulting in a 90 percent provider acceptance rate and growing list of providers. However, the firm noted that it had an easier time contacting hospitals than physicians.

Firms see provider education as especially important for early adopters of PFFS in a market. Indeed, some local competitors say that one reason they are not sponsoring such a plan is that they "don't want to soften up the market" for outside competitors. Competing national firms each claim they prepared the market for others. One said it deliberately went into markets with an existing PFFS presence ("not virgin territory") because that meant there was some product knowledge.

We have no way of judging at this time whether issues are arising with respect to provider acceptance of PFFS arrangements. Firms sponsoring these plans say they have either not experienced or have been able to handle any issues arising with providers. Those firms not offering PFFS do not necessarily agree, although no one appears to have sufficient information to adequately gauge how well this product will be accepted. Enrollment in PFFS is relatively recent and is relatively dispersed across diverse areas of the country. If there are potential problems, they may not surface if their effect is to discourage enrollees from even joining a PFFS. Open enrollment has historically allowed beneficiaries who do experience problems to switch plans. With the new "lock-in" requirements, such protections will be less available in the future, potentially leading to less willingness on the part of beneficiaries to try out new managed care products.

Financial viability is the other big ambiguity about PFFS products. By statute, firms are limited in the types of care management activities they can impose upon providers. Indeed, some firms explicitly responded to our question about the firm's interest in use of care management in PFFS products by saying these are, by design, "unmanaged products." Incorporation of any type of management technique appeared to be fairly minimal. For example, one firm had asked providers to voluntarily notify it when PFFS enrollees were admitted to a hospital. Because firms are not allowed to compel providers to adhere to certain rules, this firm asked for voluntary notice rather than pre-certification to facilitate discharge planning. A few firms were planning to implement more extensive voluntary care management activities. For example, one firm said it is attempting to actively introduce patient-focused care management into its PFFS products.

We asked about firms' ability to make money on the PFFS option if firms pay Medicare rates and incur additional administrative expenses not borne by Medicare, particularly if MA rates over time do not diverge very extensively from Medicare's own cost experience in an area. Firms not offering this type of product cited questions about viability or value as one of the reasons for not pursuing a PFFS product, although some were reconsidering given the interest in PFFS by their competitors. Most of those in the PFFS market saw these products as viable, though not necessarily as profitable as other MA products. The extent to which viability depends on location is unknown. It is possible that PFFS is successful in part because it is operating "under the radar screen" and hence not drawing attention to itself from providers or regulators. On the other hand, the viability of PFFS might be enhanced by targeting current Medigap customers already paying high premiums for coverage.

Some firms also observed that the same factors facilitating entry could also make it easier to exit the PFFS market—for example, the extent to which firms sought to capitalize in the short term on the high payment rates, especially in some floor counties; some have termed this "geographic arbitrage." This would be consistent with the large share of PFFS enrollees in "floor" counties. Few firms, however, talked too openly about this issue.

D. BENEFITS AND PRODUCT POSITIONING

Firms often designed multiple benefit packages and/or a family of products to appeal to diverse subgroups of beneficiaries. They took into account what they expected their competitors to do; as might be expected, entry with very low-priced products drew their special attention and concern, paying particular to Humana's aggressive approach. Drug coverage often was included in Part D even though firms were not required to do so. Those firms not doing so typically offered an independent PDP to complement their PFFS plan.

Traditional HMOs with in-house pharmacies and well-established formulary development processes found integrating Part D challenging. CMS's standards for Part D coverage could be inconsistent with the way the HMO had historically provided drug benefits; CMS set a very high threshold for allowing waivers to the "any willing pharmacy" requirement in Part D. In addition, these firms were concerned about (1) cost-control problems if they historically used mainly in-house pharmacies, and (2) ways in which beneficiaries would be confused or could perceive themselves as worse off under the new plan requirement. Such firms often had strong enrollment from group accounts and said they had to spend time helping employers restructure their retiree benefits.

Beneficiary education and marketing was an important focus for all firms, particularly when there were new or modified offerings. The concentration of marketing and enrollment efforts over a brief period in 2005-2006 was a concern for all firms, consuming large amount of resources for beneficiary education. This included both efforts to educate existing enrollees of changes and efforts to reach new enrollees.

Firms used a variety of channels to reach beneficiaries. Brokers and agents appear much more involved in selling MA in 2006 than they were perceived to be in prior years. Reasons for this include (1) their current role in Medigap and geographic scope; (2) their established channels for reaching beneficiaries not accessible through other firm channels; and (3) the fact that the way firms are paid provides them an incentive to enroll beneficiaries.

1. Product Alignment and Benefit Design

In setting premiums and benefits, firms clearly considered the target market for particular products. If a product sought to attract beneficiaries with limited incomes, they might start with a low target premium or no premium, and then assess the benefit package that could be offered for that price. For products less price-sensitive, such as those targeting beneficiaries whose alternative could be Medigap, the initial focus was more often on a desired set of benefits and product characteristics, with less focus on the premium. Firms often designed more than one benefit package—especially for products expected to be popular—with the goal of creating options attractive to diverse beneficiaries. Individual county rates were also clearly considered in designing benefits. However, firms said they tried to reduce administrative burden by working with their actuarial staff to identify groupings of counties that could share a combined single set of products. (Firms have flexibility within local plans to subdivide their service area to offer different benefit packages at different premiums, although drug benefits—but not drug premiums—must be uniform throughout their service area.)

Firms often expressed an interest in offering a family of products—both by type of contract and by level of premiums/benefits—that might meet the various needs of diverse populations. For example, one regional firm said its goal was to have at least two medical and two pharmaceutical products in each of the areas it served. Many firms had both local HMOs and

PPOs in the same area for historical reasons (for example, a PPO demonstration). Some, however, appeared to consider this a duplicative historical anomaly that added to their administrative expense. They indicated that future expansions would seek to introduce one or the other in new markets—typically, that meant introducing a PPO, which most firms viewed as giving beneficiaries more flexibility, and as suitable for areas of the country not already served by HMOs.

Firms appeared particularly interested in product combinations that might enlarge their appeal while at the same time minimizing administrative expense. For example, regional PPOs were commonly introduced in markets where local HMOs and PPOs existed. Indeed, the existence of the local products provided a base of experience and providers upon which to build the regional product.

Some firms also appeared to see value in offering a PFFS plan and/or Medigap supplement (if their focus spanned this spectrum) together with a managed care alternative. Those sponsoring such product combinations wanted to capture or maintain market share among beneficiaries historically seeking choice. Often, diverse products might share a common platform, such as a formulary, but have differing cost sharing arrangements. While firms sought alignment across products, sometimes they acknowledged falling short in 2006 when so many changes were being made at the same time, and products may have evolved independently of others.

In designing their plans, firms also said they paid attention to what they expected their competitors to do. This was particularly difficult heading into 2006, since much remained unknown. Firms could be in a reactive mode if they were responding to the only information they had—last year's offerings. But one firm characterized this as the conservative approach. In considering the competition, firms did not necessarily seek to be the most price-competitive plan. They "branded" their products in different ways indicating they also were concerned about other goals, including the ability to sustain the product or satisfy providers. In some cases, they admitted that they priced a particular product too conservatively and it was not competitive in the market. In those situations, firms said they hope to make changes in 2007 that better position them in the marketplace.

Geographically focused firms were all aware of the extensive expansions within their markets, especially by large and geographically dispersed firms like Humana, and UnitedHealthcare/PacifiCare. While regarded as a potential threat, firms were mixed on how much of an actual threat the new entrants and products posed. In most cases, their judgments were based on what marketing staff were saying. Entry with very low-priced products drew their special attention and concern. For example, one told us "one of our competitors has come in with a regional PPO at $7 that has comparable benefits to ours and we are concerned."

Humana's aggressive pursuit of enrollment with very low-priced products was something many firms were paying close attention to. One firm told us "It sounds risky what Humana is doing, however they are gaining ground in [our state]. I think they are doing well with beneficiaries who feel they can't afford anything and fear they will lose their homes because of drug costs. They offer an inexpensive PDP tied to a PFFS plan." But this firm also suggested that some providers are now turning PFFS patients away and questioned how beneficiaries would be affected with the new plan lock-in requirement.

Firms were reluctant to be too forthright about the profitability of diverse products both for competitive reasons and because CMS requirements call for equal profitability. For the most part, firms said they did not expect all products to be equally profitable, although they said there must be some profit in each. They characterized the differences in profitability across products as "small." Those also offering Medicare supplements said that MA had the potential to generate more profits because it included a broader benefit package that integrated the Medicare benefit.

2. Special Case: Drug Coverage in PFFS Plans

Under the MMA, Part D coverage is optional for PFFS plans. However, many PFFS plans offer an integrated drug benefit. We speculate that firms doing so viewed it as enhancing their competitive edge in MA where all the other products included drug benefits and/or as a feasible addition if firms were already sponsoring (and therefore designing) drug plans. We talked with firms that had decided not to integrate a drug benefit about their decision. In one case, the firm introduced both a geographically diverse PFFS product and a nationwide PDP. It said that it faced an aggressive timeline and "frankly didn't have the time to get a prescription drug plan integrated into [its] PFFS." However, it also noted that the particular PFFS product offered targeted those with Medigap, most of whom did not have a current Medigap supplement with drug coverage. Allowing these beneficiaries to separately purchase a PDP could give them greater flexibility to choose their own medical care provider. Although separate, the firm's PFFS and PDP plans were offered through a common network of brokers, the sole distribution channel for the PFFS plan. Beneficiaries could then put together a package of the firm's products that spanned the full spectrum of Medicare benefits if they wanted.

In another instance where a PFFS plan was offered without a drug benefit, the firm said that its parent company also had an affiliated PDP. The MA division would have liked to integrate prescription drugs into the PFFS plan directly, but the company decided that doing so would be too risky because of the differences in the structure of risk-sharing in integrated MA-PDs versus PDPs. As we understood their explanation, drug coverage under an MA-PD and PDP have features offering financial protection if an individual uses many services (that is, exceeds the coverage gap and therefore qualifies for catastrophic benefits for which Medicare bears the financial risk). However, free-standing PDPs are able to develop further risk-sharing arrangements with CMS that limit both their up- and down-side risks within a corridor. This means that although firms that decide *not* to integrate prescription drug coverage into their MA lose the financial advantage of offsetting Part D premiums with the MA capitation payment, the firm, by choosing to go with a PDP, bears less financial risk of exceeding anticipated costs for a new and relatively unknown drug benefit.

3. Special Case: Prescription Drug Coverage Design in Delivery-Based HMOs

HMOs that base their systems on integrated delivery networks (for example, Kaiser-Permanente and Group Health Cooperative of Puget Sound) said that the design of the Medicare drug benefit posed special challenges and had a large impact on their firm. If their prior benefit packages included a generous drug benefit—as did some in particular areas of the country—Part D meant that "now they are getting paid for it." But CMS's standards for Part D coverage could be inconsistent with the way the HMO had historically provided drug benefits, not just for the

Medicare population but for all its enrollees. For example, one large firm said that it had worked hard to establish a high use of generics, with both patients and physicians cooperating and receiving in turn unlimited generic coverage. Nevertheless, 75 percent of its drug costs were still in brand name drugs despite what it said was an 80 percent generic utilization rate. Medicare Part D guidelines required the firm to add more brand name coverage to their formulary. To accommodate these costs, the firm had to limit the extent of generic coverage. Members experienced with that benefit perceived the change as taking away some of their prior benefits. The introduction of Part D also required that the firm be more careful in covering very expensive drugs, some of which may have been previously covered under Part B. Concerned that some of their MA enrollees might not now be able to get drugs that had previously been covered, the firm is seeking a waiver to reinstitute the earlier coverage.

In-house pharmacies were another issue for delivery-based HMOs, many of which rely heavily on their own in-house pharmacies and use the scale of that operation to negotiate good rates with pharmaceutical companies. Firms told us that CMS set a very high threshold for allowing waivers to the "any willing pharmacy" requirement in Part D, only allowing the waiver for firms that have 98 percent of their prescriptions filled by the in-house pharmacy. Some systems were able to meet this requirement but others were not, even if they relied heavily on an in-house pharmacy (for example, had 95 percent of their prescriptions filled in-house). One firm specifically noted problems in negotiating contracts for pharmaceuticals for its enrollees in long-term care.

The changes introduced by Part D caused one firm to rename all of its products in 2006 because it wanted enrollees to know that "what many have had for 30 years is not what they have now." But another said that it has taken a very conservative approach to its MA-PD offerings by limiting the changes introduced in 2006 to provide more time to see how the market will evolve. Based on feedback from the firm's consumer council, it offered only the standard Part D benefit in 2006, with co-insurance rather than co-payments out of concern that the latter might result in high beneficiary costs. Several firms offered only one benefit plan because they were fearful that doing otherwise might fragment their risk pool and lead to adverse selection. Some firms told us that they also wanted to make as few changes as possible because of all the general confusion around the PDP benefit. However, Part D required all plans to make changes.

Group accounts are a particular concern for delivery-based organizations as enrollees "age in" to become Medicare-eligible. One firm said that 45 percent of its Medicare members are part of employer groups. It spent a lot of time helping employers decide how to structure their retiree benefits in 2006. They said 95 percent of their group accounts opted for the Part D direct subsidy (and wrap-around coverage) rather than the employer subsidy since the former proved to be more advantageous to the employer. This does not appear to be the experience of other firms, although most said the situation might change in 2007 when employers have more time to analyze their options.

4. Product Distribution and Marketing

Particularly with new or modified offerings, beneficiary education and enrollment was key for all firms. Commitment to spending in this area appeared to vary across firms, locales, and products, and with the enrollment goals and position of particular products in particular markets. Firms were markedly unwilling to describe the relative amounts spent on or yielded by each

source, viewing such information as an important proprietary fact about their operations. However, all clearly devoted substantial attention to these issues in 2006 and used a variety of outlets to do so. All firms made some use of direct mail, seminars, telemarketing, and media (especially TV advertising, which they viewed as expensive but effective.) One firm sponsored a 20-minute concert with Tony Orlando to encourage product enrollment. Another had agents in-house at Wal-Mart. Firms said they also responded to referrals they received from the CMS Website or other neutral sources, with at least one (which was particularly low-priced) indicating they got a surprisingly large amount of referrals from the CMS Website. Some firms did "kitchen table sales" by responding to consumer expression of interest with an in-home visit. Others said they were leery of such strategies because they have historically left firms vulnerable to complaints or investigations.

Brokers and agents appear much more involved in MA in 2006 than they were perceived to be in prior years. This is particularly true with respect to external brokers or agents (as distinct from the firm's internal sales staff). External agents appear more important in 2006 for several reasons. First, many firms are introducing products across broad areas of the country. Agents provide an established channel for reaching beneficiaries. Second, agents have long been a key distribution channel for Medicare supplements. This made them obvious channels for selling free-standing PDPs that would complement the firm's Medigap products. Firms seeking to attract individuals to switch from Medigap to an MA-PD also used this established channel. In some cases the same firm was offering Medigap and an MA alternative so the combination also made sense for that reason. Third, the way brokers are paid gives them an incentive to enroll people, which is attractive to firms seeking enrollment growth. Firms are allowed to pay brokers a commission for each member enrolled. We heard at least two reports that firms were giving bonuses or paying particularly high rates in individual markets to encourage brokers to enroll beneficiaries in their product, making it more difficult for other firms to compete for members. And fourth, brokers can reach people who may not be reached through other firm channels, allowing firms to expand their MA reach. This could have been especially important in 2006, given the intensity and duration of enrollment activity expected.

Some firms do not use external brokers. Local firms may not need them if they have a large and well-known market presence. They may also find it more efficient to hire their own staff in order to gain more control over the marketing practices and message used to attract beneficiaries.

The concentration of marketing and enrollment efforts over a brief period in 2005-2006 was a concern for all firms. Many talked about the large amount of resources they had to devote to answering questions both from their own enrollees and potential new ones. Firms with in-house agents were concerned about the burden and inefficiencies associated with the concentrated time for enrollment. Most firms volunteered that they were going to extend their MA marketing through the end of June since regulations allow them to continue to enroll new MA enrollees either as MA only or as MA-PDs that are converting from other prescription drug plans. They also cited plans for ongoing enrollment of beneficiaries newly aging into Medicare who are potentially a prime target for the MA market.

Although we focus here on channels used to reach potentially new enrollees, firms also described extensive efforts to educate their current enrollees on the 2006 changes. Firms were concerned with retaining current members by trying to minimize confusion resulting from the introduction of the new drug benefit. In particular, they wanted to avoid inadvertent

disenrollment by individuals who did not realize they did not have to sign up with a new plan to receive drug coverage and that doing so was likely to result in automatic disenrollment from the MA plan. They also did not want to lose current enrollees in group plans that might be converting to an individual Medicare product.

E. FIRM EXPERIENCE WITH THE 2006 ENROLLMENT PROCESS AND PLANS FOR 2007

Firms appreciated the pressures on CMS and the Agency's efforts to collaborate. However, it had also been a very demanding year for them, as they noted—the new drug benefit detracted from the energy that the firms and CMS could devote to the MA sector. Part D issues, typically more acute in PDPs, also affected MA. Firms were also especially concerned that it has been so difficult to reconcile their MA enrollment with CMS, generating financial losses and fears that some current enrollees could be inadvertently disenrolled because they were confused and enrolled in a PDP.

Firms were hesitant to share their upcoming 2007 plans fully, and also noted concerns over what the 2007 payment rates may mean. The discussions suggest the following for 2007:

- Substantial continued growth of PFFS
- Refinements in benefit structures and pricing for existing products
- Modest, if any, growth in regional PPOs
- Potential Medical Savings Account (MSA) products
- No expansion in local PPOs because of the moratorium and limited, if any, expansion in HMOs for the general population
- Continued development of SNPs and other specialized products

1. 2006 Experience with MA Enrollment

Firms went out of their way to note their appreciation for the interest CMS has shown in working with them, and to recognize the pressure this has undoubtedly placed on CMS staff. At least one firm volunteered that CMS needs more staff (while also showing appreciation for the hours CMS staff have dedicated to this assistance).

Firms noted that it had also been a very demanding year for them; some of this they considered inevitable, given the scope of changes to the MA program. The new prescription drug benefit, in particular, placed demands on their systems. Although the issues may be more extensive in the PDP sector, the introduction of the drug benefit also placed demands on MA plans. Some firms felt that CMS's call for firms to commit extensive (and unbudgeted) resources to staff telephone help lines for more time than originally requested was unfair and at times unnecessary. But they also described the extensive resources they had voluntarily committed to addressing high volumes of calls. Some firms also were concerned with what they

viewed as micro-management of the formulary and Part D benefit; they characterized this as the "Medigapping of Part D" in light of the proposals to promote product uniformity.

Many said that getting PDPs up and running detracted from the energy both the firms and CMS had to devote to the MA sector. At times, it was hard to distinguish demands of PDPs from those of MA since there can be substantial overlap. Firms suggested that CMS needs to "stay focused" on the core challenges of this extensive set of program changes, and continue to reach out to industry. They also commented on the burdensomeness of ongoing problems that have been of concern in the past and continued into 2006. For example, CMS might give them last-minute guidance related to bids well under development. In addition, issues related to review of marketing materials still exist—one firm, for example, said a radio ad was rejected for not having at least a 12-point font in its script.

Firms were particularly concerned that it has been so difficult to reconcile enrollment figures with CMS in 2006.[15] Firms said they had not yet been able to determine with any degree of certainty the precise number of enrollees in their plan. Firms were more confident in their ability to identify new enrollees than to monitor disenrollment, which requires obtaining information from CMS. Sorting out enrollment of low-income beneficiaries who might appear on multiple plan lists appeared particularly challenging. The plans we talked to said the numbers involved were small (although they may be larger for other firms) but they consumed a disproportionate amount of attention because of the difficulty of reconciliation. Firms were concerned that the new systems CMS had established for this purpose were not up to the challenge. They did not discuss in detail the ongoing work with CMS to resolve enrollment issues, but said they are devoting resources to working with CMS on this operational issue. They noted concern about how long it has taken to reconcile these processes, which also means a delay in reconciled payments.

As noted previously, a big issue for many firms was retaining current enrollees, most of whom were in HMOs. Some firms say they have seen little erosion in their core MA members; others say that there has been some erosion as individuals either are confused or as they disenroll from an HMO they may have joined mainly to get the drug benefit. Firms tended to think most disenrollment resulted from confusion and were concerned that CMS's regulations limited their ability to address such concerns directly with members. Traditional HMOs have most MA enrollment now, and a number of firms with long histories in the program were very concerned that CMS was automatically disenrolling their members if they joined a PDP without allowing them any contact to make sure this wasn't an error. (Firms are not allowed to contact an enrollee unless the enrollee contacted them first in response to the disenrollment letter, they told us.)

Two of the firms we interviewed were new to MA in 2006. One had introduced an MA PPO to counter a perceived softening of its Medigap enrollment. Although its implementation plan was progressing, the firm cautioned that firms need to have their "eyes open" and know that CMS is a very demanding client.

---

[15] Firms also raised other issues, including (1) the oft-noted challenge of inconsistency between national and local coverage determinations, and (2) CMS's newly designed Website (www.cms.hhs.gov), which was frustrating to staff who had identified favorite pages on its previous Website and now had difficulty finding material.

2. Strategies for 2007

Our interviews were conducted after firms were required to submit their 2007 intent to bid notices (due March 20, 2006) but were completed by early May 2006, about a month before firms had to submit bid amounts. Some interviews, including several with large firms, were conducted before the April release of the final 2007 MA rates by CMS. While most of the others were conducted after the April release, firms had not necessarily had time to fully analyze the rates in relation to their particular firm and markets. Both the timing of the interviews and the natural reluctance of firms to reveal decisions not yet public or still in the process of being made, limit what we can say about firm's 2007 plans.

Nevertheless, many firms were forthcoming about the changes they had underway. Further, while the notice of intent to bid may be a placeholder, it at least defines the limit of bidding. (That is, firms are limited to the kinds of new products or expansions provided in the notice of intent.) We thus learned something about what might be expected in 2007.

Many of the firms we talked with were planning to refine their products in 2007 to position them better in the marketplace (to the extent needed). Some were also considering additional expansions in 2007, as both a continuation of a growth strategy and a means of responding to the evolving marketplace. Firms acknowledged that they would be making decisions in the absence of information on their 2006 experience. They expressed frustration that CMS had not made available better enrollment data to assess the competition. They would have liked to have more experience but seemed to accept that the MA timeline was just part of the way the Medicare marketplace worked—although they noted that CMS should continue to provide as much advance notice as possible.

In our discussions with firms prior to the release of the final 2007 MA rates, several were particularly concerned that the phase-out of the "hold harmless" clause in risk adjustment—combined with CMS's recalibration of risk adjusters—would result in major reductions in both MA payment rates and the effective rate of increase in these rates for 2006. They felt they would have to balance the risks of expansion with those of being left behind as others expanded, and rates were viewed as critical to such calculations because of their influence on expected revenues.

The firms we talked with after the release of the 2007 MA rates varied in their reactions, although this could be because they had not had enough time to fully understand the implications of the rates. While some said that the results were not as bad as they had feared, it seemed that more firms were concerned that the 2007 rates would jeopardize the progress made since passage of the MMA. Firms with a long history of program participation that had decided to reduce premiums or expand benefits in 2006 expressed concern that they might have to announce a reversal of these enhancements just a few months later, and suffer adverse beneficiary reactions. They were particularly concerned that the CMS announcement made it sound like plans would be getting a relatively generous increase (based on the announced growth factor), whereas with the other adjustments it would be much lower. (According to CMS, plans would receive a 1.1 percent rate increase on average, but some firms said the actual rate of growth would be negative.) Firms seem to have taken the M+C experience to heart—given their experience with the backlash against managed care, they were concerned that beneficiaries would view them as taking advantage of the program.

We do not know the decisions that firms ultimately made and what they included in the bids submitted in early June 2006. From our interviews, what appears most likely to expect in 2007 is the following:

- ***Substantial continued growth of the PFFS product.*** The entry costs are low and these products have advantages to firms seeking to shore up their Medicare supplemental market or take advantage of the opportunity to attract new enrollees who have already chosen a private PDP. Some firms said they were dubious of the viability of PFFS in 2006 but were re-examining their decisions in light of the strong interest expressed by competitors in such products. Some PFFS expansions could be relatively broad geographically. However, we are uncertain what effect the final rates will have on the strategies firms sought to execute before this information was released.

- ***Refinements in plan benefit structures.*** Firms have assessed where their decisions led them in 2006 and are making adjustments in 2007. They talked of adding specific benefits (for example, dental care, worldwide travel benefits, or an out-of-pocket limit on PFFS in response to broker preferences). Several firms said they were going to price a specific product in their portfolio less conservatively in 2007 since their current product was not competitive. For example, they might downwardly revise utilization assumptions based on their 2006 experience. Others said they would correct internal misalignments across premiums or benefits in their full set of Medicare-related product lines, particularly to make PDP and MA-PD drug benefits comparable in similar products. Obviously too, all firms were reexamining the benefit structure and pricing of their plans in response to the announced 2007 MA rates. Many seemed to want to retain stable offerings but were uncertain whether they could do so with the new rates.

- ***Modest if any growth in regional PPOs.*** Firms that were unable to fully develop their products in time for 2006 may submit them in 2007. National firms did not want to reveal their 2007 strategies in our discussions so we do not know what they plan.

- ***Potential Medical Savings Account (MSA) products.*** We did not query firms about their interest in offering MSAs in 2007 because these products have to-date been absent from the marketplace, even though the MMA renewed authority for such products. However, we learned that one firm was actively exploring this option and that CMS had convened a conference call with at least 13 organizations to discuss outstanding issues.[16] Hence, firms may introduce MSA products in 2007.

[16] The firm we talked with had experienced difficulty in getting CMS to focus on issues associated with the viability of this product. For example, it said that CMS wanted the plan (not the agency) to deal with the subsidy, and that this could include retrieving funds advanced in a year when a beneficiary died. The firm felt this put it in an untenable position. It was also concerned that competing demands for CMS attention might make it unfeasible to launch the MSA product, despite the firm's serious interest in it.

- ***Few additional HMOs or expanded service areas (unless they are related to Special Needs Plans).*** Firms seem to have signaled that the existing market appears to them saturated, at least in areas that can well support such plans. In many markets, PPOs rather than HMOs are a more appealing product to beneficiaries because they respond to an interest in provider flexibility. However, the HMO product continues to dominate demand in some highly penetrated major markets.

- ***No expansion in local PPOs.*** Because of the moratorium, firms are prohibited from expanding their service areas or adding new products until 2008. They may, of course, plan to more aggressively market the product and add enrollment in 2007.

- ***Continued development of SNPs and other specialized products.*** Although we did not focus heavily on SNPs in our firm discussions, several firms noted ongoing efforts to introduce SNPs in specific local markets. Whereas 2006 offerings typically favored SNP products designed for dually-eligible beneficiaries, 2007 offerings may provide a more mixed set of plans targeted at other special needs beneficiary subgroups, as firms will have had more time to develop specific arrangements with the providers and clinical processes needed to support such products.

F. LONG-TERM PROSPECTS AND CONCERNS

> Most firms were clear that program stability was important to them, as were rates that were predictable, with stable increases. They provided mixed feedback on their commitment to the MA market. While they say they are committed to the market, they also typically indicated that they would need to make decisions should experience prove unfavorable over time. Aside from stability, firms also wanted some advance notice of changes. They said, for example, that SNPs interested them but that they might be reluctant to offer new plans in 2008 without timely action on reauthorization (which runs out after 2008). Firms wanted a partnership with CMS and had various additional suggestions for MA program improvement.

Most firms were clear that program stability was important, as was rate stability. They want government to be a good partner, with predictable, stable policies, and providing as much advance notice of change as possible. One firm observed that rate instability had historically yielded tremendous variability in MA premiums and benefits, making it hard to meet Medicare beneficiaries' interest in product (and premium) stability over time.

Firms provided mixed feedback on their commitment to the MA market. On one hand, they indicated that they were in it "for the long run" and would judge their experience on a multi-year basis. They said withdrawal was unpleasant for both firms and beneficiaries, and that they sought to pursue products only when they perceived they had potential for long-term success. The aging of the baby boomer generation also made developing further products for seniors attractive. On the other hand, firms also noted that their Medicare products had to be profitable in both the short and long term. While there could be some variability in profitability across MA products, each was generally expected—at least over time—to make a positive contribution to the balance sheet. In some cases, the products they were offering in MA gave firms the flexibility to raise premiums or reduce benefits in response to fiscal concerns without completing

withdrawing from a market. However, they also said that if they had to, they would withdraw particular products or exit particular markets.

Firms also had particular concerns and suggestions for program improvement. One concern involves the sunset of SNPs after 2008. While there is interest in this product, firms say uncertainty about its future could make them reluctant to propose new SNPs in 2008, with only a year's authorization remaining. They are hoping that this reauthorization issue will be resolved sooner rather than later.

Other suggestions included (1) making it easier for small firms to compete by allowing new entrants twice rather than once a year, so that workload could be balanced; (2) creating a fall-back plan when firms could not get hospitals to cooperate; (3) continuing work on frailty adjusters and risk adjustment coding; and (4) revising the open enrollment period to support smoother operations by allowing enrollment at the same time marketing begins each year (October 1st) and closing open enrollment by December 15th so that there is time to process claims before the start of the new year.

This page has been intentionally left blank for double-sided copying.

VII. CONCLUSIONS

The growth in MA contracts in 2006 has made MA more available across the country, including in areas where such contracts were previously absent or limited. Beneficiaries also have more contracts to choose from in 2006. To the extent that the MMA sought to enhance the availability of more coordinated care options for a greater number of beneficiaries, the results are mixed. HMOs and local PPOs are available to more beneficiaries in 2006 than 2005, but geographical concentration persists and there has been less activity in this sector than others in MA. For the most part, the availability of regional PPOs and PFFS contracts is responsible most for the increase in MA availability nationwide, especially in rural areas. Because of the growth of PFFS contracts, regional PPOs cannot be credited, at least directly, as the sole or even predominant driver of expanded choice.

Although many firms participate in the MA market, a small number dominate. The decisions of these firms have a major influence on the MA marketplace. Regional PPOs, for example, would be far less available had Humana not decided to enter 14 of the 26 MA regions. Decisions by Humana and PacifiCare in 2006 also had a disproportionate influence on the PFFS market.

HMOs still account for most MA enrollment. However, while HMO enrollment continues to grow, other products—especially PFFS—are driving much of the current growth in MA enrollment. Preliminary indications are that PFFS enrollment will exceed PPO enrollment in 2006. In contrast, regional PPOs, although available, have not yet proven their viability in the market and current enrollment is very limited. PFFS enrollment is particularly strong in counties benefiting from urban or rural floor payments, which raise rates above what they would otherwise be in the traditional Medicare program.

Although we focused on MA, we heard from firms that they devoted more attention to developing free-standing drug plans than MA in 2006. Such plans are more popular than MA plans that integrate prescription drug coverage, at least in 2006. Yet the analysis also shows that firms are actively pursuing MA in 2006 and are likely to continue to do so in 2007. Much of this appears driven by the opportunities created by the MMA, which both increased MA payments and made it more likely beneficiaries would consider MA by making them have to consider a private plan option if they desired a drug benefit. The MMA positioned MA firms to compete well in this marketplace by paying rates that exceed traditional Medicare program costs and allowing firms to use these funds—to the extent they have savings in delivering the Part A/B benefit—to expand Part D benefits and/or offset the beneficiary premium for such plans, as well as to support other attractive benefits. Floor payments sought to provide a cushion for firms in markets where MA has historically had the most difficulty thriving.

What these trends mean for Medicare is unclear. While beneficiaries have more choice, it appears the main expansions have given them more choice of essentially fee-for-service options—either directly through PFFS or indirectly through regional PPOs that use the same techniques in parts of their service area. This trend may provide limited opportunity for government to capitalize on private plan's ability to offer health plans with more care management potential than the traditional Medicare program. In many cases, these products take

advantage of Medicare's negotiated rates. They therefore may not improve Medicare's rates or utilization, and if they grow they could reduce the current market ability Medicare has to negotiate rates. In addition, to the extent MA enrollment grows disproportionately in floor counties, the outcome also could be expensive for Medicare because such payments are higher than what Medicare would otherwise pay in the traditional program.

It also is not clear that expanded choice will be stable over time. Regional PPOs have not yet proven themselves and may not prove to be viable in the marketplace. Local plans, particularly those with less management potential, may only be attractive because Medicare is paying above market rates to support them. Firms are likely to either exit or substantially reduce their benefits if payment levels erode. Lacking networks, PFFS plans are particularly easy to drop. To the extent firms in MA respond by raising premiums and reducing benefits, MA expansion could lead to an integrated MA/supplement package but may not make such coverage more affordable than the current combination of Medicare and Medigap.

In sum, the Medicare market has changed in 2006 but whether such changes are fundamental and, if so, how, remains to be seen.

REFERENCES

Berenson, Robert. "Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field'." *Health Affairs,* December 15, 2004. Web Exclusive.

Blue Cross and Blue Shield Association. "2006 Medicare Advantage and Prescription Drug Plans Offered by Blue Cross and Blue Shield Plans." Washington DC: Updated November 18, 2005.

Centers for Medicare & Medicaid Services. "More Than 27 Million Medicare Beneficiaries Are Enrolled in Prescription Drug Coverage." Press Release, March 23, 2006. Available at www.hhs.gov/new/press/2006pres/20060323.html.

Centers for Medicare & Medicaid Services (CMS). Special Needs Plans: Fact Sheet and Data Summary. February 14, 2006 (www.cms.hhs.gov/SpecialNeedsPlans/Downloads/finalSNPfactsheetsummary2-14-06.pdf).

Centers for Medicare & Medicaid Services. Press Release, June 30, 2005. Available at [www.cms.hhs.gov/media/press/release.asp?Counter1497].

Centers for Medicare and Medicaid Services. "Medicare Chartbook 2005." Baltimore, MD: CMS, 2005.

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

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

Gold, Marsha. "The Landscape of Private Firms Offering Medicare Prescription Drug Coverage in 2006." Washington, DC: Kaiser Family Foundation, March 2006b.

Gold, Marsha. "Private Plans in Medicare: Another Look." *Health Affairs,* September-October 2005.

Gold, Marsha. "The Medicare+Choice Program: An Interim Report Card." *Health Affairs,* vol. 20, no. 4, July-August 2001, pp. 120-138.

Gold, Marsha, Lori Achman, Jessica Mittler, and Beth Stevens. "Monitoring Medicare+Choice: What Have We Learned? Findings and Operational Lessons for Medicare Advantage." Washington, DC: Mathematica Policy Research, Inc., August 2004.

Gold, Marsha, and Lindsay Harris. "Profile and Analysis of the 26 Medicare Advantage Regions." Washington, DC: Kaiser Family Foundation, 2005.

Kaiser Family Foundation. "Medicare at a Glance—Fact Sheet." Washington, DC, April 2005.

Medicare Advantage News. "Blues Alliance Fails to Meet Enrollment on Regional PPO, but Its PDP Is Doing Well." March 23, 2006.

Medicare Payment Advisory Commission (MedPAC). “Report to Congress: Issues in a Modernized Medicare Program.” Washington, DC, June 2005.

Medicare Payment Advisory Commission. “Report to Congress: Medicare Payment Policy.” Washington, DC, March 2004.

Medicare Payment Advisory Commission. “Report to Congress: Medicare in Rural America.” Washington, DC, June 2001.

APPENDIX

This page has been intentionally left blank for double-sided copying.

Table A.1. Medicare Advantage in Puerto Rico, 2005-2006

	March 2005	December 2005	March 2006[a]
Number of Beneficiaries	611,993	620,287	620,287
Number of MA Enrollees	102,580	181,505	NA
MA Penetration	16.7%	29.3%	NA
Contracts[b]	4	9	13
Local HMO	3	6	9
Local PPO	1	2	2
Local PFFS	0	1	1
SNP[c]	0	0	6
Other	0	0	1
Enrollment	102,580	181,505	NA
Local HMO	99,940	170,890	NA
Local PPO	2,640	10,588	NA
Local PFFS	0	27	NA
Other	0	0	NA

Source: MPR analysis for publicly available CMS data, selected Months. Geographic Service Area Report (for March 2005-December 2005). 2006 contracts are from the November 2005 release of the Medicare Personal Plan Finder.

NA = Not Available

[a] Based on January 2006 data as March 2006 data were not yet available and new contracts generally are approved in January of each year.

[b] The totals may not match the sum of the rows because SNP plans are not necessarily approved as unique contracts. Many SNPs are plans that are offered under contracts approved for the general population (e.g., HMOs). Contracts which have an SNP plan were identified through an indicator developed using January 2006 SNP data. Total contract numbers reflect unique contract numbers (i.e., total contracts only count SNP contracts if they are not already counted through contracts included in other contract types.)

[c] Excludes SNPs that are not affiliated with contracts included in the September 2006 health plan finder. CMS' February 14, 2006 Fact Sheet on SNPs indicates that on January 1, 2006, there were 164 MA contracts that offered one or more special needs plans in 42 states and Puerto Rico including 20 demonstrations, 23 local PPOs and 3 regional PPOs.