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Looking at Medicare Advantage: What Has Happened Since the Launch? What Will Happen in the Future?

Final Report Revised

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EXECUTIVE SUMMARY

REPORT FOCUS

This report presents the findings from our study of how the Medicare Advantage (MA) program has evolved over the first three years of its existence, building on our previous study of the initial transition to MA in 2006.[1] Its intent is to use public data sources and discussions with firms to gain insights on how the market has evolved; we use only public sources because only that data is readily available to researchers who are not conducting projects for the Centers for Medicare and Medicaid Services (CMS). The project was developed under contract with the Office of the Assistant Secretary for Planning and Evaluation (ASPE). While there are many relevant policy issues that relate to the evolution of the market, this project focuses more on describing and analyzing key trends and the issues they bring to the fore, rather than on analyzing ways to address these issues or making recommendations for change.

DATA SOURCES AND METHODS

Four kinds of analyses, three quantitative and one qualitative, form the basis for the findings presented in this report. The former are based on data publicly released by CMS. Enrollment data for the most part reflect enrollment in March of the respective year (2005-2008).

- ***Plan Availability and Enrollment.*** We analyzed information on the number and characteristics of available MA contracts and sponsors, which contract types are offered, and how these differ across the country. We also examined how enrollment was distributed across these contract types, sponsors, and MA in general, as opposed to specialized MA plans (SNPs, group plans), and the relationship between county enrollment and payment rates.

- ***Benefits and Premiums.*** We also examined how benefits and premiums in MA plans are structured, how they differ by type of plan, the trends that exist, and what they imply for beneficiary out-of-pocket costs.

- ***Quality of Care.*** We analyzed how MA contracts performed on publicly reported quality measures. This part of the analysis was based on Health Effectiveness Data and Information Set (HEDIS) measures and data from the Consumer Assessment of Health Plan Surveys (CAHPS). While the other analyses for this report reflect 2006-2008 data, this particular analysis is less current because of lags in the way such data are collected and reported.

- ***Firms' Perspectives and Decision Making.*** We held telephone discussions with a cross-section of participating MA firms of different types, so as to understand better

[1] Gold, Marsha and Stephanie Peterson. "Analysis of the Characteristics of Medicare Advantage Plan Participation" Washington DC: ASPE/HHS, July 2006.

their rationale for participating, the structure of their MA product offerings, their experience with participating in the program, and their most salient policy concerns.

The analysis excludes Puerto Rico and the Territories, so the figures reported are not the same as those in CMS's monthly summary report. The analysis of plan availability and enrollment includes both contracts specifically authorized under MA and others (cost, HCPP, PACE and others including demonstrations) that are not part of MA but part of the private plan choice set available to beneficiaries who likely do not distinguish them from the choices available specifically under MA.

KEY FINDINGS

What has happened with respect to plan availability (*Chapter II and III*)?

- MA has proven very popular with private sector sponsors. In 2008, virtually all Medicare beneficiaries have access to a large number and wide range of MA products, including 82 percent with access to PFFS plans from six or more sponsors.
- While Congress sought to use regional PPOs to enhance availability of choice and enrollment in MA, such offerings appear to have very little traction in the marketplace. After the first year of RPPO availability (2006), there has been little expansion in offerings, and enrollment while growing, remains limited.
- More beneficiaries have access to HMOs and local PPOs in 2008 than in prior years (78 percent and 62 percent respectively), and also access to more firms sponsoring contracts of each type. However, offerings in rural areas remain more limited than for urban areas, and there is still substantial diversity in available choices across the country.
- In 2007, the first Medical Savings Account (MSA) plan was introduced. Due largely to the interest of WellPoint in offering such a product, virtually all beneficiaries had access to MSAs in 2008, although enrollment so far remains very limited.

How have expanded offerings influenced enrollment and market penetration (*Chapter IV)*?

- Under the MMA, MA enrollment has well surpassed enrollment at its previous peak in 1999, prior to erosion under Medicare+Choice. In March 2008, more than 1 in 5 Medicare beneficiaries (21 percent) were enrolled in an MA or similar private plan, and received Part A and Part B benefits (and often Part D) through that plan.
- MA is geographically "touching" beneficiaries and providers in more parts of the country. Only 7 states had fewer than 5 percent of beneficiaries enrolled in 2008, versus 24 in 2005. Rural penetration increased four-fold—from 3 percent to 12 percent—although it remains substantially below the rate in urban areas (24 percent).

- There are signs that enrollment from group accounts is gaining importance in the MA market. A recent data release shows group enrollment growing 60 percent in the two year period from 2006 to 2008 in contrast to a 20 percent growth in MA overall.[2] While groups always have had a role in the MA market (as an HMO option for some retirees),the current growth in MA enrollment appears, from our firm discussions, to be driven by groups using PFFS offerings to replace traditional retiree benefits for Medicare-eligible group retirees. This is happening unevenly in different parts of the country.

Which sectors of the MA market are driving the market and growth in enrollment (*Chapter IV*)?

- PFFS growth is behind much of the increase in MA enrollment. It accounts for more than half of the growth in enrollment under MA, with a penetration rate of 4.5 percent in 2008. Of rural beneficiaries in MA, 57 percent are in PFFS plans.

- PFFS growth is based much more extensively in "floor" counties than other forms of MA, even though enrollment in rural floor counties has become a smaller share of the total in 2008, compared to 2005. In 2008, 42 percent of PFFS enrollees were in urban floor counties and 30 percent in rural floor counties.

- Among coordinated care plans, HMO enrollment continues to dwarf PPO enrollment in both local and regional PPOs, although local PPOs in particular are more available than previously, and enrollment is growing slowly.

- HMO enrollment has been influenced by the substantial growth of Special Needs plans (SNPs). It grew by 1.3 million between March of 2005 and 2008; more than half of this net change (0.8 million) reflects enrollment in SNPs.

- In 2008, SNP enrollment accounted for more than 10 percent of all MA enrollees, with most enrolled under HMO contracts, although many local and regional PPO contracts also offer such plans. (PFFS is precluded from such offerings.)

Has MA attracted additional firms to the MA marketplace (*Chapter V)*?

- While a small number of firms still account for a disproportionate share of contracts and enrollment, there is less concentration than in the past—at least in the short term—as MA has attracted additional sponsors that previously had only a limited presence in the market.

- In 2008, more than half (52 percent) of all MA enrollees participated under contracts affiliated with just four national firms or affiliates: UnitedHealthcare/Secure Horizons, Kaiser Permanente, Humana, and firms affiliated with Blue Cross/Blue

[2] Medicare Payment Advisory Commission. "Section 10. Medicare Advantage" *A Data Book: Health Care Spending and the Medicare Program* Washington DC: June 2008.

Shield. This share is down from 59 percent in 2005, a difference that would be greater were it not for the substantial expansion by Humana since the MMA was enacted.

- Firms such as Coventry and Universal American have moved aggressively into the MA market by acquiring firms with a limited base of coordinated care enrollment, and using PFFS to expand to national scope. WellPoint's expansion builds almost exclusively on PFFS and MSA contracts, which the firm also offers nationwide.

- Firms such as Aetna and Cigna, which reduced their MA offerings substantially in the early 2000s, have begun a cautious expansion of their products.

- The SNP market is less concentrated and, (with the exception of UnitedHealth/Secure Horizons), its sponsors draw from a broader spectrum of firms (see Chapter VI).

Within the marketplace, how "competitive" are the benefits and premiums of MA plans (*Chapter VII*)?

- Firms offer a range of MA plans to suit the interests of diverse beneficiaries. Characteristics of the average plan (unweighted by enrollment) show what beneficiaries are offered. In contrast, enrollment-weighted data incorporate the beneficiary response to available plans and what enrollees actually pay or receive. Both types of statistics provide policy-relevant information though our ability to examine the latter in this study was limited by the availability of data on enrollment at the plan level within counties. Because of these data constraints, the weighted analysis assumes that all contract enrollment in a county is in the "lowest premium" plan. (The findings below are based on unweighted estimates except where indicated.)

- MA-PD premiums typically are substantially lower than commonly reported premiums for Medigap coverage even though the latter commonly do not include prescription drug coverage. The mean combined premium (Part C and D after rebate) across lowest premium plans available for general enrollment in 2008 was $23 per month, and $45 per month for all MA-PD plans. (These data are unweighted for enrollment and reflect what the average plan offered rather than the actual premiums enrollees pay after taking into account the plans they join; the combined Part C and D premium is in addition to the Part B minimum monthly that all Part B enrollees pay, which was $96.40 in 2008.) For the drug coverage they provide, such plans also typically waive the initial deductible and use tiered payments. Some (but a minority) also provide partial coverage in the "gap."

- MA plans generally structure their cost sharing for Parts A and B differently from that of Medicare, but coverage for Medicare's cost sharing is less comprehensive than in the most common standardized Medigap plan designs. Roughly estimated, the mean lowest-premium MA plan within contracts would require $504 per year additional spending for hospital and physician services (in-network, if relevant, and excluding any Part D cost sharing). Because of the way they are structured, MA plans generate higher out-of-pocket spending at point-of-service for sicker patients. Among healthier patients, such costs average $157 across lowest premium plans of all types, but rise

steeply to $985 per year for those with more needs, and $2,268 per year for those with the highest needs. This means that MA plans are more competitive for healthier as opposed to sicker patients when compared against Medigap, although this comparison is relevant only for those beneficiaries with incomes high enough to give them the practical option of affording the premiums charged for Medigap plans. (These estimates of out-of-pocket costs apply cost sharing features of each plan to Healthmetrix's use assumptions for enrollees in three health status groups, a method further discussed in Chapter VII.)

- The limited data available suggest that those enrolling in MA from the individual market tend to be highly price-sensitive. Mean monthly premiums are substantially lower when weighted for enrollment. ($21 versus $23 respectively in 2008, with the spread larger within HMOs and PFFS plans.)

- As MedPAC (2008a) has documented, MA plans are able to provide more comprehensive benefits than traditional Medicare for limited or no additional costs to the beneficiary, at least in part because they are paid substantially more than Medicare would pay for the same beneficiary in the traditional program. Such spending adds to Medicare's total expenditures.

How different are the benefits and premiums across diverse contract types in 2008 (*Chapter VII*)?

- Among types of MA contracts, HMOs have the lowest combined Part C/D premiums on average ($12 per month in 2008 for lowest premium MA-PD HMOs, unweighted for enrollment), with 76 percent of contracts offering at least one zero-premium MA-PD. While it exceeds the mean HMO premium, the mean PFFS premium ($30 for lowest premium MA-PD PFFS) is substantially lower than those for local and regional PPOs ($46 and $48 respectively.).

- While HMOs are less likely to set a limit on out-of-pocket spending than other contract types, the mean out-of-pocket spending for hospital and physician services (implied by their benefit packages) still is lower for the average lowest premium HMO plan than for other plan types; this also is true for the sickest beneficiaries. While PFFS plans, on average, have lower mean expected out-of-pocket costs than local PPOs, the PFFS benefit structure means that the spread in these costs for healthy versus sick enrollees is much greater than for other plan types. RPPOs have the highest expected out-of-pocket costs, on average, as well as for beneficiaries within each category of need. (Out-of-pocket spending associated with prescription drugs and selected other services like home health care is not included in these estimates.)

- CMS's publicly available data impose limits in analysts' ability to compare benefit packages—especially cost sharing—for individual plans. For example, cost sharing features often are summarized and important qualifications about how they are applied or rules on exclusions associated with benefits may not be noted. Because such public data are created from the information used to support beneficiary choice, these limitations may also make it difficult for beneficiaries to understand fully how

their choice of plan may influence their likely out-of-pocket burden. (The Tool does provide advice on plans by beneficiary age, perceived health status, and current prescription drug use and ranks plans by estimated of out of pocket costs but this analysis also may not account for the kinds of details noted.).

Has the structure of benefits and premiums changed substantially from 2006 to 2008 *(Chapter VII)*?

- Our analysis uses both weighted and unweighted data on selected characteristics of lowest premium MA-PDs to address this question. The mean premium in an MA-PD increased between 2006 and 2007, but declined in 2009. A larger share of plans, but with a slightly smaller share of enrollees, offer zero-premium plans in 2008 than 2006 (assuming that enrollees select the lowest premium plans offered under a contract.)

- More plans include an out-of-pocket limit in spending in 2008 than in 2006, although the amount of the limit has increased during this period.

- A greater share of plans also are providing coverage in the "gap" in 2008 than in 2006, although our analysis, and those of others, shows that such coverage tends to be limited to select classes of drugs.

- Using the rough measures available to us, the estimated out-of-pocket costs for hospital and physician cost sharing (whether weighted by enrollment or not) declined between 2006 and 2008. PPOs, particularly regional PPOs, are notable exceptions.

What do public data show about the quality and performance of MA (*Chapter VIII)*?

- Because of data lags and differences in reporting requirements across contact types, HEDIS measures of quality are much more readily available for HMOs than for other MA plan types, although incomplete reporting occurs across all plan types, as described further in Chapter VIII.

- Performance on HEDIS measures varies substantially across the measure set in ways that do not necessarily fit clear patterns by measure type. Performance tends to be higher on process than intermediate outcome measures.

- In general, reporting and performance on HEDIS measures of quality are higher under contracts having a longer experience with the program. Among the five largest firms and affiliations, there is substantial variability across contracts within each firm as well as across firms. The limited reporting by PPOs provides some evidence of lower performance on indicators associated with chronic conditions, although many caveats apply to the findings (especially given that lower performance tends to occur on "hybrid" HEDIS measures).

- HEDIS performance tends to be higher in larger contracts (i.e., contracts with more enrollees), so the average performance experienced by an enrollee exceeds that of the average contract.

- Between 2005 and 2006, average performance on HEDIS tended to stay the same or improve on most quality measures.

- Enrollees tend to rate their MA plans highly, according to our analysis of CAHPS data. In 2007, 86 percent of enrollees in the average contract rated the health care they received as 8 or higher on a 10-point scale, and 79 percent gave the same ratings for their health plan. (HMOs are more highly represented in the available data than other plan types.)[3]

- Cost contracts, which are authorized separately from MA and which the MMA seeks to phase out (assuming sufficient competition otherwise exists), score relatively high on both HEDIS and CAHPS indicators. Such contracts tend to be with large prepaid group practice HMO plans that have an infrastructure that facilitates care management. (The Medicare Patient Improvement and Protection Act of 2008 (MIPPA) extends authority for cost plans through 2009.)

- Because of the time lag and incomplete reporting for newer plans, publicly available HEDIS and CAHPS data now available through the online Medicare Options Compare Tool provide beneficiaries with limited insight into the variation in quality and performance among plans in the marketplace, particularly in terms of current performance, and for all contract types. However CMS has sought to make available data more useful to beneficiaries by incorporating five star ratings on composites that take into account comparative performance.

How do our discussions with firms enhance understanding of the market (*Chapter IX*)?

- Firms view the MA marketplace as highly competitive in 2008, both from a price perspective and because there are a large number of plans and products being offered. Firms have experienced challenges in differentiating their products. The growth of PFFS is viewed as driving much, though not all, of the growth in competition. Such competition likely is providing short-term pressure on firms to remain competitive in the premiums charged for their products and what those products cover. In the long term, however, firms say they need to break even or make a profit, which means that, if payments do not keep up with medical costs, they will raise premiums or reduce benefits to maintain margins.

- Firms view market segmentation across available MA, PDP, and even other supplemental products, as key to successful competition. They try to identify particular niches where they have a competitive edge, and use them to grow their business. They appear to view it as beneficial to offer many types of MA contracts and plans, rather than a few. While firms say that coordinated care options are more attractive to them, most are not actively transitioning beneficiaries from one contract type to another.

[3] The publicly posted data does not include information on PFFS plans though such data appear to be available internally at CMS since they are included in MedPAC (2008) analysis.

- Our discussions confirm the growing relevance of the group market to MA, although there is regional variation. Recent expansion in the group market appears particularly centered around PFFS products offered as total or near total replacement of a firm's existing retiree offerings for Medicare-eligible individuals. Growth is driven by cost and accounting pressures, the attraction to purchasers of an integrated retiree offering, and the active role some consultants play in encouraging the transition. Some coordinated care plans expressed a disadvantage in their ability to compete in the group market because of the limitations of network requirements and service areas; discussions held after CMS indicated it would be more flexible in applying the network requirements to group accounts showed that firms were considering taking advantage of such requirements. (MIPPA requires PFFS plans to develop networks beginning in 2011.)

- None of the firms we talked with saw RPPOs as currently viable in a market where their regional packages and premiums competed with local plans. For the most part, they saw this lack of viability as relatively difficult to modify through legislative refinement.

- Firms appear to be expanding local coordinated care offerings, both generally, and as a hedge against changes in the PFFS program. However, we have yet to find much evidence indicating that these strategies would result in the large-scale movement of enrollment. In fact, local HMOs appear to be encountering challenges in growing their enrollment, despite their expressed success in member retention. Current MA requirements—and the shape of the market—are viewed by many as limiting their competitive position; such indications are more implicit than explicit in their comments.

- The main attraction of SNPs appears to be their ability to allow firms to develop tailored benefit packages for subgroups of beneficiaries, although some offerings incorporate expanded care management. Firms generally seem to use SNPs in any of three ways: (1) to capture early information on beneficiaries with special needs; (2) as a learning laboratory for future changes in MA overall; and (3) as a source of new enrollment in a crowded marketplace. The discussions suggest that coordinating with states on care for dual eligibles will be limited both by variation in state interest and by the fact that some SNP sponsors do not view such engagement as an important strategy for their product development.

What are firms' perspectives on MA administrative and policy concerns (*Chapter IX*)?

- Most firms involved in discussions viewed their interaction with CMS as relatively positive, although they appreciated that MA's "high profile" was encouraging CMS to practice what they saw as more formal and demanding oversight.

- The MMA, and Part D in particular, are perceived as adding substantially to the complexity of the MA program and the volume of day-to-day demands made on them. While they supported oversight to protect beneficiaries and encourage high performance, they wanted CMS to make requirements more consistent, predictable,

and transparent, and to undertake them holistically, recognizing the burdens imposed by systems changes. At least one large firm expressed the hope, however, that transparency not be used to reduce the flexibility they viewed as important to innovation. The complexity of MA means that firms see the benefits of economies of scale and prior Medicare experience.

- The strongest specific concern that firms expressed related to the continued problems associated with enrollment reconciliation, particularly for enrollees whose claims, often going as far back as 2006, which they have paid already. Firms also were very worried about how CMS addresses concerns about changes in the patterns of diagnostic codes they use for risk adjustment, despite expressing support for risk adjustment in general.

- Firms supported CMS's efforts to strengthen oversight on marketing, and expressed concerns about the role that differential sales commissions play in the market. National firms were concerned about CMS using states to oversee marketing due to the lack of uniformity. Firms also had suggestions about better targeting oversight.

Where do firms see themselves in MA in the future (*Chapter IX*)?

- Firms generally are committed to the MA marketplace, although they acknowledge that their continued participation will require an ability to break even, at a minimum. Their comments suggest that their views of the market have matured, particularly in terms of accepting the legislative uncertainty associated with MA.

- Firms describe multi-year strategies for MA expansion, which they seem to be pursuing consistently because of the compelling business opportunity MA creates within a growing senior market. To address uncertainty, they are developing their strategies in ways that help them to "hedge their bets" and refine their strategies incrementally in response to annual rate and policy changes.

- Those based in firms more heavily oriented towards the historical MA program and delivery systems expressed concern about the way in which MA was evolving, and what that might mean for the ability of MA to improve care management as part of Medicare and the MA program overall.

CONCLUSIONS AND DISCUSSION

What the Findings Show

The findings provide evidence of an active MA market that has expanded since 2006. The higher payment rates associated with MA have encouraged firms to take advantage of existing (e.g., PFFS) and new (e.g., SNP) authority to expand rapidly the number of MA plans they offer and premiums and develop benefit structures sufficiently competitive to generate substantial enrollment growth within the MA sector. The proliferation of choice reflects an expanded set of MA contract types, the value firms see in offering a range of types to attract a range of

beneficiaries with different interests, and the expanded number of organizations seeking to sponsor MA plans.

Regardless of where they live, all Medicare beneficiaries now have access to multiple types of MA, although access to coordinated care plans is more limited, especially in rural areas. Beneficiaries also have access to PFFS plans offered by many competing sponsors. MA enrollment is growing rapidly. Penetration rates also have increased substantially (even in rural areas), although most beneficiaries remain in the traditional Medicare program (where they receive standardized Part A and B benefits and can choose to be in a free-standing PDP). In related work for others (Gold 2008), we have shown that among those enrolled in Part D, a large share are in MA—one third—although MA-PDs remains less popular than the free-standing PDP choice. If groups continue to have a growing presence in MA, the MA's share of the Medicare market is likely to increase still further.

The information we provide about the structure of premiums and benefits in MA provides a basis for understanding why segments of Medicare beneficiaries have found MA increasingly attractive. Most Medicare beneficiaries have low to moderate incomes (KFF 2008). While plan structure varies depending on the market, the presence of MA means that most beneficiaries probably have an MA plan available to them that offers—for no additional premium, or a very limited one over and above what Medicare charges for Part B—an enhanced drug plan and some offsets for the cost sharing Medicare imposes. With PFFS widely available, a beneficiary can choose the plan and, at least in theory, not have to change anything about the way they get care. These advantages probably are easy to convey in marketing, whereas downside risks associated with the remaining cost sharing and actual provider availability are more difficult to assess when comparing MA plans or deciding between MA and Medigap if the latter is a financially feasible choice.

Where the Findings Provide Less Insight

While the findings from this study present good documentation of the range of choices that are available to beneficiaries under the MA program, they are more limited in terms of answering questions about the value provided by the MA program to beneficiaries or to Medicare as a whole.

For example, the available public data upon which we based our study provide very limited information on the actual structure of cost sharing within plans as it would be experienced by the typical beneficiary. Available public data also have limited utility in assessing the comprehensiveness of coverage or the value of additional benefits – such as whether a beneficiary's current providers are "in-network", whether a plan's providers are accepting MA enrollees, how coverage is defined for particular services, what drug coverage in the "gap" actually provides for a beneficiary with a particular constellation of drugs and needs, and how well a plan would be able to accommodate the uncertainty of a beneficiary's future health needs within a given year.

Additionally, at the time that the study was completed, CMS did not provide public information on the actual plans in which individuals were enrolled within geographically distinct parts of the country, which limited our ability to accurately calculate the average premium paid

by a beneficiary enrolled in MA. (CMS recently began releasing plan-level enrollment data at the State and county levels in May 2008).

Moreover, publicly available quality data, are often several years old, tend to be incomplete (with more indicators available for contracts with substantial experience in the program), and certain important contract types such as PFFS plans not being required to begin reporting on certain quality measures until 2010), and are reported at the contract level rather than at the plan level (an important caveat when contracts can include a range of regular, SNP, and group-only plans).

Because of these limitations, the publicly available data provide only limited evidence of the "value" of MA in enhancing the quality of care for beneficiaries, limiting their out-of-pocket costs, or enhancing equity in the Medicare program as a whole." The MMA sought to encourage competition as a means of controlling costs, yet Medicare now pays more for each beneficiary within MA than outside it, meaning that costs grow as the program expands. Policymakers can debate the values behind current decisions on the design of the MA program; this study's data highlight the relevance of those debates and the issues at stake. Arguably the most important thing we do not know is what form the value equation takes. That is, what is Medicare gaining to offset the additional complexity and costs of MA compared to the traditional program?

Key Issues for Policymakers

The MMA arguably has changed fundamentally the Medicare program by expanding choice and competition among private plans for Medicare beneficiaries. The findings of this study point out some key issues for consideration:

- ***Equity.*** While Medicare makes benefits universally available to all beneficiaries, the benefits of MA are targeted to those who enroll. MA therefore divides the Medicare risk pool by location and by the characteristics of beneficiaries and their needs. Policymakers seeking to understand the overall impact of the MA program on Medicare need to assess the underlying equity of the changes introduced by MA and understand the winners and losers from this process.

- ***Choice.*** Is the current absence of limits on the number of marketplace choices desirable? How many choices can beneficiaries consider simultaneously? Are inefficiencies introduced by a large number of firms that often compete to offer essentially the same product? Are sufficient beneficiary protections in place to support a marketplace of expanded choice among plans?

- ***Data for Oversight.*** Medicare's databases for oversight were developed in the context of the traditional program. They emphasize information on where spending occurs across provider types and geographic areas, and the services provided. In the context of MA, such questions remain relevant, but others emerge, and may be even more critical. For example, indicators of rapid disenrollment could reveal potential confusion in the marketplace, and complaint data by plan and state could highlight where problems are more likely to occur. If care coordination is a goal, indicators of

management capacity would provide an indication of the infrastructure being supported. Requiring HEDIS reports both for PFFS and the traditional Medicare program would support better assessment of their relative performance. (Under MIPPA, PFFS plans are required to begin reporting HEDIS data starting in 2010.) Publicly available data on the risk distribution within particular contracts (named or unnamed) could help to identify how equitably MA is serving diverse subgroups. One might envision, for example, CMS briefing Congress annually on the performance of the program, as judged on a series of measures and over time.

- ***Resources for Administration and Oversight.*** The findings from this study highlight the complexity of MA within the Medicare context. Administering MA creates new demands on CMS to oversee an annual process of soliciting interest in the program, updating rates, reviewing bids for large numbers of plans, and overseeing marketing of an annual choice, as well as the overall performance of firms participating in MA. As participating firms point out, the administrative demands on both CMS and the firms themselves are substantial. In future deliberations on MA, it will be important for policymakers to consider the administrative requirements of such a complex program and provide adequate operational resources to CMS to accommodate both MA and the simultaneous operation of the traditional Medicare program, which requires individual claims processing and provider oversight. Policymakers also may want to consider potential issues relating to administrative inefficiencies associated with running s such a complex system with so many participants.

- ***Future Program Direction.*** Our study documents ways in which the MA program has evolved that, arguably, were unanticipated when the MMA was enacted. That legislation intended to encourage a broader availability of choice within MA, using coordinated care models, with regional PPOs serving as an alternative vehicle in those markets where local plans could not thrive. The hope was that regional PPOs would mean that each beneficiary had at least a few MA choices in a program that encouraged better care management and quality through the traditional program. Instead, growth in PFFS plan availability and enrollment have come to drive the market—a trend that contrasts with the evolution of the private commercial insurance market, in which provider choice is more restricted and based around preferred provider organizations that may have more flexibility to work with providers and so be better able to coordinate care than traditional Medicare. SNPs were intended to support specialized care delivery for subgroups of beneficiaries with unique and challenging needs, but our firm discussions suggest that the majority of these plans appear, at least to date, to have focused more on targeting their benefit packages and attracting increased enrollment, than in improving care coordination more than would be feasible in general MA.

In sum, through its use of public data and discussions with firms, our study has highlighted much of the evolution and complexity associated with MA, but also has drawn attention to the limitations on what is known, as well as the policy considerations inherent in both the data and the limitations. After the 2008 election, if not before, these issues likely will gain even more prominence. Our hope is that this analysis will provide insights that can help frame that debate and those issues worthy of consideration.

I. PROJECT PURPOSE, SCOPE, RESEARCH QUESTIONS, AND METHODS

This chapter provides an introduction to the main report. Here, we first describe the purposes of the project, and then the background and policy context in which it has been undertaken. We lay out the research questions addressed by the project, and then describe the methods that are used. The chapter also provides an overview of the different parts of the research and the cross-cutting issues. (Appendix A discusses the specific methods used for each of the four parts of the analysis.) We end by providing an overview of how the rest of the report is organized.

A. PROJECT BACKGROUND AND PURPOSE

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) made major changes in the Medicare Advantage (MA) program. In 2006, MA expanded to include regional Preferred Provider Organization (RPPO) plans, as well as local MA plans—such as health maintenance organizations (HMOs), 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 was modified to include additional competitive features, such as the new competitive bidding system. Regional and local MA plans now provide beneficiaries with access to a comprehensive set of benefits that include the new and voluntary prescription drug benefit (Part D), 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 builds on our earlier work with the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in 2006, and is aimed at helping them understand the changes that occurred initially under the MMA, and provide a basis for responding to questions.[1] That earlier work used publicly available data to profile products offered under MA in 2006, how they compared to what was available in 2005, early evidence on enrollment patterns in 2006, and their consistency with the past. The project also included discussions with diverse MA firms to learn about the initial decisions and experiences under the MMA in 2006. For the current project, we have built on that work to look more closely at how MA has evolved up to early 2008. We also expanded our focus beyond plan availability and enrollment to examine what can be learned from public data about trends in benefits and premiums for different kinds of plans under MA, and also about quality and beneficiary experiences with care when enrolled in MA plans.

[1] Gold, Marsha and Stephanie Peterson. "Characteristics of Medicare Advantage Plan Participation" Washington DC: ASPE/HHS, July 2006.

Major Types of Medicare Advantage Plans*

Local Coordinated Care Plans. These are network-based plans that define their service area by aggregations of counties. Authority for HMOs has existed the longest; in 1997, the BBA added authority for other types of coordinated care plans.

- ***HMOs.*** These are typically the most tightly managed plans. They have a defined network of providers, which beneficiaries generally must use to receive coverage (with some exceptions, such as emergency care). These plans have the longest history in Medicare, and account for the majority of MA enrollment.
- ***PSOs.*** These Provider Sponsored Organizations (PSOs) are network-based plans offered by provider organizations. They were authorized by the BBA to provide additional flexibility for providers seeking plans. There are few PSO contracts and they accounted for only 34 of the 3307 plans often in 2008.
- ***PPOs.*** Like HMOs, these also are network-based plans. In a PPO, enrollees generally may go to any provider they choose. However, using providers outside of the network will result in higher out-of-pocket costs.

Regional PPOs. These are PPOs serving 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 this is not required.) To encourage regional plans, in 2006 and 2007, the MMA included a moratorium on new local PPOs. The MMA also allowed Medicare to share financial risk with sponsors of regional PPOs, provided selected provisions to make it easier to establish networks in rural areas, and, starting in 2007, established a regional stabilization fund to encourage entry of new plans and retention of existing ones. (Funding for this subsequently has been reduced, and it has not been used.)

Private Fee for Service. 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 beneficiaries who are in such plans. These plans must pay providers on a fee-for-service basis and accept all providers who are willing to accept their payment rates. While the statute provides substantial flexibility to set rates that differ from Medicare and to balance bill, a PFFS must pay based on Medicare rates. Service areas for PFFS are set on a county-by-county basis.

Medical Savings Accounts. Like PFFS, these plans allow members to seek care from any provider, but they incorporate high deductibles. The distinguishing features of MSAs are twofold. First, they must require beneficiaries to pay a substantial amount out of pocket (the "annual deductible") before insurance benefits apply. Second, Medicare makes an annual deposit into an interest-bearing account on behalf of enrollees, who may use these funds to pay for qualified health expenses. In 2007, when the first such plans were offered, deductibles ranged from $2,500 and $4,500. MSAs may not offer prescription drug coverage, but beneficiaries may purchase it through a free-standing prescription drug plan. (Traditional Medicare has no combined Part A/B deductible but does require hospitalized patients to pay a deductible equal to the first day of their hospitalization ($1024 in 2008.)

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 severe chronic or disabling conditions. SNPs may be offered through separate contracts, but also as unique plans under existing HMO, PPO, or other contracts. Some have been approved under demonstration authority.

Other Types of Private Medicare Plans. Cost contracts, National PACE program, and various demonstrations also may be offered in particular locales. Except for a few types of demonstrations (e.g. the MSA demonstration), these are not considered to be part of the MA program. For more information on available types of plans, see Gold (2006a).

*While most plans are available for individual enrollment, some contracts have plans serving a group market. These are open only to Medicare eligible individuals through an employment group.

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 health insurance products. In 1982, the Tax Equity and Fiscal Responsibility Act (TEFRA) created the Medicare risk contracting program, which allowed beneficiaries to contract with private HMOs and similar organizations. In 1997, the Balanced Budget Act (BBA) authorized the Medicare+Choice (M+C) program, enabling beneficiaries to enroll with a broader range of private plans. Although the intent was to increase private plan options under Medicare, for a variety of reasons—including restrictions on annual payment rate increases—the opposite occurred. Between 1999 and 2003, plan choices and enrollment declined rather than expanded (see Table I.1).

Under MA, existing HMO, PPO, and PFFS options are referred to as "local plans," because their service areas are established on a county-by-county basis most serving geographically defined markets that tend to be locally based. The MMA made immediate changes in payment rates for local plans effective March 1, 2004, 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 would be either 2 percent (previous policy) or the National Gross Percentage, which was 6.3 percent in 2004 and 6.6 percent in 2005.

Table I.1 Trends in Private Medicare Plan Contracts, Enrollment, and Availability, 1999-2005

	1999	2003	2004	2005
Contracts				
All[a]	412	235	234	273
CCP	303	143	143	182
PPO demonstration	0	35	35	34
PFFS	0	4	4	8
Enrollment				
All[a]	6,573,435	5,140,293	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[a]	72	82	77	85
CCP	71	63	62	68

Source: Table 1 in M. Gold. "Medicare Advantage in 2006-2007" *Health Affairs* (2005) (based on MPR Analysis of CMS Geographic Service Area Reports for March of each year).

[a]Includes cost contracts and demonstrations in addition to PPO demonstrations but not Health Care Prepayment Plans (HCPPs) or plans under the Program for All-Inclusive Care for the Elderly (PACE). Data includes plans in Puerto Rico; such plans are not included in later analysis.

Effective 2004, those with certain special needs also were allowed to obtain benefits through a Special Needs Plan (SNP), developed for dually eligible, institutionalized, or other defined populations with severe chronic or disabling conditions. This was the first time private plans were allowed to limit in a major way the enrollees eligible to join that plan.

The MMA authorized more extensive changes starting January 1, 2006. These 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 each region. (Although beneficiaries pay the same amount, CMS varies what it pays 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 both 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 modified the previous method of payment by introducing an element of competitive bidding into the administered pricing system previously in place for MA (Berenson 2004; MedPAC 2005).[2] The changes apply to both regional and local MA offerings, although details differ between the two types of plans.

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 still serves most beneficiaries—and also access Medicare's coverage for prescription drugs must enroll in a stand-alone 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 dually eligible Medicare/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.

The M+C experience showed that complex legislation often results in unexpected outcomes—for instance, choices decreasing rather than increasing as intended (Gold 2001; MedPAC 2004). To meet its responsibility, ASPE needs the capacity both to generate timely analyses of MA and address questions or issues that may arise in response to the results. This study is designed to enhance ASPE's overall understanding of the MA market, and provide a basis for responding when questions arise.

[2] Plans submit separate bids for basic Medicare Parts 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 receive 75 percent of the difference between the bid and the benchmark which they are required to return to beneficiaries by, for example, expanding benefits or reducing 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 a particular plan.

C. RESEARCH QUESTIONS

This study builds upon and expands the research questions addressed in our previous study for ASPE, which examined the 2005-2006 period to analyze what was known about the MA program as the prescription drug benefit was implemented and other changes in MA were introduced, including the availability of regional PPOs. That study examined the effects of the MMA on available MA offerings; enrollment and firm participation; the way those offerings were configured geographically, and by benefit design; how they were marketed; and the reasons for the decisions underlying those features.

This study will allow ASPE to accomplish two major goals. The first is to update its knowledge of MA, now that there is more experience and more information available. The initial study dealt only with the 2006 offerings and had very limited enrollment information for those offerings. In this project, we extend the analysis through the early part of 2008. The three-year retrospective provides valuable insights as to how the market has changed over time, as experience with the program has grown and the political environment has evolved.

The second goal is to go beyond the scope of the original study to include additional quantitative analysis that can be supported with public data. This expansion includes a general analysis of MA benefits and premiums in 2007 and 2008, which updates selected measures developed in 2005 and 2006 on this same topic through MPR's prior work for AARP's Public Policy Institute (Gold et al. 2006). It also examines what can be learned from publicly available data on quality measures and beneficiary assessments of their care under MA. Because of constraints inherent in these sources, this part of the analysis involves a national view only, whereas we look at variation within the nation in our analysis of availability and enrollment.

Table I.2 summarizes the main questions addressed through the quantitative and qualitative analyses conducted for this project.

D. METHODS

1. Overview

For this project, MPR analyzed publicly available data on MA, and also convened telephone discussions with a carefully selected set of diverse firms participating in MA. Public data on MA are developed for operational, not research, purposes. As a result, the files are not necessarily constructed in a consistent manner over time, nor are the definitions used to develop them necessarily well documented. Different files are not always consistent with one another in the contracts/plans or enrollees they include. As a result, the structure of the files constrained the analysis, requiring compromise and creativity to address questions of interest.

Four kinds of analysis, three quantitative and one qualitative, form the basis for the findings presented in this report. They include the following.

Table I.2. Research Questions of Interest

QUANTITATIVE ANALYSIS

1. What are the trends from 2005 to 2008 in MA contracts of each type available nationwide, and in the share of beneficiaries with access to them?

2. How are contracts distributed nationally, how does availability vary across MA regions and states, and what have been the major changes between 2005 (pre-MMA) through 2008?

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

4. How are payment rates associated with diverse offerings, and has this changed over time?

5. How many beneficiaries are enrolled in MA, what is the market penetration, and how does this differ across the country, by type of contract, and over time?

6. What do we know from public data sources about the plans offered under contracts of each type, such as whether or not they include at least one MA-PD plan, are available generally or only through employer group accounts, and the availability of SNP versus general products post-2006?

7. What are the key trends in premiums, benefits, and out-of-pocket costs for plans offered under each contract between 2005 and 2008, and what are the key characteristics of their drug coverage?

8. From available public data, what do we know about performance under MA on basic measures that CMS collects through HEDIS and CAHPS? (Because of resource constraints and data limitations, we did not examine data from the Health Outcomes Survey (HOS) or disenrollment surveys.)

QUALITATIVE ANALYSIS

9. What are the main factors that have led firms to change their offerings from 2006 through 2008 in the ways that they have (or not change)? To what extent are strategies influenced by firm interests in stand-alone PDPs and Medigap?

10. What are the similarities and differences in the factors of influence by types of contracts or markets? Are employers becoming more of a market, especially for PFFS?

11. How do firms view their contract types compared to one another, particularly when they offer multiple types of contracts in the same markets? In addition, what tradeoffs do firms make by offering SNP and other plans?

12. As firms have gained experience with MA, has this modified the way they think about the task of forming provider networks in different parts of the country, and how does this influence the market?

13. How likely is it that firms active in PFFS will want to/be able to transition enrollment to more managed forms? Conversely, are there reasons to move beneficiaries from managed care to PFFS plans? Are plans targeting specific patient populations for increased enrollment, and how does this affect firms' overall strategies?

14. How are firms thinking about the RPPO option today or in the future, particularly within the context of legislative debate over the future of PFFS? Is the RPPO option likely ever to become viable, and what policy changes might make it so?

15. How have congressional deliberations on MA payment and other program changes influenced how firms think about the way they position themselves in the MA market? What are firms likely to do if Congress reduces payments? Which kinds of changes are of greatest concern, and why?

16. What kinds of changes in benefits/premiums or marketing have firms made over time in response to MA or related experience with PDPs? In general, how do firms view CMS's oversight and support for operational concerns relevant to the program, such as marketing, bidding, and enrollment?

17. Have firms made decisions about 2009, and what are their long-term interests in the MA program?

18. What modifications in bidding or other policies do firms view as important to making the program work better in the future?

- ***Plan Availability and Enrollment.*** We analyzed public data to generate information on the number and characteristics of available MA contracts and sponsors, which contract types are offered, and how these differ across the country. We also examined how enrollment was distributed across these contract types, sponsors, and MA in general, versus specialized MA plans (SNPs, group plans), and the relationship between county enrollment and payment rates. (Because private plans authorized outside of MA (like cost contracts) are part of the choice set available to individuals, we include these plans in our analysis of availability and enrollment to provide context and show more fully the proportion of Medicare eligible beneficiaries receiving Medicare A/B benefits through private plans.)

- ***Benefits and Premiums.*** We also analyzed public data to examine how benefits and premiums in MA plans are structured, how they differ by type of plan, the trends that exist, and what they imply for beneficiary out-of-pocket costs.

- ***Quality of Care.*** We analyzed data to examine overall performance by contract on publicly reported quality measures. This part of the analysis was based on Health Effectiveness Data and Information Set (HEDIS) measures and Consumer Assessment of Health Plan Surveys (CAHPS) data. While the other analyses for this report reflect 2006-2008 data, this analysis is less current because of lags in the way such data are collected and reported.

- ***Firm Perspectives and Decision Making.*** We held telephone discussions with a cross-section of participating MA firms of different types so as to understand better their rationale and the structure of their MA product offerings, their experience with participating in the program, and the most salient of their policy concerns.

In this section, we summarize the cross-cutting issues that apply to the analysis. (Appendix A.1 provides more detail on the data sources used for each of the four basic kinds of analyses included in this paper.)

Readers should note that the analyses conducted here are limited to MA in the 50 states and District of Columbia. *They exclude MA in Puerto Rico and the Territories because of their unique characteristics.* Because of this and others exclusions, the data reported here are based on a smaller number of contracts than reported on in CMS's Monthly Summary Report. (Sources of variation are discussed in more detail below, as well as in Appendix B.3.)

2. Cross-Cutting Concerns Related to Use of Public Data

By design, this project uses publicly available data on the MA program obtained from CMS, augmented with firm discussions. The available public data have limitations. CMS also can, at any time and with no notice, change what data are reported and the timing of their release. Lack of data release at predictable times was a particular problem at the start of 2006, and still presents issues today. Below, we review some general issues that apply to the use of CMS's public data on MA as they relate to this contract.

Focus on Contracts, not Plans. CMS's public files were developed years ago when contracts, not plans, were the most important unit of analysis. Even today, the public files most

useful for analysis are based mainly around contracts—namely, contract enrollment by county (the Geographical Service Area file [GSA file], now referred to as the State-County-Contract file). However, most contracts offer more than one plan (i.e., type of benefit package and beneficiary target (general, SNP, group). Further, sponsors can divide their service areas geographically into multiple "contract segments," and offer different benefit plans in each. Historically, the service area for an entire contract usually was limited to a metropolitan statistical area or state market but many newer forms of contracts (e.g., PFFS, MSA, RPPOs) actually comprise a single contract that spans large sections of the United States.[3] Problems arise because the only enrollment data by plan are released only once a year (July), and are not available broken down by county. The structure of public data sources means that analysis of offerings regarding enrollment, penetration, and other key features usually can be assessed only at the contract level for geographical analysis at levels smaller than the nation.

Until May 2008, CMS did not provide any publicly available data on MA enrollment by contract at the plan and county level (SNP data sometimes was available by state but its form was not easily merged with general MA data). Since the number of plans offered in a county within a contract is now much larger than in the past, the absence of such enrollment data has been a major constraint on analysis, as it greatly limits the ability to construct averages that take into account the large variation in enrollment across plans and contracts. While CMS began releasing plan-level enrollment data by county in May 2008, these data were not available in time to use in this study.

Some Analysis Possible by Plan. The CMS Medicare Plan Finder[4] includes a file with plan level data that can be downloaded, although it is hard to manipulate and lacks links to the enrollment in each plan. The data comprise a text file that incorporates information CMS uses to describe plans on its public website. CMS provides no documentation for the file, and certain fields may have been populated inconsistently from year to year. The main value of this file is that it allows analysis of benefits and premiums, and does so at a level of analysis that makes sense. (That is, using data from this file, one can analyze plans within a contract, as divided into segments, and thus examine the full range of benefits available to beneficiaries in different counties.)[5]

Data Gaps and Uncertainties. The public data also have gaps, and their quality and consistency often are less than ideal. For example, CMS does not publicly release files

[3] For example, in 2006, Humana had only three contracts, which spanned 14 regions, for its RPPOs. Humana's PFFS plans, available to 83 percent of the population, are offered through only four contracts, with one contract accounting for plans in 2,908 counties, which comprise almost the entire United States (Gold 2007a).

[4] Within the context of this report, any references to "Personal Plan Finder," "the Plan Finder," or "Health Plan Compare database" refer to that portion of CMS's Medicare Options Compare website housing the database on Medicare Advantage plans. Within the Options Compare website, one also may search specifically for Medicare prescription drug plans. CMS refers to this database as the Medicare Prescription Drug Plan Finder; we are not referring to this database when we use the words "Plan Finder."

[5] CMS does not report data in instances where there are 10 or fewer enrollees under contract in a county, although it does report how many enrollees are excluded by this criterion. Fortunately the numbers are sufficiently small that the omission does not cause major problems. However, the same practice could be a more significant constraint on analyzing plan enrollment data if CMS ever decides to make it publicly available, as many have urged.

containing the many kinds of data it uses to monitor the program (e.g., bids). In addition, CMS is not necessarily consistent in what it provides over time, which also generates critical gaps. We are aware of three such issues that are particularly relevant to this project.

- ***Beneficiary Counts.*** Before 2006, CMS issued quarterly releases of data on the number of MA-eligible beneficiaries by county, a necessary denominator for calculating penetration rates. CMS released the file containing these data for December 2005, and then stopped releasing any routine data on MA enrollment until November 2006. When CMS resumed the releases, it modified the file structure used, and dropped the file containing the basic data on the beneficiary counts that provide denominators for examining availability and penetration. Both the Medicare Payment Advisory Commission (MedPAC) and MPR had to use December 2005 data on beneficiaries for their 2007 analyses. In the absence of better alternatives, we used the December 2005 number for the total eligible Medicare population because the December 2006 counts are much lower, and result in changes in trends that are hard to explain.[6] (Appendix B.1 shows the impact of the decision to use December 2005 data, and what it means for key measures of availability and penetration.)

- ***Quality Indicators.*** Historically, it has not been easy to examine the quality of or patient experiences with care tied to any specific contract or plan, although CMS collects data on these topics. In recent years, CMS has begun to incorporate a small set of data from HEDIS and the Medicare CAHPS into the Personal Plan Finder used to support beneficiary choice; a wider set of variables also are available as a downloadable file. We use these data to the extent feasible to support our analysis. There are limitations, however: (1) the data typically lag a year behind, so they do not necessarily provide information on current performance (e.g., the 2007 Health Plan Compare database includes performance data for 2006); (2) because of lags, data typically are available only for contracts that have been in place for some time; with the rapid growth of the program, this means that newer kinds of contracts (e.g., RPPOs) are not well represented, and some are not even included in the data (e.g., PFFS); (3) reporting does not appear complete, which could reflect small numbers of enrollees and CMS's concern with confidentiality; and (4) while the data are *reported* in the file at the plan level, they are *collected* at the contract level. To the extent that benefit design influences outcomes or beneficiary experiences, this data source does not allow them to be studied. Also, most SNPs are offered under contracts that include one or more traditional MA plans, so the data do not provide information on SNPs except for the subset of contracts that offer *only* SNP plans.

- ***Shifting Practices for Data Release.*** Because of the scope of changes under the MMA, there is great interest in having data on both offerings and enrollment in a timely fashion. CMS's monthly reports on contracts and enrollment provide the basic

[6] In particular, the December 2006 number includes only beneficiaries eligible for Parts A *and* B, rather than Part A *or* Part B, as included in the 2005 calculation. Further, the December 2005 file also includes those individuals who were enrolled in the original Medicare, along with a future effective date. Since our analysis was completed, CMS has revised its data release policy and now provides updated Medicare enrollment monthly. However these data were not available in time for our study.

data on offerings and beneficiary response, but these data are available only once a contract year has started. Because current-year offerings are approved in September, there is interest in knowing as early as possible how offerings may change.[7] In 2006 and 2007, CMS released the Plan Finder file in early fall, enabling us to use it to assess availability. In 2008 however, CMS did not release the file until the end of January 2008, and at one point it was not certain it would be released at all. Fortunately, we were able to use another public source, "the Landscape file," as a substitute. Shifting sources contribute to inconsistencies across years, because each source has its own definition of what contracts it includes.

E. ORGANIZATION OF THE REMAINDER OF THE REPORT

Chapters II-VI review in turn various aspects of MA availability and enrollment, including national availability (Chapter II), regional and state availability (Chapter III), national enrollment and payment (Chapter IV), the role of individual firms (Chapter V), and SNPs (Chapter VI).

In Chapter VII, we provide a description of benefit and premiums within plans, including an overview of the characteristics of plans, 2008 benefits and premiums, and trends in benefits and premiums from 2006 through 2008.

In Chapter VIII, we discuss plan performance on HEDIS and CAHPS indicators, and the quality of and beneficiary experiences with care.

Chapter IX reviews what we learned through firm discussions about the MA marketplace and the dynamics behind some of the trends this report identified.

Chapter X provides a discussion of the findings, the conclusions we draw, and implications for certain issues.

Appendix A includes more detail on the data sources and methods used in each part of the analysis. Appendix B addresses specific methodological issues. Appendix C includes tables with information on 2007 MA benefits and premiums.

Because the tables are extensive, we put them at the end of each chapter rather than interspersed to avoid distracting from the flow of the text while still making them readily accessible to the reader.

[7] Prior to 2006, CMS released a data file showing terminations and also approvals as they were granted. Whereas such approvals now occur on an annual basis, they previously could occur throughout the year. These data meant that it was possible to estimate the following year's offerings using just the Geographical Service Area file, particularly since the program was not rapidly expanding until mid 2005. These conditions no longer exist.

II. NATIONAL TRENDS IN MA OFFERINGS, 2005-2008

In this chapter, we review trends in the MA contract offerings by type. We begin by reporting on the number of contracts, a measure CMS traditionally has used to describe the size of the MA program. Next, we consider what the previous findings mean as they translate into changes in the availability of different contracts to beneficiaries nationally, as well as within urban and rural areas. We end with a review of the dynamics of change in terms of new entrants and terminations of contracts.

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—for example, regional PPOs, PFFS, and MSA 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 be less meaningful in the future, they remain a common measure of changes in the size of and interest in the MA program over time.

Total Contracts. There are almost twice as many MA contracts in 2008 as there were in 2005 (Table II.1).[1] The total number of contracts increased from 249 in March 2005 to 489 in March 2008, excluding HCPP, PACE, SNP-only, and selected other contracts not consistently included in the database from year to year. While growth has been steady over 2006-2008, the data also seem to suggest that the response to the MMA occurred most dramatically in two waves: (1) in 2005, as firms expanded in anticipation of the MMA and had their contracts approved late in that year for 2006; and (2) in 2008, when firms presumably had additional time to plan their expansions (see Figure II.1).

Only a small amount of the growth in contracts reflects increases in contract types not authorized before 2006 (regional PPOs, MSAs). There were only 11 new RPPO contracts in 2006, a number that remained constant through 2008.[2] MSAs were not offered until 2007, when there were 2 contracts, expanding to 9 in 2008. As discussed later, the growth largely reflects a decision by Wellpoint to offer such products.[3]

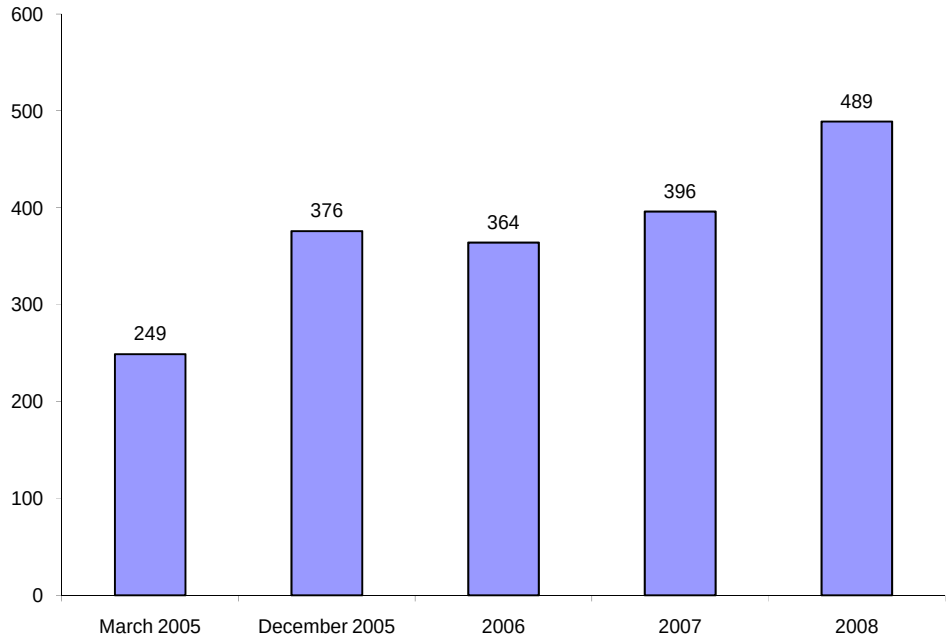
Trends by Contract Type. From 2005 through 2008, contracts of each type increased, except for a few types, such as RPPOs, which remained constant. Cost contracts, which the

[1] Total contracts includes cost, HCPP, PACE, and others authorized outside MA (when data are available) but we use MA here generally to speak to the issues of total private plan contracts.

[2] Counts that show 14 contracts in 2008 include 3 that are available only for SNP enrollment or in Puerto Rico.

[3] Of the 9 contracts offered in 2008, all but 2 are affiliated with Wellpoint, one under a contract with its non-Blues subsidiary that covered 2,118 counties in 2007 and 2,186 in 2008 (Gold 2008 [forthcoming]).

Figure II.1. Number of MA and Related Private Plan Contracts, 2005-2008



Source: MPR analysis for ASPE of publicly available CMS data (see Table II.1).

Note: Cost contracts and PPO demonstrations were authorized outside of MA. Excludes HCPP, PACE, SNP-only, and other demonstrations.

MMA sought to phase out, declined in number.[4] Local coordinated care contracts declined as a percentage of all contracts between 2005 and 2008—from 85 percent to 79 percent—but remain the dominant type of contract (statistics computed from Table II.1). Among local coordinated care contracts, HMOs remain dominant in number, despite new local PPO entrants. (The MMA restricted new local PPO entrants in 2006 and 2007, but new contracts were approved before and after.) The most recent data (2008) indicate that 54 percent of the contracts of the type we can count consistently over time are for HMOs, and 25 percent are for local PPOs (statistics computed from Table II.1). PFFS contracts have increased steadily, but their numbers understate their importance in terms of availability across the nation because the contract count does not reflect differences in service areas included under different types of contracts.[5]

[4] While "other" contracts declined, this mainly seems to reflect the reclassification of some demonstrations into SNP contracts between 2007 and 2008.

[5] State licensure laws and network requirements typically result in HMO and other local coordinated care contracts that are market- and state-specific, whereas this is not the case for PFFS or MSA contracts.

B. AVAILABILITY BY CONTRACT TYPE, NATIONALLY

MA availability is a function not only of the number of contracts offered, but also their service areas. Many new contracts cover wide service areas. As a result, MA became more available nationwide between 2005 and 2008. Virtually all Medicare beneficiaries, regardless of where they live, have access to one or more MA contracts. Beneficiaries also have gained access to plans offered under more contracts from different sponsors.

Overall Availability. Even before the MMA was fully effective in 2006, most beneficiaries (91 percent) had access to at least one type of contract. This percentage grew by the end of 2005 (96 percent), and expanded further in 2006 (97 percent; shown in Table II.2). By 2007, virtually all beneficiaries in the nation had access to an MA plan.[6] By 2008, virtually everyone could select, at a minimum, between plans under one PFFS and one MSA contract; 87 percent also resided where a regional PPO contract was in place. There remains more variability in local coordinated care offerings, although 83 percent of beneficiaries nationwide reside where at least one such contract is in place.

Availability of Coordinated Care Plans. Only 64 percent of Medicare beneficiaries had access to an HMO or PPO in 2005, but 83 percent did in 2008. Over this period, HMOs continued to be more available than PPOs, with the percentage of beneficiaries with access to a local HMO increasing by 16 percent (from 62 percent to 78 percent). However, availability of local PPOs grew more rapidly (from 38 percent to 68 percent). Service areas for HMO and local PPO contracts appear to overlap substantially, however—or the share with access to either of such contracts would be higher. When regional PPO contracts also are considered, however, 97 percent of beneficiaries reside where one or more coordinated care contracts is in place, and most have at least three (see Table II.2).

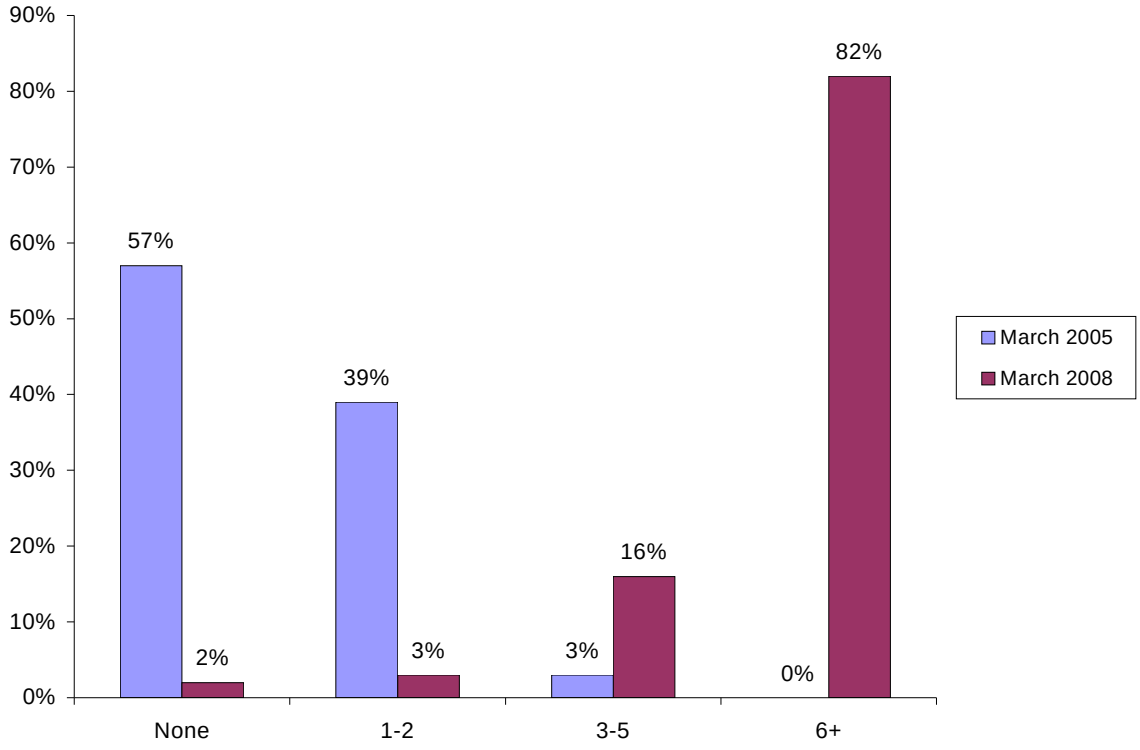
Availability of PFFS. PFFS contracts have not only increased in number from 2005 to 2008, but their service areas are such that a large number of beneficiaries have access to plans from a variety of sponsors. At the start of 2005, only a minority (43 percent) of all beneficiaries had access to any PFFS plan, and most beneficiaries served by only one contract (28 percent). By 2007, more than half (53 percent) had access to 6 or more such contracts, a figure that increased to 82 percent in 2008 (Figure II.2).

Availability of MSAs. MSAs are available to virtually all Medicare beneficiaries in 2008 after their introduction in 2007. In 2007, availability mainly was through Wellpoint's Unicare product in most of the country and its Blue Cross of California affiliate.[7] In 2008, Wellpoint expanded its nationwide Unicare product from 2,118 to 2,186 counties, and its Blues-affiliated contracts under legacy Anthem plans also started offering such products. Two other firms also started offering MSAs (Coventry and Geisinger) (See Gold 2008).

[6] Figures of 99 percent may reflect data limitations; a few beneficiaries live in areas whose codes make it difficult to line them up with the county-based MA data.

[7] Because of the way data are arrayed by CMS, we do not show the MSA demonstration in this count. However, it is available only to a small share of beneficiaries.

Figure II.2. Percentage of Beneficiaries with Available PFFS Contracts, 2005-2008



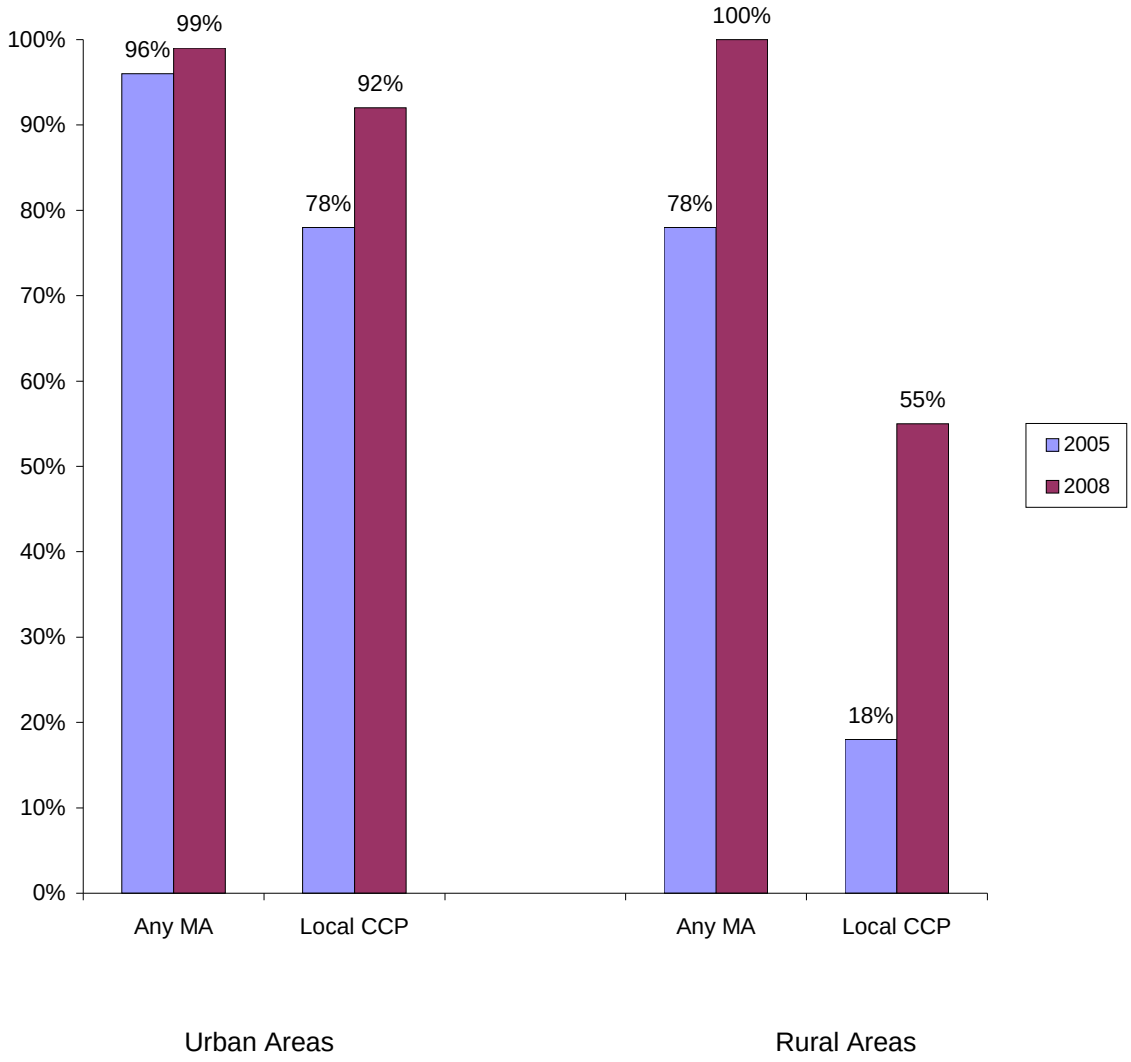
Source: MPR analysis for ASPE of publicly available CMS data (see Table II.2).

C. AVAILABILITY, URBAN VERSUS RURAL COUNTIES

Historically, MA has been more available in urban areas than in rural areas of the country (Gold et al. 2004; MedPAC 2001). Under the MMA, the gap has narrowed, although the extent and kinds of contracts available typically remain narrower in rural than urban areas, particularly when local network based products are involved (Figure II.3).

Beneficiaries in Urban Counties. 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 in their area (Table II.3). By 2006, all Medicare beneficiaries in urban areas had at least one MA choice, and 83 percent had access to an HMO. By 2008, 89 percent had access to an HMO, 71 percent to a PPO, 99 percent to a PFFS, 87 percent to a regional PPO, and 99 percent to an MSA. Perhaps even more significant was the growth in the number of competing sponsors in urban areas. In 2008, 67 percent of urban beneficiaries could choose among coordinated care products offered through 6 or more contracts (including regional PPOs). Even more (82 percent) could choose among PFFS plans from 6 or more sponsors (i.e., different contracts.)

Figure II.3. Percentage of Beneficiaries with Available MA Plan in Urban and Rural Counties, 2005-2008



Source: MPR analysis for ASPE of publicly available CMS data (see Tables II.3 and II.4).

Beneficiaries in Rural Counties. MA offerings are more limited in rural areas, but the availability of such options did grow substantially between 2005 and 2008 (Table II.4). In March 2005, 78 percent of Medicare beneficiaries had access to at least one MA contract. This rose to 93 percent in 2006 and 100 percent in both 2007 and 2008 Figure II.3. To a substantial extent, the rise in availability reflects expansion in non-network based products. The percentage of rural beneficiaries with a PFFS plan was only 51 percent in 2005. It is now 100 percent, and beneficiaries have many more such options. Indeed, the availability of PFFS in rural areas is on a par with urban areas. (In 2008, 85 percent of rural beneficiaries had 6 or more PFFS contracts available in their county, up from 55 percent in 2007.) Coordinated care contracts also are available in counties where more rural beneficiaries live, although local HMOs and PPOs remain available to a smaller share. While rising, the percentage of rural beneficiaries with an HMO contract serving their county reached a high of 43 percent in 2008. That same year, 32 percent

had a local PPO option, and 55 percent had at least one of the other types. Only 4 percent had no coordinated care option, once regional PPO availability is considered. As we will see later, however, availability of coordinated care in rural areas remains highly skewed across the country.

D. NEW ENTRANTS AND TERMINATIONS

We found that it was not very easy or satisfying to analyze contract entry and exit in MA through the data we have available; this is complicated for several reasons, particularly since 2006.

First, such analysis requires the use of contract numbers. While most are consistent over time, there are some that are not. The different files we have used across the three years to examine availability do not each have all of the same contract types. As we noted before, such instances were more likely for PACE, HCPP, and demonstration contracts than for other contract types. We found cases for which a contract available in one year disappeared the next, but then reappeared in the third year. In addition, some contracts seemed to enter or exit when examined by type; however, what was really happening was that a contract transitioned in type. The most common instance of this was the reclassification of a number of SNPs from demonstrations to plan status in 2007; this was even more common in 2008.

The fact that SNPs are a plan, not a contract type also introduces complexity, because contracts could at least in theory change from being all SNP to having regular plans as well (or from no SNPs to some). Because we exclude "SNP-only" plans in looking at general availability, such transitions could be problematic in looking at entry and exit. Also, particularly in past years, CMS kept SNP data separate from general MA data, so the latter files were incomplete, and there was inconsistency between the two files.

In Table II.5, we provide counts of the number of contracts newly appearing in the database in 2007 and 2008, as well as those terminating in those years. For this purpose, we do *not* exclude all SNP contracts if they are otherwise showing in the database. We also do not show 2006 data, because the transition to Part D resulted in very messy data for the 2005-2006 period.[8] Viewed from this perspective, new entrants exceeded terminations in each year. In 2007, there were 106 new entrants and 16 terminations. In 2008, there were 144 new entrants and 77 terminations. The substantial influx of new HMOs probably in part reflects SNP entrants.

It is of interest that, while the program is growing, some firms are departing the market. It is not surprising that the number of terminations grew in 2008 compared to 2007. In earlier work on Medicare+Choice we observed "shake-out" that probably was occurring along with the exits,

[8] Our analysis showed, for example, that only 64 contracts were added, when in fact we know that many more contracts were newly approved in the second half of 2005 in anticipation of 2006. Of the 64 we show as new, 34 appear to be new local PPOs, despite the moratorium on such offerings for 2006; we believe that these are terminating PPO demonstrations that were included in this count in 2005. The file shows 11 new regional PPOs (just authorized that year, so all were new). It otherwise shows only four new HMOs, three new cost contracts, eight HCPPs, and four new demonstrations. No new PFFS contracts are shown, although we know that new PFFS were approved late in 2005. We are uncertain whether SNP-only plans were included in this file in 2006, and believe that PACE also were excluded.

due to industry reaction to slow growth in premiums. Market theory would argue that such change in offerings is an inevitable part of the market.

We list in Table II.6 those HMOs, local PPOs, and PFFS plans that exited from MA in 2007 and 2008. While further exploration would be required to assess what the terminations reflect, our knowledge of the industry suggests that many of the terminations are substantively not very salient because they appear to reflect industry consolidation or what may be small realignments among the many contracts of some firms. A good example is the merger of PacificCare and UnitedHealthcare which appears to have resulted in selective contract terminations that we speculate were made to eliminate duplicate offerings. Similarly HIP and GHI are in the process of a merger and may have consolidated offerings in anticipation.

Overall, we were not able to construct as detailed an analysis as we might have liked on these data and also perceive that they do not add much to what one learns by looking at the cross-section of plans. This could change in the future if terminations become more extensive. In the past CMS has released a file of terminations each fall. That could be a useful practice to reinstitute.

Table II.1. MA and Related Private Plan Contracts by Type, United States, 2005-2008

Contracts by Type	March 2005	December 2005	March 2006[a]	March 2007	March 2008
Total Contracts[b]	306	440	NA	NA	NA
Total HCPP, PACE, and other shown that year	57	64	0	79	15
Total SNP-only	NA	NA	34	80[c]	NA[c]
Total Excluding HCPP, PACE, Other, SNP-Only[b]	**249**	**376**	**364**	**396**	**489**
Local HMO, PSO, or PPO (formerly CCPs)[d]	212	327	314	317	386
Local HMO[e]	148	194	198	214	266
Local PPO or PSO[f]	64	133	116	103	120
PFFS	8	16	21	45	67
Regional PPO[g]	0	0	11	11	11
MSAs	0	0	0	2	9
Cost contracts	29	29	18	21	16
HCPP[h]	5	6	NA	NA	NA
PACE[h]	32	34	NA	39	NA
Other[h]	20	24	NA	40	15

Source: MPR analysis of files developed from publicly available CMS data. 2005 data are from the Geographical Service Area Report for March and December 2005. 2006 data are from a file created from the November 2005 release of the 2006 Medicare Personal Plan Finder. 2007 data are from a file created from the November 2006 release of the Plan Finder, and 2008 data are compiled from the MA Landscape files.

NA= Data not available.

[a] Based on January 2006. Starting in 2006 contracts, are approved only at the beginning 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. Because such contracts are handled unevenly across years, our subtotal excludes them so as to compare overall trends in contacts across years.

[c] Thirteen of the SNP-only contracts were demonstrations.

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

[e] Local HMOs include those with point-of-service options.

[f] The MA Landscape file we are using for 2008 availability does not contain information on SNPs, so it does not show SNP-only contracts.

[g] Regional PPOs were not authorized until 2006.

[h] HCPP, PACE, and other contracts (many demonstrations) are not included in the 2006 Medicare Personal Plan Finder, which was used to create the file on which 2006 statistics are computed. In 2007, HCPPs were excluded.

Table II.2. Selected Measures of Availability of MA and Related Private Plan Contracts to Medicare Beneficiaries by Type, United States, 2005-2008

Percentage of Beneficiaries with:	March 2005	December 2005	March 2006[a]	March 2007	March 2008
Any Available Plan[b]	91	96	97	99	98
Local HMO, PSO, or PPO (formerly CCP)	64	78	77	81	83
Local HMO	62	70	70	75	78
Local PPO or PSO[c]	38	64	62	61	62
PFFS	41	75	78	99	98
Regional PPO[d]	0	0	86	87	87
MSA	0	0	0	71	98
Cost contracts	23	23	9	13	9
Other (HCPP, Demo, PACE)[e]	62	57	NA[e]	73	26
Number of all available HMO, PSO, or PPOs (including regional PPOs)					
None	36%	23%	4%	3%	3%
1	2	1	1	13	1
2	6	2	4	16	11
3-5	29	20	29	34	31
6+	28	54	61	34	55
Number of PFFS Contracts Available					
None	57	24	20	1	2
1	28	29	NA	3	0
2	11	24	NA	6	1
3-5	3	22	NA	36	16
6+	0	0	NA	53	82

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. 2007 data are from a file created from the November 2006 release of the Plan Finder, and 2008 data are compiled from the MA Landscape files.

NA = Data not available.

[a] Based on January 2006 data, because 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. Excludes SNP-only contracts because they are not available to all beneficiaries. 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 are not 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 from which 2006 statistics are computed. 2007 data excludes HCPPs. 2008 data excludes HCPPs and PACE contracts.

Table II.3. Selected Measures of Availability of MA and Related Private Plan Contracts to Medicare Beneficiaries by Type, Urban Counties Only, United States, 2005-2008

Percentage of Beneficiaries with:	March 2005	December 2005	March 2006[a]	March 2007	March 2008
Any Available Plan[b]	96	99	100	100	99
Local HMO, PSO, or PPO (formerly CCPs)	78	90	89	91	92
Local HMO	76	83	84	87	89
Local PPO or PSO[c]	47	76	74	71	71
PFFS	38	73	76	99	99
Regional PPO[d]	0	0	88	88	87
MSA	0	0	0	73	99
Cost contracts	27	27	10	14	9
Other (HCPP, PACE, or other demo)[e]	68	62	NA[e]	78	31
With available HMO, PSO, or PPOs (including regional PPOs)					
None	22%	10%	1%	1%	2%
1	1	1	1	6	0
2	6	2	2	11	5
3-5	34	20	23	39	26
6+	37	67	74	43	67
Number of PFFS Contracts Available					
None	61	27	24	1	1
1	25	28	NA	3	0
2	11	23	NA	7	1
3-5	2	21	NA	35	16
6+	0	0	NA	53	82

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. 2007 data are from a file created from the November 2006 release of the Plan Finder, and 2008 data are compiled from the MA Landscape files.

NA = Data not available.

[a] Based on January 2006 data, because 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. Excludes SNP-only contracts, because they are not available to the general population. CMS data for 2005 includes HCPP, PACE, and other (largely demonstration) contracts, which are not included in the data available for 2006.

[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 from which 2006 statistics are computed. 2007 data excludes HCPPS. 2008 data excludes HCPPs and PACE contracts.

Table II.4. Selected Measures of Availability of MA and Related Private Plan Contracts to Medicare Beneficiaries by Type, RuralCounties Only, United States, 2005-2008

Percentage of Beneficiaries with	March 2005	December 2005	March 2006[a]	March 2007	March 2008
Any Available Plan[b]	78%	89%	93%	100	100
Local HMO, PSO, or PPO (formerly CCPs)	18	39	38	45	55
Local HMO	15	27	25	35	43
Local PPO or PSO[c]	8	27	24	25	32
PFFS	51	86	91	100	100
Regional PPO[d]	0	0	84	89	89
MSA	0	0	0	70	100
Cost	9	10	8	8	8
HCPP, PACE or Other[e]	44	41	NA[e]	56	9
Number of available HMO, PSO, or PPOs (including regional PPOs)					
None	82%	61%	12%	5	4
One	0	1	1	39	2
Two	5	3	13	36	32
3-5	12	24	52	18	51
6+	1	11	22	2	11
Number of PFFS Contracts Available					
None	41	8	3	0	0
One	39	36	NA	0	0
Two	13	30	NA	2	0
3-5	7	27	NA	43	14
6+	0	0	NA	55	85

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. 2007 data are from a file created from the November 2006 release of the Plan Finder, and 2008 data are compiled from the MA Landscape files.

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. Excludes SNP only contracts because they are not available for the general population. CMS data for 2005 includes HCPP, PACE, and other (largely demonstration) contracts, which are not included in the data available for 2006.

[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. 2007 data excludes HCPPs. 2008 data excludes HCPPs and PACE contracts.

Table II.5. Contract Entrants and Terminations by Type, 2007-2008

	New Contracts		Terminating Contracts	
	2007	2008	2007	2008
All	106	144	16	77
HMOs	60	80	5	16
Local PPOs	0	29	9	6
Regional PPOs	3[a]	0	0	0
PFFS	25	26	1	2
MSA	2	7	0	0
Cost contracts	0	0	1	9
PACE	5	0	0	39
HCFP	0	0	0	4
Demonstrations	11	2	0	1

[a]All three are SNP-only, excluded from Table II.1. Contracts that switched type (e.g., demonstration to HMO) are not counted as new or terminating.

Table II.6. MA Contracts Terminating in 2007 or 2008[a]

	Contract Type	Organization Name	State
Terminations 2007			
H0538	HMO	Universal Care Health Advantage	CA
H2204	HMO	Harvard Pilgrim Health Care of New England	NH
H2206	HMO	Harvard Pilgrim Health Care	MA
H3657	HMO	QualChoice Health Plan, Inc.	OH
H3972	HMO	Elder Health Personal Care Choice	PA
H0315	PPO	United HealthCare Insurance Company	AZ
H1905	PPO	Humana Health Benefit Plan of LA	LA
H3621	PPO	SummaCare	OH
H3622	PPO	QualChoice Health Plan, Inc.	OH
H5506	PPO	Group Health Plan, Inc.	IL
H5514	PPO	Healthfirst PPO	NY
H55515	PPO	United HealthCare Insurance Co. of New York, Inc.	NY
H5518	PPO	United HealthCare Insurance Company, Inc.	OH
H5524	PPO	Healthspring, Inc.	TN
H5602	PFFS	Sterling Partners – Pennsylvania	PA
Terminations 2008			
H1034	HMO	America's Health Choice	FL
H3856	HMO	Regence BlueCross Blue Shield of Oregon	OR
H4208	HMO	Carolina Medicare Prime	SC
H5604	HMO	Aveta CarePartners	IL
H5611	HMO	American Pioneer Health Plans	FL
H5702	HMO	Aveta CarePartners	NV
H5794	HMO	Unison Advantage	NJ
H5880	HMO	Volunteer State Health Plan	TN
H5936	HMO	American Pioneer Life Insurance Company	FL
H5942	HMO	SunCoast Physicians Health Plans, Inc.	FL
H6717	HMO	UNITED HEALTHCARE INSURANCE COMPANY	PA
H7254	HMO	UNITED HEALTHCARE INSURANCE COMPANY	GA
H9016	HMO	Care 1st Medicare Advantage Plan	CA
H9136	HMO	Medicare Ultra	PR
H9418	HMO	UNITED HEALTHCARE INSURANCE COMPANY	CT
H9984	HMO	Viva Salud	PR
H3340	PPO	GHI Medicare Choice PPO	NY

Table II.6 *(continued)*

	Contract Type	Organization Name	State
H3345	PPO	HIP Insurance Company of New York	NY
H5418	PPO	California Health Plan	CA
H5500	PPO	SecureHorizons	AL
H5527	PPO	Secure Horizons	RI
H1407	PFFS	Humana Insurance Company	IL
H5820[b]	PFFS	Universal Health Care Insurance Company	AZ

Source: MPR Analysis of CMS Data.

[a]Includes only coordinated care, PFFS, and MSA contracts.

[b]CMS suspended new enrollment for this plan. Ultimate availability in 2008 is not known.

III. VARIATION IN CHOICE ACROSS MA REGIONS AND STATES

In this chapter, we examine more closely how the number and type of MA contracts and availability of choice varies across the nation. The primary focus is on variation by state and, within state, by urban and rural areas. We examine trends from 2006-2008; this review complements our earlier report that details the initial trends from 2005 to 2006 after the introduction of the MMA. The tables also group states into the 26 MA regions with which they are associated, and provide region-wide totals across states. Because to date regional PPOs have not turned out to be a dominant force in the market, and offerings have not changed since 2006, we do not discuss the regional data on their availability.[1] As in the previous chapter, the analysis of availability excludes contracts that offer *only* SNP plans or employer-direct plans, since these are not available to all beneficiaries.

A. NUMBER OF CONTRACTS BY TYPE

The number of MA contracts varied substantially across regions and states in 2006, and continues to do so through 2008. (Table III.1). To provide insight on this variation, we define a contract as existing in a state or region if its service area includes one or more counties in the state or region—a common practice, and one that obviously overstates the contracts available to beneficiaries, since they are limited to options that service their county of residence, not those available only elsewhere in the state or region. (The exceptions are regional PPOs, which must serve the entire region, and all counties in the states within it.) There are more contracts in place in 2008 than there were in 2006, but variability across states remains. As is also true nationally, HMO contracts are most numerous, a factor driving many of the differences in MA across states. The range of geographic availability in PFFS plans is more limited.

HMO Contracts. In 2008, Florida had 28 HMO contracts, the highest of any state, up from 25 in 2006. New York and California are states with very large populations. New York had 20 HMO contracts in 2008 (up from 18 in 2006), and California also had 20 (up from 16 in 2006). Other states with 10 or more HMO contracts in 2008 included: Alabama (17), Texas (17), Wisconsin (12), Oregon (12), Ohio (11), Utah (11), and Pennsylvania (10).

Over this period, fewer states had *no* HMO contracts, but in 2006, 8 states had none: Maine, Vermont, Delaware, Montana, North Dakota, South Dakota, Wyoming, and Alaska. Three of these states had added such a contract by 2008—Delaware, Maine, and Wyoming. However, New Hampshire, which had 1 such contract in 2006, lost it. As a result, by 2008, there were five states still lacking HMO contracts serving at least one county—New Hampshire, Vermont, North Dakota, South Dakota, and Alaska. North and South Dakota each had a regional PPO contract in place; New Hampshire, Vermont and Alaska did not, and also did not have a local PPO contract in place. This indicates that coordinated care options seem to be a particular challenge in these locations.

[1] The earlier report found that regions attracting regional PPO entrants had a balance of urban and rural areas and counties with higher and lower payment rates. Entry was less likely in regions with lower population numbers and with a heavy dominance of rural areas.

PPO Contracts. Over the 2006-2008 period, there was no change in the regions in which regional PPO contracts were operating (21 of 26), nor in the number of contracts in place within individual regions and their associated states. Changes in local PPOs have been influenced heavily by the fact that firms were not allowed to offer new local PPOs or expand their service areas in 2006 and 2007. Because firms anticipated the 2006 moratorium and were able to gain approval of expansions in late 2005, the moratorium is particularly relevant to changes in offerings between 2006 and 2007. There were 15 fewer local PPO contracts in 2007 than in 2006 because withdrawals were not offset by new entrants. Although 20 new local PPO contracts were added in 2008, the net impact from 2006 to 2008 was an increase of only 5 (118 to 123). As was the case in 2005-2006, local PPOs appear to be more popular in some geographic areas than others, although it is rare to find a substantial number in states with no HMOs. It is striking that local PPOs continue to be rare in California (only 1 local PPO contract in 2008, down from 3 in 2006). Minnesota also has no PPOs, despite having 3 HMOs and 2 to 3 cost contracts (depending on the year). These states both have active HMO markets.

PFFS Contracts. In 2006, each of the 26 MA regions had at least one PFFS contract operating in at least one county in the region, and such contracts also were in place in all states except for Massachusetts. Since that time, the number of PFFS contracts has increased from 22 (2006) to 70 (2008). PFFS contracts often have broad service areas that include multiple states. This limits the variation across states in the number of contracts in place. By 2008, only four states and the District of Columbia had fewer than 10 contracts that serve at least one county in the state—Rhode Island (5), Alaska (6), New Jersey, and the District of Columbia (8 each), and Hawaii (9). Pennsylvania (with 18) and Texas (with 16) had the most PFFS contracts among states. Massachusetts, which had no PFFS contracts in 2006, had 7 such contracts in 2007 and 13 in 2008.

B. AVAILABILITY OF MA CONTRACTS BY TYPE

Overall Availability. MA beneficiaries have had at least one MA contract available to them since 2006, regardless of where they reside (Table III.2). The one exception is Alaska, where only 12 percent had such a choice in 2006, although most beneficiaries do now.[2] Previously, we found that a key driver of change was the growing availability of PFFS contracts (between 2005 and 2006), although the new regional PPO option also contributed to growth. PFFS growth continued to be a major driver of expanded availability between 2006 and 2008, with such options available to all beneficiaries regardless of where they live. In 2007, such an option was available to all beneficiaries except for a few counties in Alaska and Massachusetts. By 2008, only Alaska was a potential exception.

Availability of Local Coordinated Care Options. HMOs, originally the sole private plan option in Medicare, have dominated MA enrollment from the program's inception (Gold 2005). Our analysis of the data in Table III.2 indicates that HMOs are more likely than other options to be available across states, but also that such availability continues to differ by state. By 2008,

[2] The data show that 73 percent of beneficiaries in Alaska had at least one such choice in 2007 and 2008. The number may be understated to the extent that unique circumstances exist in particular geographic locales, creating complications in using the data files used here (e.g., areas without county identifiers allowing them to be included in the statistics).

only 22 states had HMOs available to 75 percent or fewer of their beneficiaries, down from 28 in 2006 (see Figure III.1). Of the 8 states with no HMOs available in 2006, all but Delaware continued to have either no HMOs available or HMOs available to only a small percent (25 percent or less) of their beneficiaries. Among the four states with HMOs available in 2006 to only 25 percent or fewer of their beneficiaries, all had expanded this availability by 2008, placing them in the next higher category (Virginia, Indiana, South Carolina) or better (Mississippi).

In recent years, local PPOs have become more available. Policymakers have hoped that more open provider access (albeit for additional cost sharing) would attract beneficiaries to private plans with incentives and structures more suited to care management than the traditional Medicare program (and PFFS). Universal availability remains an issue, however, and the growth of local PPOs does not really compensate for this. The only states for which a relatively small share of their beneficiaries have access to an HMO but substantially more have access to a local PPO are Montana (71 percent), West Virginia (100%), New Mexico (100 percent), and Alabama (100%).

Availability of MSAs. The first MSA was offered in 2007 and, as noted in Chapter II, such offerings continue to be restricted mainly to a single firm and its affiliates (Wellpoint). As with PFFS contracts, however, MSAs tend to encompass broad service areas. In 2007, the first year that MSAs were offered, such offerings were available to all beneficiaries in 44 states, and some beneficiaries in an additional 2 states.[3] In 2008, all beneficiaries, regardless of their state of residence had such a choice (except in some areas of Alaska).

C. AVAILABILITY IN URBAN AND RURAL AREAS WITHIN STATES

Tables III.3 and III.4 are identical to Table III.2 except that they show availability and changes from 2006 through 2008 in urban and rural areas, respectively. As discussed in Chapter II, all urban beneficiaries had an MA choice in 2006; by 2008 such beneficiaries had, at a minimum, choice among PFFS and MSA contracts; 90 percent could choose an HMO, 88 percent could choose a regional PPO, and 72 percent a local PPO (Table III.3). Rural beneficiaries were equally likely to have PFFS, MSA, and regional PPO choices (Table III.4). But only 43 percent of rural beneficiaries had an HMO choice in 2008, and 32 percent a local PPO choice. Therefore, in the remainder of this section, we focus therefore on variations in HMO and local PPO choice by state for rural beneficiaries.

In the majority of states, most rural beneficiaries cannot choose an HMO, even if the choice is available elsewhere in the state. By 2008, there were only four states in which all rural beneficiaries had an HMO choice: Connecticut, Ohio, Minnesota, and Hawaii. There were only 11 more states for which HMO availability extended beyond half of all rural beneficiaries: Pennsylvania (81 percent), Oregon (75 percent), Wisconsin (70 percent), Washington (68 percent), New York (66 percent), Arizona (65 percent), Arkansas, Louisiana, and Tennessee (64 percent each), Florida (62 percent), and Iowa (61 percent). We are not certain what distinguishes these states from others, but speculate that it could be a combination of factors,

[3] This analysis excludes the MSA demonstration, which is included in the demonstration category. However, its inclusion would have limited impact on the findings since the demonstrations service area is limited.

Figure III.1. States Where 25 Percent or More of Beneficiaries Do Not Have Access to HMO Contracts, 2006-2008

Percent of Beneficiaries with at Least 1 HMO Option	2006		2008		2008 HMO Category with Percent with Local PPO Availability
0 percent	Maine, Vermont, Delaware, Montana, North Dakota, South Dakota, Wyoming, Alaska	8	New Hampshire, Vermont, North Dakota, Alaska, South Dakota	5	New Hampshire (0%), Vermont (0%), North Dakota (0%), South Dakota (2%), Alaska (0%), South Dakota (2%)
1-25 percent	Virginia, Mississippi, Indiana, South Carolina	4	Montana, Wyoming	2	Montana (71%), Wyoming (0%)
26-50 percent	New Hampshire, Arkansas, Nebraska, Kansas, West Virginia, Nebraska, New Mexico, Kentucky, Georgia, Louisiana	10	West Virginia, Indiana, Virginia, Kentucky, South Carolina, Kansas, Nebraska	7	West Virginia (100%), Virginia (63%), South Carolina (58%), Indiana (39%), Kentucky (39%), Kansas (38%), Nebraska (31%)
57-75 percent	North Carolina, Oklahoma, Utah, Texas, Missouri, Idaho, Iowa	7	Delaware, Oklahoma, Georgia, Alabama, Missouri, Mississippi, North Carolina, New Mexico	8	Delaware (0%), Alabama (100%), Georgia (45%), Missouri (67%), Mississippi (0%), North Carolina (56%), New Mexico (100%), Oklahoma (63%)

Source: MPR analysis for ASPE of publicly available CMS data on MA (see Table III.2).

depending on the state's (1) geography (the location of rural areas relative to urban areas); and (2) Medicaid history (in states with more broad-based Medicaid managed care initiatives, state efforts may have spurred the development of HMOs with a more statewide focus.)

Local PPO availability in rural areas is not necessarily consistent with that of HMO availability, although the pattern of variation is hard to discern. In most states, the share of rural beneficiaries with access to a local PPO is the same or less than for an HMO. In a few states, substantially more rural beneficiaries had access to a local PPO than to an HMO in 2008: New York (100 versus 66 percent), West Virginia (100 versus 35 percent), Alabama (100 versus 41 percent), Montana (57 versus 22 percent), and Oregon (100 versus 75 percent).

Table III.1. MA and Related Contracts by MA Region and State, 2006-2008

MA Region	State	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			Number of Cost Contracts Serving 1 or More Counties		
		2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008
All Regions		**11**	**11**	**11**	**207**	**214**	**279**	**118**	**103**	**123**	**22**	**44**	**70**	**18**	**21**	**16**
1	**Region**	**0**	**0**	**0**	**1**	**2**	**3**	**1**	**1**	**2**	**2**	**9**	**11**	**0**	**0**	**0**
	Maine	0	0	0	0	2	3	1	1	2	2	7	11	0	0	0
	New Hampshire	0	0	0	1	0	0	0	0	0	2	9	10	0	0	0
2	**Region**	**0**	**0**	**0**	**10**	**10**	**12**	**5**	**4**	**4**	**2**	**11**	**17**	**0**	**0**	**0**
	Connecticut	0	0	0	3	5	6	1	0	1	1	7	9	0	0	0
	Massachusetts	0	0	0	7	3	4	3	3	3	0	7	13	0	0	0
	Rhode Island	0	0	0	2	2	2	1	1	0	1	5	5	0	0	0
	Vermont	0	0	0	0	0	0	0	0	0	2	7	9	0	0	0
3	**Region**	**1**	**1**	**1**	**18**	**17**	**20**	**11**	**9**	**8**	**1**	**11**	**14**	**1**	**3**	**1**
	New York	1	1	1	18	17	20	11	9	8	1	11	14	1	3	1
4	**Region**	**1**	**1**	**1**	**5**	**5**	**7**	**1**	**1**	**1**	**2**	**7**	**8**	**0**	**0**	**0**
	New Jersey	1	1	1	5	5	7	1	1	1	2	7	8	0	0	0
5	**Region**	**1**	**1**	**1**	**3**	**4**	**6**	**2**	**2**	**2**	**2**	**11**	**12**	**1**	**1**	**1**
	Delaware	1	1	1	0	1	1	0	0	0	2	8	12	0	0	0
	District of Columbia	1	1	1	2	2	3	1	1	1	1	9	8	1	1	1
	Maryland	1	1	1	2	2	3	1	1	1	1	8	11	1	1	1
6	**Region**	**1**	**1**	**1**	**12**	**11**	**11**	**10**	**10**	**11**	**7**	**13**	**20**	**1**	**1**	**0**
	Pennsylvania	1	1	1	11	10	10	8	8	8	7	13	18	0	0	0
	West Virginia	1	1	1	1	1	1	2	2	3	2	11	13	1	1	0
7	**Region**	**1**	**1**	**1**	**4**	**5**	**6**	**6**	**6**	**6**	**6**	**12**	**16**	**1**	**1**	**1**
	Virginia	1	1	1	2	2	3	3	3	3	6	10	14	1	0	0
	North Carolina	1	1	1	2	3	3	3	3	3	6	12	15	0	1	1
8	**Region**	**2**	**2**	**2**	**6**	**9**	**9**	**5**	**5**	**8**	**7**	**14**	**17**	**0**	**0**	**0**
	South Carolina	2	2	2	1	7	7	2	3	5	6	13	14	0	0	0
	Georgia	2	2	2	5	3	2	3	2	4	5	13	15	0	0	0
9	**Region**	**2**	**2**	**2**	**25**	**26**	**28**	**9**	**9**	**7**	**3**	**9**	**12**	**0**	**0**	**0**
	Florida	2	2	2	25	26	28	9	9	7	3	9	12	0	0	0
10	**Region**	**2**	**1**	**2**	**21**	**10**	**25**	**8**	**4**	**8**	**8**	**14**	**20**	**2**	**0**	**0**
	Alabama	2	1	2	16	3	17	5	2	4	5	8	15	2	0	0
	Tennessee	1	1	1	5	7	9	3	2	4	5	13	15	0	0	0
11	**Region**	**1**	**1**	**1**	**5**	**5**	**7**	**1**	**1**	**2**	**4**	**11**	**13**	**0**	**0**	**0**
	Michigan	1	1	1	5	5	7	1	1	2	4	11	13	0	0	0
12	**Region**	**2**	**2**	**2**	**10**	**10**	**11**	**9**	**5**	**7**	**3**	**13**	**15**	**2**	**2**	**1**
	Ohio	2	2	2	10	10	11	9	5	7	3	13	15	2	2	1
13	**Region**	**2**	**2**	**2**	**2**	**2**	**5**	**7**	**7**	**7**	**6**	**12**	**15**	**3**	**3**	**3**
	Indiana	2	2	2	1	1	4	5	5	5	6	12	15	3	3	3
	Kentucky	2	2	2	1	1	2	3	3	3	4	12	12	0	0	0

Table III.1 *(continued)*

MA Region	State	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			Number of Cost Contracts Serving 1 or More Counties		
		2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008
14	**Region**	**1**	**1**	**1**	**14**	**16**	**18**	**8**	**7**	**10**	**8**	**14**	**17**	**5**	**5**	**5**
	Wisconsin	1	1	1	3	12	12	2	5	7	6	12	12	4	1	1
	Illinois	1	1	1	11	4	6	6	2	3	6	11	16	1	4	4
15	**Region**	**1**	**1**	**1**	**8**	**9**	**13**	**5**	**4**	**7**	**6**	**14**	**16**	**0**	**0**	**0**
	Arkansas	1	1	1	2	3	4	0	0	3	5	12	14	0	0	0
	Missouri	1	1	1	6	6	9	5	4	6	4	10	13	0	0	0
16	**Region**	**1**	**1**	**1**	**4**	**6**	**8**	**2**	**1**	**1**	**4**	**13**	**14**	**0**	**0**	**0**
	Mississippi	1	1	1	1	4	5	0	1	1	2	11	12	2	0	0
	Louisiana	1	1	1	3	2	3	2	0	0	3	9	9	0	0	0
17	**Region**	**1**	**1**	**1**	**11**	**12**	**17**	**5**	**5**	**5**	**3**	**12**	**16**	**1**	**1**	**1**
	Texas	1	1	1	11	12	17	5	5	5	3	12	16	1	1	1
18	**Region**	**1**	**1**	**1**	**5**	**7**	**8**	**4**	**4**	**6**	**3**	**10**	**13**	**0**	**0**	**0**
	Oklahoma	1	1	1	3	2	3	1	3	3	3	10	13	0	0	0
	Kansas	1	1	1	2	5	5	3	1	3	3	9	13	0	0	0
19	**Region**	**1**	**1**	**1**	**7**	**8**	**10**	**2**	**2**	**5**	**8**	**15**	**17**	**5**	**4**	**4**
	Iowa	1	1	1	4	4	4	1	1	2	6	11	12	1	1	1
	Minnesota	1	1	1	3	3	3	0	0	0	6	10	11	3	2	2
	Montana	1	1	1	0	1	1	1	1	1	4	8	12	0	0	0
	Nebraska	1	1	1	2	2	3	0	0	1	5	8	12	0	0	0
	North Dakota	1	1	1	0	0	0	0	0	0	3	8	11	1	2	1
	South Dakota	1	1	1	0	0	0	0	0	1	4	8	12	1	1	1
	Wyoming	1	1	1	0	0	1	0	0	0	2	8	10	1	0	1
20	**Region**	**0**	**0**	**0**	**5**	**7**	**11**	**5**	**5**	**6**	**4**	**14**	**15**	**1**	**0**	**1**
	New Mexico	0	0	0	2	5	6	4	1	1	4	11	13	0	0	1
	Colorado	0	0	0	3	2	5	1	4	5	3	9	8	1	0	0
21	**Region**	**2**	**2**	**2**	**9**	**9**	**9**	**4**	**3**	**3**	**5**	**12**	**15**	**0**	**0**	**0**
	Arizona	2	2	2	9	9	9	4	3	3	5	12	15	0	0	0
22	**Region**	**1**	**1**	**1**	**4**	**3**	**6**	**2**	**2**	**4**	**3**	**9**	**13**	**0**	**0**	**0**
	Nevada	1	1	1	4	3	6	2	2	4	3	9	13	0	0	0
23	**Region**	**0**	**0**	**0**	**15**	**17**	**24**	**12**	**12**	**13**	**6**	**15**	**18**	**1**	**2**	**2**
	Washington	0	0	0	7	1	1	4	3	3	3	10	13	0	1	1
	Oregon	0	0	0	10	11	12	4	4	5	4	10	13	1	1	1
	Idaho	0	0	0	1	1	4	3	3	3	4	12	13	0	0	0
	Utah	0	0	0	1	8	11	3	4	5	6	11	14	0	0	0
24	**Region**	**1**	**1**	**1**	**16**	**18**	**20**	**3**	**1**	**1**	**2**	**9**	**13**	**0**	**1**	**0**
	California	1	1	1	16	18	20	3	1	1	2	9	13	0	1	0
25	**Region**	**1**	**1**	**1**	**2**	**2**	**2**	**1**	**1**	**1**	**1**	**7**	**9**	**1**	**1**	**1**
	Hawaii	1	1	1	2	2	2	1	1	1	1	7	9	1	1	1
26	**Region**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**5**	**6**	**0**	**0**	**0**
	Alaska	0	0	0	0	0	0	0	0	0	1	5	6	0	0	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. 2007 data are from a file created from the November 2006 release of the Plan Finder, and 2008 data are compiled from the MA Landscape files. Beneficiary data are for December 2005, and are from the Market Penetration Report.

Table III.2. Selected Measures of MA Contract Availability by Region and State, 2006-2008

MA 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			Percent with 1+ MSA Choice		
		2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008
All Regions		**100**	**100**	**100**	**72**	**76**	**80**	**63**	**61**	**63**	**88**	**88**	**88**	**80**	**100**	**100**	**0**	**72**	**100**
1	**Region**	**82**	**100**	**100**	**12**	**32**	**44**	**25**	**25**	**31**	**0**	**0**	**0**	**82**	**100**	**100**	**0**	**0**	**100**
	Maine	86	100	100	0	57	79	44	44	56	0	0	0	86	100	100	0	0	100
	New Hampshire	76	100	100	27	0	0	0	0	0	0	0	0	76	100	100	0	0	100
2	**Region**	**97**	**100**	**100**	**93**	**93**	**93**	**84**	**62**	**77**	**0**	**0**	**0**	**17**	**90**	**100**	**0**	**72**	**100**
	Connecticut	100	100	100	100	100	100	75	0	81	0	0	0	10	100	100	0	5	100
	Massachusetts	97	100	100	97	97	97	97	97	97	0	0	0	1	82	100	0	100	100
	Rhode Island	100	100	100	100	100	100	86	86	0	0	0	0	100	100	100	0	100	100
	Vermont	70	100	100	0	0	0	0	0	0	0	0	0	70	100	100	0	100	100
3	**Region**	**100**	**100**	**100**	**93**	**94**	**95**	**99**	**99**	**100**	**100**	**100**	**100**	**34**	**100**	**100**	**0**	**0**	**100**
	New York	100	100	100	93	94	95	99	99	100	100	100	100	34	100	100	0	0	100
4	**Region**	**100**	**100**	**100**	**100**	**100**	**100**	**87**	**87**	**87**	**100**	**100**	**100**	**35**	**100**	**100**	**0**	**100**	**100**
	New Jersey	100	100	100	100	100	100	87	87	87	100	100	100	35	100	100	0	100	100
5	**Region**	**100**	**100**	**100**	**70**	**77**	**81**	**70**	**70**	**74**	**100**	**100**	**100**	**26**	**100**	**100**	**0**	**100**	**100**
	Delaware	100	100	100	0	54	54	0	0	0	100	100	100	100	100	100	0	100	100
	District of Columbia	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	0	100	100
	Maryland	100	100	100	79	79	84	79	79	84	100	100	100	4	100	100	0	100	100
6	**Region**	**100**	**100**	**100**	**85**	**86**	**87**	**96**	**98**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Pennsylvania	100	100	100	95	95	96	95	98	100	100	100	100	100	100	100	0	100	100
	West Virginia	100	100	100	28	28	35	100	100	100	100	100	100	100	100	100	0	100	100
7	**Region**	**100**	**100**	**100**	**39**	**48**	**54**	**48**	**48**	**59**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**56**	**100**
	North Carolina	100	100	100	56	58	67	41	41	56	100	100	100	100	100	100	0	100	100
	Virginia	99	100	100	16	36	36	57	57	63	99	100	100	99	100	100	0	0	100
8	**Region**	**100**	**100**	**100**	**34**	**43**	**44**	**46**	**46**	**50**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**38**	**100**
	Georgia	100	100	100	41	45	52	45	45	45	100	100	100	100	100	100	0	0	100
	South Carolina	100	100	100	23	40	32	47	47	58	100	100	100	100	100	100	0	100	100
9	**Region**	**100**	**100**	**100**	**90**	**93**	**97**	**78**	**78**	**81**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Florida	100	100	100	90	93	97	78	78	81	100	100	100	100	100	100	0	100	100
10	**Region**	**100**	**100**	**100**	**78**	**76**	**75**	**63**	**57**	**76**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Alabama	100	100	100	74	68	58	57	57	100	100	100	100	100	100	100	0	100	100
	Tennessee	100	100	100	82	82	88	68	56	56	100	100	100	100	100	100	0	100	100
11	**Region**	**100**	**100**	**100**	**73**	**81**	**84**	**50**	**50**	**56**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Michigan	100	100	100	73	81	84	50	50	56	100	100	100	100	100	100	0	100	100

Table III.2 *(continued)*

MA 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			Percent with 1+ MSA Choice		
		2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008
12	**Region**	**100**	**100**	**100**	**88**	**89**	**100**	**89**	**89**	**90**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**0**	**100**
	Ohio	100	100	100	88	89	100	89	89	90	100	100	100	100	100	100	0	0	100
13	**Region**	**100**	**100**	**100**	**17**	**17**	**40**	**39**	**39**	**39**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**0**	**100**
	Indiana	100	100	100	4	4	44	39	39	39	100	100	100	100	100	100	0	0	100
	Kentucky	100	100	100	35	35	36	38	38	39	100	100	100	100	100	100	0	0	100
14	**Region**	**100**	**100**	**100**	**74**	**74**	**77**	**75**	**75**	**76**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**67**	**100**
	Illinois	100	100	100	76	75	77	88	88	88	100	100	100	100	100	100	0	100	100
	Wisconsin	100	100	100	71	73	78	48	48	52	100	100	100	100	100	100	0	0	100
15	**Region**	**100**	**100**	**100**	**52**	**63**	**71**	**43**	**43**	**61**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**34**	**100**
	Arkansas	100	100	100	30	60	76	0	0	51	100	100	100	100	100	100	0	100	100
	Missouri	100	100	100	63	65	68	65	65	67	100	100	100	100	100	100	0	0	100
16	**Region**	**100**	**100**	**100**	**36**	**52**	**77**	**26**	**14**	**14**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Louisiana	100	100	100	49	66	89	46	24	24	100	100	100	100	100	100	0	100	100
	Mississippi	100	100	100	18	33	61	0	0	0	100	100	100	100	100	100	0	100	100
17	**Region**	**100**	**100**	**100**	**67**	**76**	**79**	**55**	**55**	**55**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Texas	100	100	100	67	76	79	55	55	55	100	100	100	100	100	100	0	100	100
18	**Region**	**100**	**100**	**100**	**45**	**53**	**53**	**49**	**49**	**53**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Kansas	100	100	100	35	39	41	30	30	39	100	100	100	100	100	100	0	100	100
	Oklahoma	100	100	100	52	64	62	63	63	63	100	100	100	100	100	100	0	100	100
19	**Region**	**100**	**100**	**100**	**54**	**61**	**64**	**11**	**11**	**22**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Iowa	100	100	100	68	77	78	22	22	47	100	100	100	100	100	100	0	100	100
	Minnesota	100	100	100	88	97	100	0	0	0	100	100	100	100	100	100	0	100	100
	Montana	100	100	100	0	12	23	71	71	71	100	100	100	100	100	100	0	100	100
	Nebraska	100	100	100	32	32	33	0	0	31	100	100	100	100	100	100	0	100	100
	North Dakota	100	100	100	0	0	0	0	0	0	100	100	100	100	100	100	0	100	100
	South Dakota	100	100	100	0	0	0	0	0	2	100	100	100	100	100	100	0	100	100
	Wyoming	100	100	100	0	0	3	0	0	0	100	100	100	100	100	100	0	100	100
20	**Region**	**100**	**100**	**100**	**72**	**72**	**77**	**75**	**75**	**75**	**0**	**0**	**0**	**100**	**100**	**100**	**0**	**34**	**100**
	Colorado	100	100	100	84	84	81	63	63	63	0	0	0	100	100	100	0	0	100
	New Mexico	100	100	100	49	49	69	100	100	100	0	0	0	100	100	100	0	100	100
21	**Region**	**100**	**100**	**100**	**92**	**92**	**92**	**81**	**81**	**86**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Arizona	100	100	100	92	92	92	81	81	86	100	100	100	100	100	100	0	100	100
22	**Region**	**100**	**100**	**100**	**89**	**89**	**89**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**0**	**100**
	Nevada	100	100	100	89	89	89	100	100	100	100	100	100	100	100	100	0	0	100

Table III.2 *(continued)*

MA 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			Percent with 1+ MSA Choice		
		2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008
23	**Region**	**100**	**100**	**100**	**82**	**89**	**92**	**85**	**85**	**92**	**0**	**0**	**0**	**96**	**100**	**100**	**0**	**100**	**100**
	Idaho	100	100	100	56	83	83	70	70	78	0	0	0	100	100	100	0	100	100
	Oregon	100	100	100	93	95	93	100	100	100	0	0	0	86	100	100	0	100	100
	Utah	100	100	100	61	61	92	87	87	89	0	0	0	100	100	100	0	100	100
	Washington	100	100	100	87	94	94	78	78	91	0	0	0	100	100	100	0	100	100
24	**Region**	**100**	**100**	**100**	**93**	**93**	**93**	**41**	**33**	**8**	**100**	**100**	**100**	**25**	**100**	**100**	**0**	**100**	**100**
	California	100	100	100	93	93	93	41	33	8	100	100	100	25	100	100	0	100	100
25	**Region**	**100**	**100**	**100**	**100**	**100**	**100**	**77**	**72**	**72**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Hawaii	100	100	100	100	100	100	77	72	72	100	100	100	100	100	100	0	100	100
26	**Region**	**12**	**73**	**73**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**12**	**73**	**73**	**0**	**73**	**73**
	Alaska	12	73	73	0	0	0	0	0	0	0	0	0	12	73	73	0	73	73

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. 2007 data are from a file created from the November 2006 release of the Plan Finder, and 2008 data are compiled from the MA Landscape files. Beneficiary data are for December 2005, and are from the Market Penetration Report.

Table III.3. Selected Measures of MA Contract Availability by Region and State, All URBAN Counties, 2006-2008

MA 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			Percent with 1+ MSA Choice		
		2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008
All Regions		**100**	**100**	**100**	**84**	**87**	**90**	**74**	**71**	**72**	**88**	**88**	**88**	**76**	**99**	**100**	**0**	**73**	**100**
1	**Region**	**84**	**100**	**100**	**22**	**44**	**55**	**35**	**35**	**47**	**0**	**0**	**0**	**84**	**100**	**100**	**0**	**0**	**100**
	Maine	100	100	100	0	79	100	64	64	85	0	0	0	100	100	100	0	0	100
	New Hampshire	64	100	100	49	0	0	0	0	0	0	0	0	64	100	100	0	0	100
2	**Region**	**97**	**100**	**100**	**97**	**97**	**97**	**90**	**66**	**81**	**0**	**0**	**0**	**13**	**90**	**100**	**0**	**73**	**100**
	Connecticut	100	100	100	100	100	100	83	0	83	0	0	0	5	100	100	0	5	100
	Massachusetts	97	100	100	97	97	97	97	97	97	0	0	0	1	82	100	0	100	100
	Rhode Island	100	100	100	100	100	100	86	86	0	0	0	0	100	100	100	0	100	100
	Vermont	0	100	100	0	0	0	0	0	0	0	0	0	0	100	100	0	100	100
3	**Region**	**100**	**100**	**100**	**97**	**98**	**98**	**100**	**100**	**100**	**100**	**100**	**100**	**27**	**100**	**100**	**0**	**0**	**100**
	New York	100	100	100	97	98	98	100	100	100	100	100	100	27	100	100	0	0	100
4	**Region**	**100**	**100**	**100**	**100**	**100**	**100**	**87**	**87**	**87**	**100**	**100**	**100**	**35**	**100**	**100**	**0**	**100**	**100**
	New Jersey	100	100	100	100	100	100	87	87	87	100	100	100	35	100	100	0	100	100
5	**Region**	**100**	**100**	**100**	**77**	**86**	**90**	**77**	**77**	**81**	**100**	**100**	**100**	**24**	**100**	**100**	**0**	**100**	**100**
	Delaware	100	100	100	0	77	77	0	0	0	100	100	100	100	100	100	0	100	100
	District of Columbia	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	0	100	100
	Maryland	100	100	100	85	85	91	85	85	91	100	100	100	5	100	100	0	100	100
6	**Region**	**100**	**100**	**100**	**93**	**93**	**94**	**98**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Pennsylvania	100	100	100	100	100	100	97	100	100	100	100	100	100	100	100	0	100	100
	West Virginia	100	100	100	24	24	35	100	100	100	100	100	100	100	100	100	0	100	100
7	**Region**	**99**	**100**	**100**	**46**	**57**	**62**	**61**	**61**	**72**	**99**	**100**	**100**	**99**	**100**	**100**	**0**	**51**	**100**
	North Carolina	100	100	100	74	75	83	56	56	70	100	100	100	100	100	100	0	100	100
	Virginia	99	100	100	16	39	39	66	66	73	99	100	100	99	100	100	0	0	100
8	**Region**	**100**	**100**	**100**	**47**	**57**	**59**	**59**	**59**	**64**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**38**	**100**
	Georgia	100	100	100	56	62	69	58	58	58	100	100	100	100	100	100	0	0	100
	South Carolina	100	100	100	32	48	43	61	61	75	100	100	100	100	100	100	0	100	100
9	**Region**	**100**	**100**	**100**	**96**	**98**	**100**	**82**	**82**	**85**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Florida	100	100	100	96	98	100	82	82	85	100	100	100	100	100	100	0	100	100
10	**Region**	**100**	**100**	**100**	**90**	**89**	**85**	**81**	**75**	**84**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Alabama	100	100	100	80	76	67	80	80	100	100	100	100	100	100	100	0	100	100
	Tennessee	100	100	100	99	99	100	83	71	71	100	100	100	100	100	100	0	100	100
11	**Region**	**100**	**100**	**100**	**92**	**96**	**96**	**65**	**65**	**71**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Michigan	100	100	100	92	96	96	65	65	71	100	100	100	100	100	100	0	100	100
12	**Region**	**100**	**100**	**100**	**96**	**97**	**100**	**96**	**96**	**97**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**0**	**100**
	Ohio	100	100	100	96	97	100	96	96	97	100	100	100	100	100	100	0	0	100

Table III.3 *(continued)*

MA 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			Percent with 1+ MSA Choice		
		2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008
13	**Region**	**100**	**100**	**100**	**25**	**25**	**58**	**56**	**56**	**57**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**0**	**100**
	Indiana	100	100	100	5	5	55	50	50	50	100	100	100	100	100	100	0	0	100
	Kentucky	100	100	100	63	63	64	67	67	70	100	100	100	100	100	100	0	0	100
14	**Region**	**100**	**100**	**100**	**85**	**83**	**87**	**84**	**84**	**85**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**71**	**100**
	Illinois	100	100	100	89	86	90	93	93	93	100	100	100	100	100	100	0	100	100
	Wisconsin	100	100	100	74	75	81	62	62	65	100	100	100	100	100	100	0	0	100
15	**Region**	**100**	**100**	**100**	**74**	**85**	**87**	**62**	**62**	**86**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**28**	**100**
	Arkansas	100	100	100	51	87	87	0	0	84	100	100	100	100	100	100	0	100	100
	Missouri	100	100	100	83	84	87	87	87	87	100	100	100	100	100	100	0	0	100
16	**Region**	**100**	**100**	**100**	**60**	**79**	**98**	**47**	**25**	**25**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Louisiana	100	100	100	67	81	99	65	35	35	100	100	100	100	100	100	0	100	100
	Mississippi	100	100	100	43	75	93	0	0	0	100	100	100	100	100	100	0	100	100
17	**Region**	**100**	**100**	**100**	**80**	**85**	**89**	**68**	**68**	**68**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Texas	100	100	100	80	85	89	68	68	68	100	100	100	100	100	100	0	100	100
18	**Region**	**100**	**100**	**100**	**75**	**83**	**84**	**76**	**76**	**82**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Kansas	100	100	100	63	70	73	54	54	67	100	100	100	100	100	100	0	100	100
	Oklahoma	100	100	100	83	92	92	93	93	93	100	100	100	100	100	100	0	100	100
19	**Region**	**100**	**100**	**100**	**76**	**79**	**80**	**16**	**16**	**33**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Iowa	100	100	100	91	98	98	46	46	79	100	100	100	100	100	100	0	100	100
	Minnesota	100	100	100	98	100	100	0	0	0	100	100	100	100	100	100	0	100	100
	Montana	100	100	100	0	0	26	100	100	100	100	100	100	100	100	100	0	100	100
	Nebraska	100	100	100	66	66	68	0	0	68	100	100	100	100	100	100	0	100	100
	North Dakota	100	100	100	0	0	0	0	0	0	100	100	100	100	100	100	0	100	100
	South Dakota	100	100	100	0	0	0	0	0	5	100	100	100	100	100	100	0	100	100
	Wyoming	100	100	100	0	0	0	0	0	0	100	100	100	100	100	100	0	100	100
20	**Region**	**100**	**100**	**100**	**94**	**94**	**96**	**82**	**82**	**82**	**0**	**0**	**0**	**100**	**100**	**100**	**0**	**27**	**100**
	Colorado	100	100	100	100	100	95	76	76	76	0	0	0	100	100	100	0	0	100
	New Mexico	100	100	100	77	77	100	100	100	100	0	0	0	100	100	100	0	100	100
21	**Region**	**100**	**100**	**100**	**97**	**97**	**97**	**88**	**88**	**94**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Arizona	100	100	100	97	97	97	88	88	94	100	100	100	100	100	100	0	100	100
22	**Region**	**100**	**100**	**100**	**96**	**96**	**96**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**0**	**100**
	Nevada	100	100	100	96	96	96	100	100	100	100	100	100	100	100	100	0	0	100
23	**Region**	**100**	**100**	**100**	**92**	**95**	**99**	**95**	**95**	**99**	**0**	**0**	**0**	**97**	**100**	**100**	**0**	**100**	**100**
	Idaho	100	100	100	80	99	99	97	97	99	0	0	0	100	100	100	0	100	100
	Oregon	100	100	100	100	100	100	100	100	100	0	0	0	90	100	100	0	100	100
	Utah	100	100	100	69	69	99	99	99	99	0	0	0	100	100	100	0	100	100
	Washington	100	100	100	97	99	99	91	91	98	0	0	0	100	100	100	0	100	100

Table III.3 *(continued)*

MA 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			Percent with 1+ MSA Choice		
		2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008
24	**Region**	**100**	**100**	**100**	**96**	**96**	**96**	**43**	**34**	**9**	**100**	**100**	**100**	**25**	**100**	**100**	**0**	**100**	**100**
	California	100	100	100	96	96	96	43	34	9	100	100	100	25	100	100	0	100	100
25	**Region**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Hawaii	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	0	100	100
26	**Region**	**18**	**100**	**100**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**18**	**100**	**100**	**0**	**100**	**100**
	Alaska	18	100	100	0	0	0	0	0	0	0	0	0	18	100	100	0	100	100

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. 2007 data are from a file created from the November 2006 release of the Plan Finder, and 2008 data are compiled from the MA Landscape files. Beneficiary data are for December 2005, and are from the Market Penetration Report.

Table III.4. Selected Measures of MA Contract Availability by Region and State, All RURAL Counties, 2006-2008

MA 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			Percent with 1+ MSA Choice		
		2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008
All Regions		99	100	100	27	35	43	26	25	32	89	89	89	97	100	100	0	70	100
1	**Region**	**79**	**100**	**100**	**0**	**17**	**30**	**12**	**12**	**12**	**0**	**0**	**0**	**79**	**100**	**100**	**0**	**0**	**100**
	Maine	70	100	100	0	31	54	21	21	21	0	0	0	70	100	100	0	0	100
	New Hampshire	91	100	100	0	0	0	0	0	0	0	0	0	91	100	100	0	0	100
2	**Region**	**96**	**100**	**100**	**38**	**38**	**38**	**0**	**0**	**25**		**0**	**0**	**82**	**99**	**100**	**0**	**62**	**100**
	Connecticut	100	100	100	100	100	100	0	0	64		0	0	64	100	100	0	0	100
	Massachusetts	69	100	100	0	0	0	0	0	0	0	0	0	69	69	100	0	100	100
	Rhode Island[a]																		
	Vermont	95	100	100	0	0	0	0	0	0	0	0	0	95	100	100	0	100	100
3	**Region**	**100**	**100**	**100**	**53**	**53**	**66**	**95**	**95**	**100**	**100**	**100**	**100**	**95**	**100**	**100**	**0**	**3**	**100**
	New York	100	100	100	53	53	66	95	95	100	100	100	100	95	100	100	0	3	100
4	**Region**[a]																		
	New Jersey[a]																		
5	**Region**	**100**	**100**	**100**	**0**	**0**	**0**	**0**	**0**	**0**	**100**	**100**	**100**	**43**	**100**	**100**	**0**	**100**	**100**
	Delaware	100	100	100	0	0	0	0	0	0	100	100	100	100	100	100	0	100	100
	District of Columbia[a]																		
	Maryland	100	100	100	0	0	0	0	0	0	100	100	100	0	100	100	0	100	100
6	**Region**	**100**	**100**	**100**	**60**	**62**	**66**	**91**	**92**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Pennsylvania	100	100	100	74	76	81	87	89	100	100	100	100	100	100	100	0	100	100
	West Virginia	100	100	100	32	32	35	100	100	100	100	100	100	100	100	100	0	100	100
7	**Region**	**100**	**100**	**100**	**22**	**28**	**36**	**18**	**18**	**30**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**68**	**100**
	North Carolina	100	100	100	26	28	39	15	15	31	100	100	100	100	100	100	0	100	100
	Virginia	100	100	100	15	28	28	25	25	29	100	100	100	100	100	100	0	0	100
8	**Region**	**100**	**100**	**100**	**0**	**8**	**6**	**10**	**10**	**11**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**39**	**100**
	Georgia	100	100	100	0	1	7	9	9	9	100	100	100	100	100	100	0	0	100
	South Carolina	100	100	100	0	19	4	11	11	14	100	100	100	100	100	100	0	100	100
9	**Region**	**100**	**100**	**100**	**20**	**27**	**62**	**31**	**27**	**31**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Florida	100	100	100	20	27	62	31	27	31	100	100	100	100	100	100	0	100	100
10	**Region**	**100**	**100**	**100**	**54**	**49**	**54**	**27**	**20**	**60**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Alabama	100	100	100	63	51	41	12	12	100	100	100	100	100	100	100	0	100	100
	Tennessee	100	100	100	47	48	64	40	26	26	100	100	100	100	100	100	0	100	100
11	**Region**	**100**	**100**	**100**	**7**	**33**	**43**	**0**	**0**	**4**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Michigan	100	100	100	7	33	43	0	0	4	100	100	100	100	100	100	0	100	100
12	**Region**	**100**	**100**	**100**	**56**	**59**	**100**	**61**	**61**	**66**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**0**	**100**
	Ohio	100	100	100	56	59	100	61	61	66	100	100	100	100	100	100	0	0	100

Table III.4 *(continued)*

MA 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			Percent with 1+ MSA Choice		
		2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008
13	**Region**	**100**	**100**	**100**	**4**	**4**	**9**	**8**	**8**	**8**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**0**	**100**
	Indiana	100	100	100	0	0	11	8	8	8	100	100	100	100	100	100	0	0	100
	Kentucky	100	100	100	7	7	7	8	8	9	100	100	100	100	100	100	0	0	100
14	**Region**	**100**	**100**	**100**	**39**	**44**	**45**	**43**	**43**	**44**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**53**	**100**
	Illinois	100	100	100	16	23	23	62	62	62	100	100	100	100	100	100	0	100	100
	Wisconsin	100	100	100	66	68	70	21	21	24	100	100	100	100	100	100	0	0	100
15	**Region**	**100**	**100**	**100**	**17**	**27**	**44**	**12**	**12**	**21**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**43**	**100**
	Arkansas	100	100	100	8	31	64	0	0	16	100	100	100	100	100	100	0	100	100
	Missouri	100	100	100	24	25	28	20	20	25	100	100	100	100	100	100	0	0	100
16	**Region**	**100**	**100**	**100**	**4**	**16**	**50**	**0**	**0**	**0**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Louisiana	100	100	100	4	30	64	0	0	0	100	100	100	100	100	100	0	100	100
	Mississippi	100	100	100	3	7	42	0	0	0	100	100	100	100	100	100	0	100	100
17	**Region**	**100**	**100**	**100**	**14**	**39**	**41**	**2**	**2**	**5**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Texas	100	100	100	14	39	41	2	2	5	100	100	100	100	100	100	0	100	100
18	**Region**	**100**	**100**	**100**	**7**	**16**	**13**	**14**	**14**	**16**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Kansas	100	100	100	0	0	0	0	0	5	100	100	100	100	100	100	0	100	100
	Oklahoma	100	100	100	12	27	23	24	24	24	100	100	100	100	100	100	0	100	100
19	**Region**	**100**	**100**	**100**	**33**	**43**	**47**	**6**	**6**	**11**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Iowa	100	100	100	48	58	61	0	0	18	100	100	100	100	100	100	0	100	100
	Minnesota	100	100	100	70	92	100	0	0	0	100	100	100	100	100	100	0	100	100
	Montana	100	100	100	0	18	22	57	57	57	100	100	100	100	100	100	0	100	100
	Nebraska	100	100	100	3	3	3	0	0	0	100	100	100	100	100	100	0	100	100
	North Dakota	100	100	100	0	0	0	0	0	0	100	100	100	100	100	100	0	100	100
	South Dakota	100	100	100	0	0	0	0	0	0	100	100	100	100	100	100	0	100	100
	Wyoming	100	100	100	0	0	4	0	0	0	100	100	100	100	100	100	0	100	100
20	**Region**	**100**	**100**	**100**	**7**	**7**	**19**	**54**	**54**	**54**	**0**	**0**	**0**	**100**	**100**	**100**	**0**	**54**	**100**
	Colorado	100	100	100	9	9	17	0	0	0	0	0	0	100	100	100	0	0	100
	New Mexico	100	100	100	5	5	20	100	100	100	0	0	0	100	100	100	0	100	100
21	**Region**	**100**	**100**	**100**	**65**	**65**	**65**	**37**	**37**	**37**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Arizona	100	100	100	65	65	65	37	37	37	100	100	100	100	100	100	0	100	100
22	**Region**	**100**	**100**	**100**	**47**	**47**	**47**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**0**	**100**
	Nevada	100	100	100	47	47	47	100	100	100	100	100	100	100	100	100	0	0	100
23	**Region**	**100**	**100**	**100**	**49**	**68**	**68**	**51**	**51**	**70**	**0**	**0**	**0**	**90**	**100**	**100**	**0**	**100**	**100**
	Idaho	100	100	100	19	59	59	29	29	46	0	0	0	100	100	100	0	100	100
	Oregon	100	100	100	78	82	75	100	100	100	0	0	0	75	100	100	0	100	100
	Utah	100	100	100	20	20	48	20	20	34	0	0	0	100	100	100	0	100	100
	Washington	100	100	100	38	68	68	13	13	56	0	0	0	100	100	100	0	100	100
24	**Region**	**100**	**100**	**100**	**19**	**19**	**19**	**0**	**0**	**0**	**100**	**100**	**100**	**26**	**100**	**100**	**0**	**100**	**100**
	California	100	100	100	19	19	19	0	0	0	100	100	100	26	100	100	0	100	100

Table III.4 *(continued)*

MA 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			Percent with 1+ MSA Choice		
		2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008
25	**Region**	**100**	**100**	**100**	**100**	**100**	**100**	**18**	**0**	**0**	**100**	**100**	**100**	**100**	**100**	**100**	**0**	**100**	**100**
	Hawaii	100	100	100	100	100	100	18	0	0	100	100	100	100	100	100	0	100	100
26	**Region**	**14**	**100**	**100**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**14**	**100**	**100**	**0**	**100**	**100**
	Alaska	14	100	100	0	0	0	0	0	0	0	0	0	14	100	100	0	100	100

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. 2007 data are from a file created from the November 2006 release of the Plan Finder, and 2008 data are compiled from the MA Landscape files. Beneficiary data are for December 2005, and are from the Market Penetration Report.

[a]Area does not contain any rural counties.

IV. ENROLLMENT TRENDS, 2005-2008

Enrollment in Medicare Advantage has increased substantially under the MMA—from 5.4 million in March 2005 to 9.1 million in March 2008, an increase of 68 percent, or just under 23 percent per year (Figure IV.1).[1] In this chapter, we review trends in total enrollment by contract type nationwide, how overall enrollment distributes across states, and what these counts imply about the penetration of MA nationwide and within states. Because sufficient data were not available for our previous study to examine trends in enrollment from 2005 to 2006, this chapter focuses on trends throughout the entire period of 2005-2008. While the availability analysis included only MA contracts with at least one plan that was generally available (i.e., not SNP-only or employer group only), this chapter includes all enrollees in MA because this is relevant to understanding the full penetration of MA into the marketplace.

A. NATIONAL ENROLLMENT TRENDS, 2005-2008

Table IV.1a shows trends in MA enrollment by contract type at various points in time from March 2005 to March 2008. Over this period, there was a net gain of 3.7 million Medicare beneficiaries enrolled under MA contracts. The most substantial growth occurred in PFFS (2.0 million enrolled in March 2008, up from 0.08 million in 2005). Growth in local coordinated care plans also was extensive (6.5 million up from 4.8 million in 2005, more than 90 percent of which was in the HMO sector). As we will discuss in Chapter VI, SNP growth is influencing the expansion in local coordinated care enrollment. A relatively small number of enrollees are in regional PPOs, newly authorized in 2006, although the number is growing (from around 90,000 in 2006 to 253,000 in 2008.) Despite their wide availability since 2007, MSAs still have few enrollees (under 2,000).

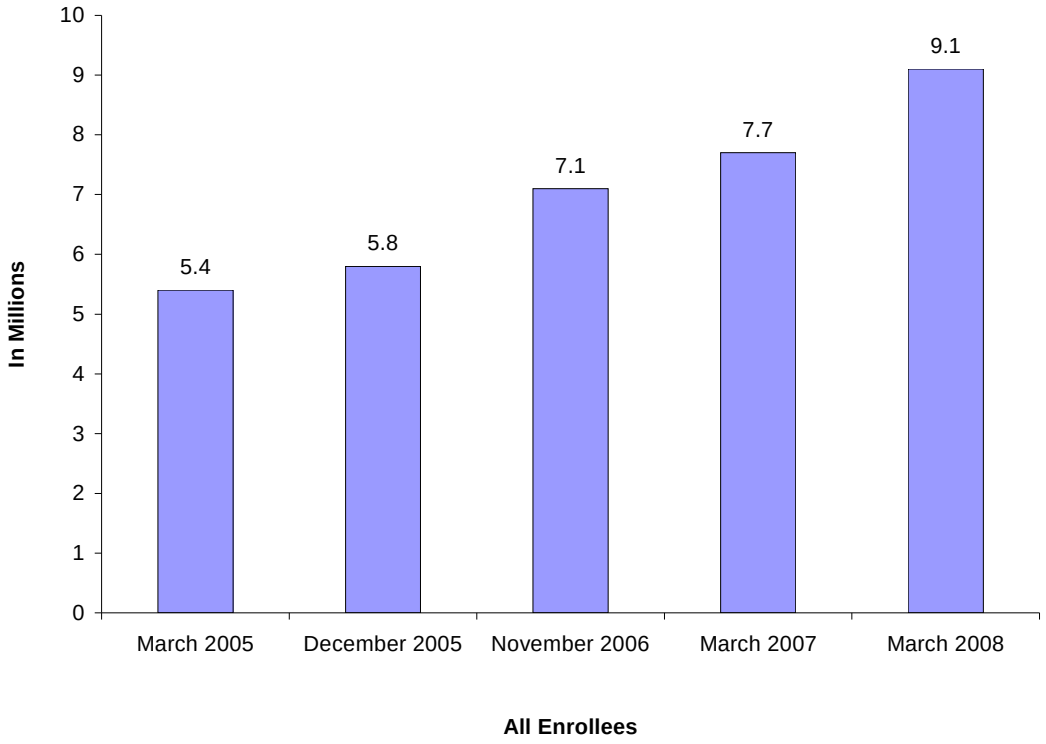
Enrollment growth means that more than 1 in 5 Medicare beneficiaries are enrolled now in an MA or similar private plan—a penetration of 21.2 percent. One in every 20 is in a PFFS plan. PFFS penetration has been growing rapidly and, at least through March 2008, at an accelerating pace. In fact, over the three-year period between March 2005 and March 2008, PFFS accounted for 53 percent of the growth in MA enrollment (Figure IV.2).

B. TRENDS IN URBAN AND RURAL AREAS

Tables IV.1b and IV.1c show MA enrollment and penetration data for urban and rural counties, respectively. Over the period from March 2005 through March 2008, MA enrollment in urban areas increased by 55 percent. It increased by 368 percent in rural areas. Despite the rapid growth in rural areas, MA enrollment remains disproportionately based in urban counties. In March 2008, urban counties still accounted for 86 percent of MA enrollment.

[1] Total enrollment includes the relatively small share of enrollees under contracts authorized outside MA (e.g., cost, HCPP, PACE, and demonstrations when data are available). For simplicity, we refer to "total MA enrollment" rather than "enrollment in MA and related plans."

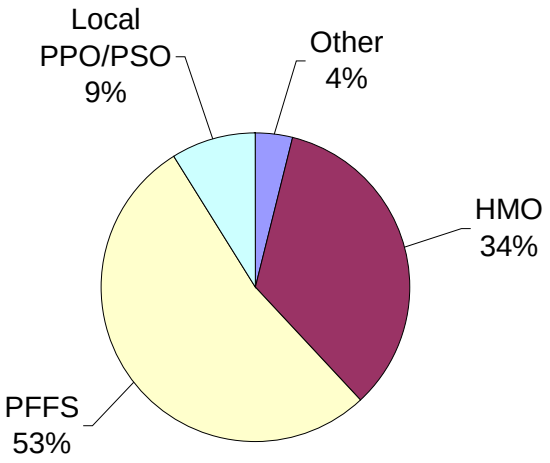
Figure IV.1. MA and Related Private Plan Enrollment Trends, 2005-2008



Source: MPR analysis for ASPE of CMS' publicly available MA data (see Table IV.1).

Note: Excludes Puerto Rico and The Territories.

Figure IV.2. Distribution of New MA Enrollment by Contract Type, March 2005-March 2008

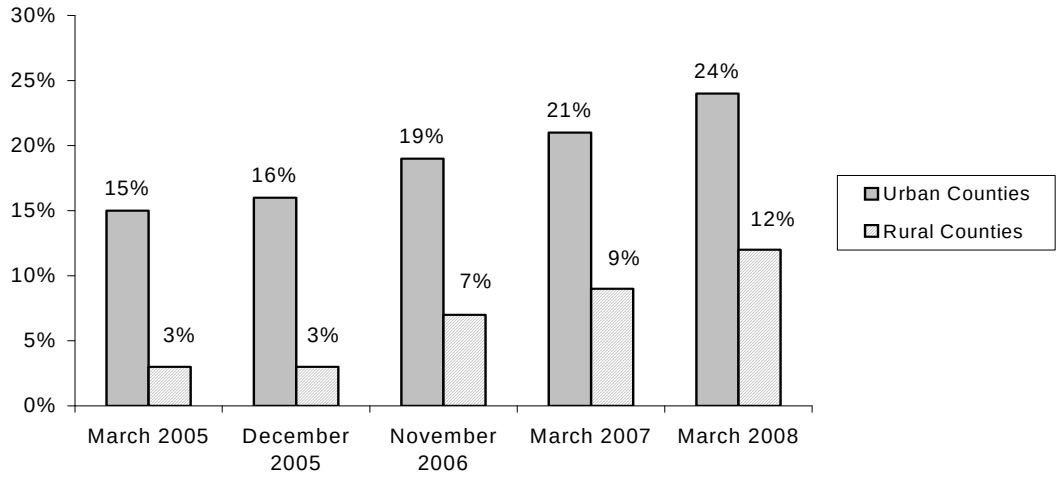


Net Enrollment Growth = 3.7 million

Source: MPR analysis for ASPE of CMS' publicly available MA data (see Table IV.1).

Note: Excludes Puerto Rico and The Territories.

Figure IV.3. Trends in MA Penetration, Urban and Rural Counties, 2005-2008



Source: MPR analysis for ASPE of CMS' publicly available MA data (see Tables IV.4 and IV.5).

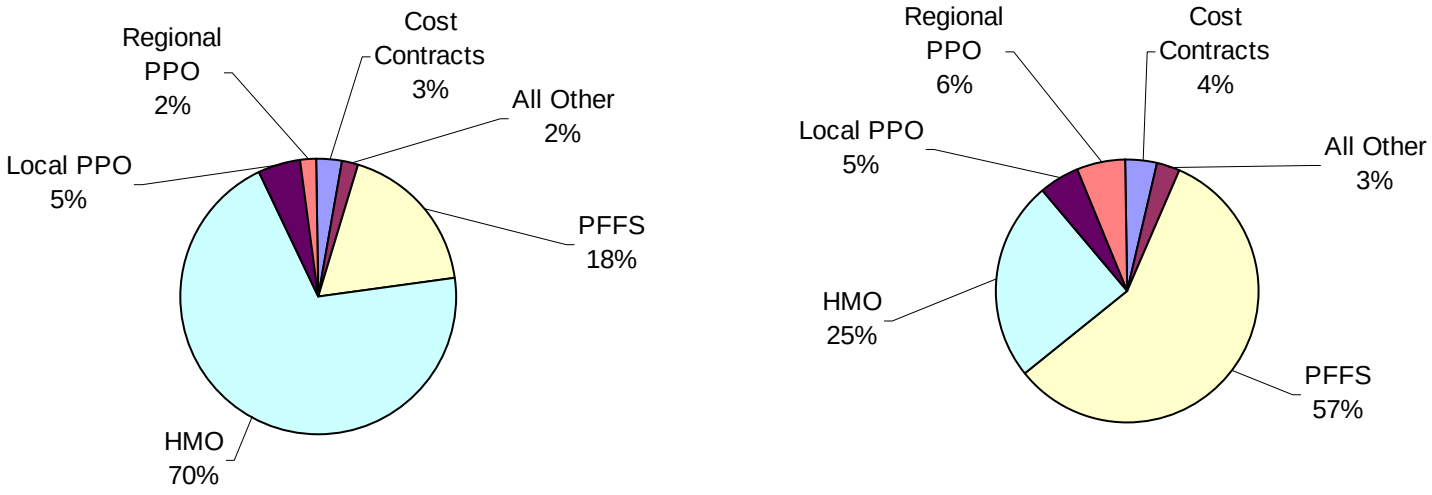
Note: Excludes Puerto Rico and The Territories.

However, from 2005 through 2008, the gap in penetration nationwide between the urban and rural counties declined (Figure IV.3). Between 2005 and 2008, MA penetration in urban counties increased 60 percent—from 15 percent MA penetration in March 2005 to 24 percent penetration in March 2008. Growth was relatively steady over time. In contrast, penetration in rural areas improved fourfold over the same period—from 3 percent to 12 percent. Thus, while penetration in rural areas remains much lower than in urban areas nationwide, the gap has been reduced, a fact that largely reflects growth of MA in rural areas over the period.

While MA enrollment in rural areas has increased across the spectrum, it has been driven most extensively by the growth in PFFS enrollment in rural areas (Table IV.1c). Of the roughly 863,000 net MA enrollees added in rural areas between March 2005 and March 2008, 69 percent were under PFFS contracts.

In March 2008, the distribution of MA enrollees by contract type in rural counties differed substantially from that in urban areas (Figure IV.4). In the latter, 70 percent of MA enrollment was in HMOs, 18 percent in PFFS, 7 percent in local or regional PPOs, 3 percent in cost contracts, and the rest in "other" (MSA, HCPP, PACE, demonstrations and other, etc.) In contrast, well over half—57 percent—of rural MA enrollees were in PFFS plans, and only 25 percent in local HMOs. Rural areas also have a higher percentage of enrollees in regional PPOs than do urban areas (6 percent versus 2 percent), although only a small share of enrollment in either type of county comes from this source.

Figure IV.4. Distribution of MA Enrollees within Urban and Rural Counties, March 2008



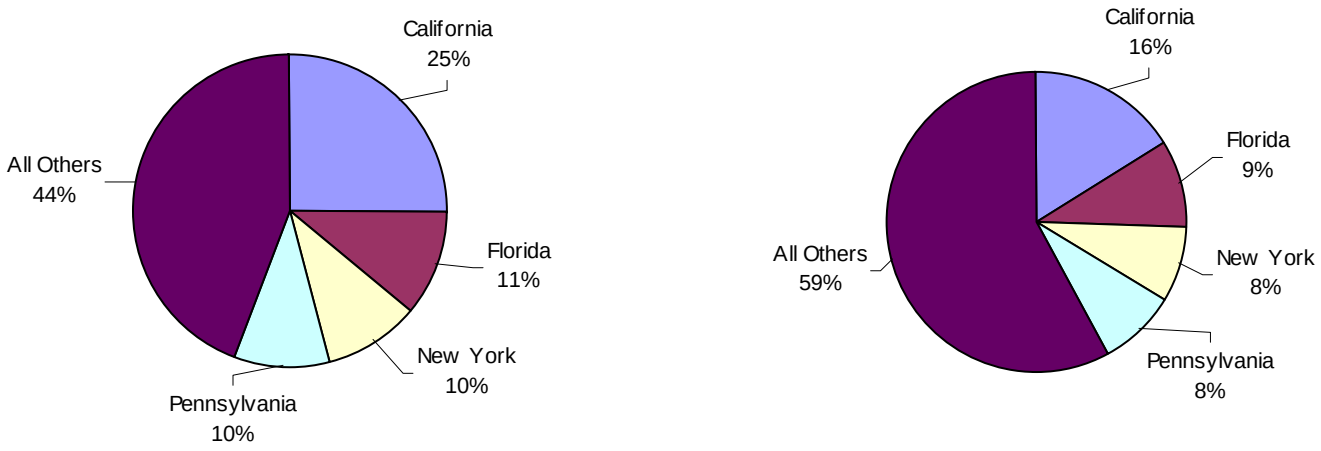
Source: MPR analysis for ASPE of CMS' publicly available MA data (see Tables III.1b and III.1c).

National figures present an oversimplified view of the dynamics of MA in urban and rural areas. As we will discuss later in the findings from the MA discussions, firms say there is substantial diversity across urban markets, and that rural areas also vary substantially in their ability to support MA. A key question of policymakers is whether PFFS is the only option viable for developing MA in rural areas, or whether coordinated care forms ultimately can be supported. The answer probably is that it depends, since market conditions vary considerably throughout the country.

C. ENROLLMENT BY STATE

MA enrollment has increased both in the nation and in each state, although enrollment remains very low in Alaska (Table IV.5). As in 2005, California and several other states continue to dominate MA enrollment in 2008, but their dominance is diminishing somewhat (Figure IV.5). In early 2005, California accounted for 25 percent of MA enrollment, and Florida, New York, and Pennsylvania accounted for another 30 percent (Figure IV.5). Thus, 55 percent of all MA enrollees were in these four populous states. By early 2005, the market share of these four states was only 42 percent, as enrollment grew more slowly (especially in California) than elsewhere in the country. Among the largest states, enrollment grew particularly rapidly in Texas (up from 194,000 to 441,000), Ohio (223,000 to 446,000), and Minnesota (108,000 to 241,376). Some medium-sized states such as North Carolina and Wisconsin tripled their enrollment. Except for Alaska, all states had at least 1,000 MA enrollees by 2008. Only Vermont, New Hampshire, Delaware, the District of Columbia, North Dakota, and Wyoming had fewer than 10,000 enrollees. (See Table IV.2.)

Figure IV.5. MA Enrollment by State, 2005-2008



March 2005
Enrollment = 5.4 million

March 2008
Enrollment = 9.1 million

Source: MPR analysis for ASPE of CMS' publicly available MA data (see Table IV.2).

Note: Excludes Puerto Rico and The Territories.

MA penetration provides the most sensitive profile of MA enrollment by states that differ substantially in both overall population and in number of Medicare beneficiaries. In March 2005, almost half of the states (24) had an MA penetration of under 5 percent. By November 2006, this number fell to 7 states, although 5 still are at or below this level in 2008 (Table IV.3).

At the other end of the spectrum, in early 2005, the highest MA penetration states were Rhode Island at 33 percent, Hawaii at 32 percent, and Oregon and California, each at 31 percent (Table IV.3). Of these four states, Oregon has grown the most rapidly in penetration since then, reaching 41 percent (the highest of any state) in March 2008. Hawaii's penetration stood at 37 percent in March 2008. Rhode Island and California each have grown steadily, but at a slower rate. In March 2008, penetration in these states was 35 percent and 34 percent, respectively. Minnesota, which had only a 15 percent penetration in March 2005, was also at 34 percent in March 2008. Pennsylvania's penetration also grew rapidly (from 24 percent to 34 percent), as did Colorado (25 to 33 percent). Arizona's rapid growth also means that its 37 percent penetration in March 2008 exceeds the penetration of all other states except Oregon and Hawaii.

None of the states not already mentioned has 30 percent or more of its Medicare beneficiaries in MA. Several, however, now have penetration rates of 20 percent or more: New York (26 percent), West Virginia (21 percent), Florida (27 percent), Michigan (21 percent), Ohio (25 percent), Wisconsin (23 percent), New Mexico (23 percent), Idaho (24 percent), and Washington (22 percent). These reflect substantial increases in all states, as well as very substantial increases in some. For example, penetration increased in West Virginia from 2 percent to 21 percent, and in Michigan from 1 percent to 21 percent. Both of these are states that

enrolled their state retirees in MA in 2007 or 2008, although the increase in penetration is unlikely to be explained fully by this factor.

State Variation Across Urban/Rural Areas. MA penetration varies across states in ways not explained solely by the mix of urban and rural areas within each state. Looking solely within urban counties in each state (Table IV.4), MA penetration is highest in Oregon (48 percent), Arizona (40 percent), Hawaii, Minnesota, and Pennsylvania (37 percent each), and California (35 percent). Although urban areas tend to have higher penetration than rural areas, 11 states and the District of Columbia have MA penetration of under 10 percent—Maine, New Hampshire, Vermont, New Jersey, Delaware, the District of Columbia, Maryland, Illinois, Mississippi, North Dakota, Wyoming, and Alaska. Although urban areas are a minority in most of these states, some of them—such as Delaware, Illinois, and Maryland—have extensive urban areas, and two are classified as entirely urban—New Jersey and the District of Columbia.

Consistent with national patterns, MA penetration within the rural areas of states is much lower than in urban areas. However, there exists substantial state-by-state variability (Table IV.5). MA penetration in rural areas in March 2008 was notably high in Hawaii (36 percent), Minnesota (27 percent), Oregon (24 percent), Wisconsin (23 percent), and Pennsylvania (22 percent). Five additional states had penetration rates of 15 percent or more (West Virginia, Idaho, Utah, Michigan, and Ohio). In contrast, MA penetration was 5 percent or less in 11 states, and between 5 and 10 percent in another 14 states. Thus, half of the states had penetration of under 10 percent at the end of the first quarter of 2008.

D. INFLUENCE OF GROUP VERSUS INDIVIDUAL ENROLLMENT ON PENETRATION

Throughout Medicare's history, it has provided various options to allow employer groups to enroll their Medicare-eligible retirees in MA and its predecessor programs. Anecdotal evidence suggests that such enrollment has become more common in recent years, as employers and unions have attempted to address rising health care costs, in addition to new requirements under the Government Accounting Standards Board (GASB) and the Financial Accounting Standards Board (FASB) to predict and adequately fund such future obligations (McNichol 2008, Dukdduk 2008). This has raised interest in learning more about the group market for MA.

Unfortunately, it is not possible to distinguish between individual versus group-based enrollment using the public data on MA enrollment by contract and county that is available from CMS.[2] The publicly available data file provides enrollment counts by county that are totals of all plans offered under each contract in that particular county. Contracts that formally enroll from groups do so under a specific group plan, which is not necessarily the same as that for individual enrollment.[3] CMS, in fact, provides no public data at all to distinguish group versus individual

[2] In May 2008, CMS made changes in this reporting that may improve upon previous limitations.

[3] As we understand it, firms commonly do not file separate plans for each group. Instead, they file for a barebones "MA" group plan that covers mainly the core Medicare benefits, perhaps with separate plans approved for MA-only and MA-PD. With this plan as a base, they negotiate individualized "wrap around" benefits, buydowns of cost sharing, and premiums with diverse employer groups. For more on group plans, see MedPAC's forthcoming *June 2008 Report to Congress.*

MA enrollment at the county level. However, CMS does release an annual contract/plan file that lists each contract, the plans offered under each, and the enrollment in that plan over the entire service area (not by county).

Under a separate contract with the Kaiser Family Foundation, we recently analyzed CMS's 2007 Annual Plan Report to learn about group enrollment (Gold 2008). According to that report, 16 percent of all MA enrollees were in group plans, most (71 percent) either in HMOs or cost contracts that reflect the past history of the program. For example, almost one-quarter of group enrollees were in plans affiliated with Kaiser Permanente as of mid-2007. Nineteen percent—about 242,000 enrollees—were in PFFS plans, including a small number (approximately 11,000) in employer direct PFFS plans. At that time, there were approximately 113,000 enrollees in the BCBS of Michigan PFFS plan. Almost 100,000 of the other PFFS group enrollees were in plans affiliated with Aetna or Humana. (See Appendix A.4 for Fact Sheet on Group Enrollment.)

Based on data not available publicly, CMS reports that enrollment in group plans has increased since mid-2007, at least in PFFS, with a total of about 536,000 enrolled in group plans of this type, reflecting 26 percent of MA enrollment in PFFS in early 2008.[4] The Medicare Payment Advisory Commission (MedPAC) staff briefed Commission members on enrollment growth among groups in MA at their April 9, 2008 public meeting. The staff conclusion was that most (though not all) growth in the employer group market since 2006 was in PFFS. Staff also indicated that bids for PFFS in employer groups were higher, as a share of the benchmark, than for plans available for individual enrollment. Staff expressed concern that such bidding could result in Medicare subsidizing extra benefits for enrollees in group plans.

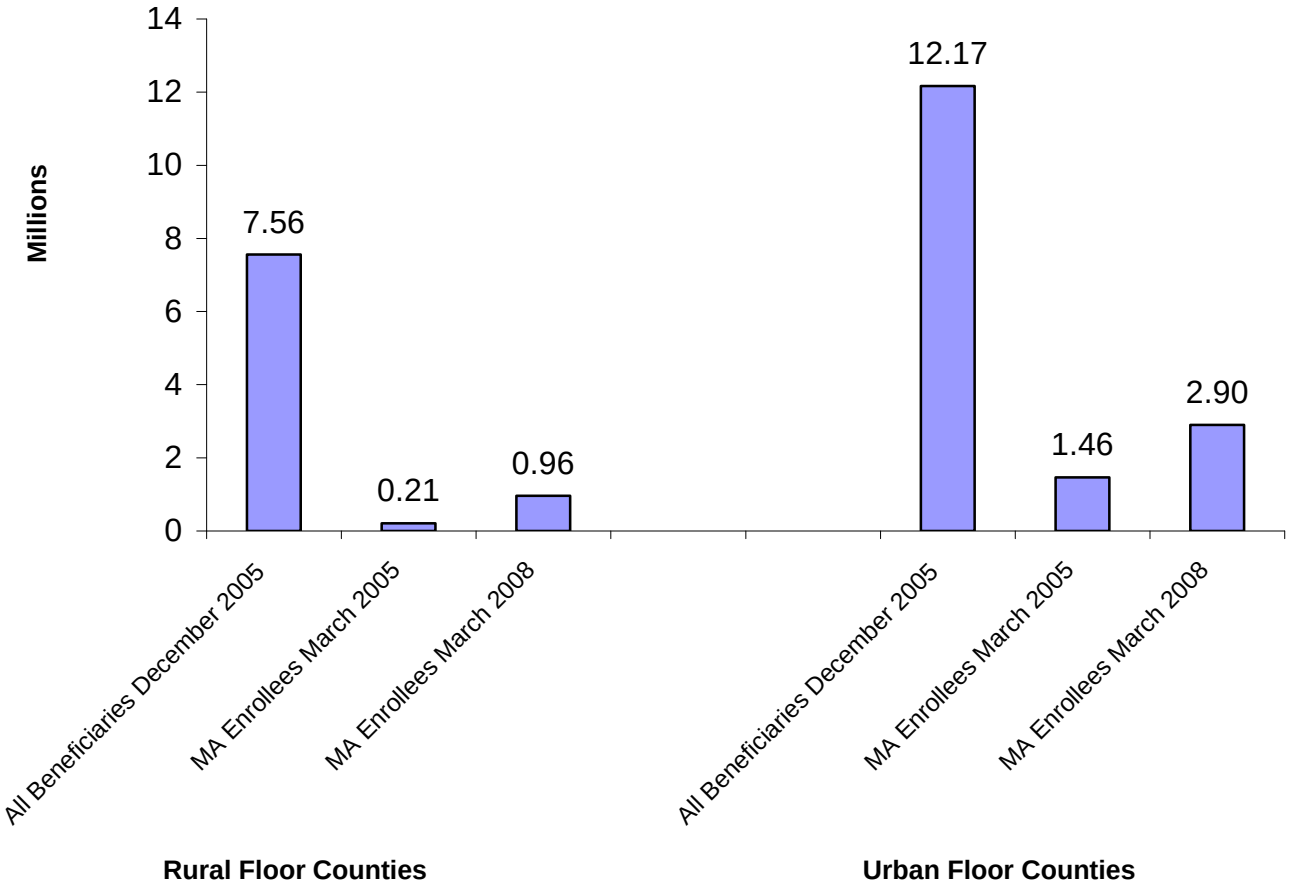
E. MA ENROLLMENT BY COUNTY BENCHMARK AND PAYMENT TYPE

Table IV.6 shows the distribution of MA enrollment by county benchmark rate for various points in time between 2005 and 2008. For point of reference, we show the same distribution for all Medicare beneficiaries as of December 2005, the last available date for which this type of beneficiary data is publicly available. Distribution of enrollment in rural and urban floor counties is of particular interest, since the floors, enacted respectively in the Balanced Budget Act of 1997 and the Budget Improvement and Protection Act of 2000, aimed to increase equity across MA (and expand rural MA presence) by setting an absolute minimum payment level or "floor" in such counties. As a result, payments in floor counties tend to exceed substantially those under the traditional Medicare program (MedPAC 2008a).

Figure IV.6 summarizes data on beneficiaries and MA enrollment in both urban and rural counties. In December 2005, 18 percent of Medicare beneficiaries resided in counties qualifying for rural floor payments; only 5 percent of beneficiaries—approximately 214,000 nationwide—were enrolled in MA in March of that year, however. By March 2008, more than four times as many such beneficiaries were enrolled in MA (approximately 964,000). While MA enrollment was growing in all counties, it grew about twice as fast in rural floor counties over that time period. Thus, while only 5 percent of MA enrollees were in such counties in December 2005, more than twice as many—10.6 percent—were enrolled in March 2008.

[4] These data were provided by Abby Block, CMS, at a National Health Policy Forum meeting on Employer Use of Private Fee-for-Service Plans on April 11, 2008.

Figure IV.6. Medicare Beneficiaries and MA Enrollees in Urban and Rural Floor Counties, 2005-2008



Source: MPR analysis for ASPE of CMS' publicly available MA data (see Table IV.6).

Note: Excludes Puerto Rico and The Territories.

Disparities between the distribution of beneficiaries and MA enrollees historically have been less in urban floor counties. In 2005, 28 percent of beneficiaries lived in urban floor counties and 27 percent of MA enrollees were in such counties in March 2005. As with rural floor counties, MA enrollment has grown somewhat faster in urban floor counties than in the MA program as a whole—increasing from 1.5 million in March 2005 to 2.9 million in March 2008. Enrollees from urban floor counties represented 32 percent of all MA enrollees in 2008, up from 28 percent in March 2005.

In relative terms, PFFS is much more extensively based in floor counties than are other forms of MA (Table IV.7). In relative terms, rural floor counties in 2008 have become a smaller proportion of total MA enrollment under PFFS contracts than they were in 2005. However, in March 2008, enrollment from rural floor counties still accounted for 30 percent of PFFS enrollment. Urban floor counties have maintained their relative position in the PFFS market since 2005, accounting for 42 percent of PFFS enrollees in 2008. Combined, the two types of floor counties accounted for 72 percent of PFFS enrollment in March 2008, almost twice as high as in MA overall (42 percent). Among HMO enrollees, only 30 percent were in floor counties in March 2008, mostly in urban ones.

Although more MA enrollees are in urban than rural counties even in PFFS contracts, PFFS contracts are particularly relevant to enrollment in rural floor counties. In March 2008, 63 percent of MA enrollees in rural floor counties were in PFFS contracts (Table IV.8). This compares to 30 percent in urban floor counties.

Table IV.1a. MA Enrollment Trends by Contract Type, United States, 2005-2008

Contracts by Type	March 2005	December 2005	November 2006	March 2007	March 2008	Net Change 2005-2008
Total Enrollees	5,426,316	5,829,387	7,133,420	7,765,461	9,127,543	+3,701,227
Local HMO, PSO, or PPO (formerly CCPs)	4,833,000	5,083,129	5,622,145	5,711,176	6,478,583	+1,595,583
Local HMO	4,655,406	4,823,558	5,218,069	5,295,129	5,925,682	+1,270,276
Local PPO[a]	177,594	259,571	404,076	416,047	522,901	+345,307
PFFS	79,372	199,062	819,098	1,329,296	2,032,587	+1,953,215
Regional PPO	NA	NA	89,393	118,030	253,214	+253,214
MSA	NA	NA	NA	1,346	1,706	+1,706
Cost contracts	317,932	317,749	313,405	304,988	267,616	-50,316
HCPP	20,917	20,880	75,477	69,864	66,781	+45,864
PACE	9,866	10,865	12,116	12,180	13,539	+3,653
Other[b]	165,229	197,702	201,786	218,581	13,517	-151,712
MA Penetration Overall	12.6%	13.6%	16.6%	18.1%	21.2%	
Local HMO/PPO Penetration	11.2%	11.8%	13.1%	13.3%	15.1%	
Private FFS Penetration	0.2%	0.5%	1.9%	3.1%	4.7%	

Source: MPR analysis of files created from publicly available CMS data. Data for March and December 2005 are from the Geographic Service Area Reports. Data from 2006 forward are from the Monthly MA Enrollment by State/County/Contract files. SNP enrollment is included in the relevant contract category.

[a] In 2005, the figure includes the PPO demonstration.

[b] The significant decrease in enrollment in "Other" contracts from March 2007 to March 2008 is largely due to a 2008 reclassification by CMS of demonstration contracts as SNPs that then were counted in their appropriate category (e.g., HMO). More than half of the enrollment reduction reflects reclassification of enrollment in contracts for the former social HMOs (SHMOs) from SCAN, Elderplan, and several demonstration HMOs in Minnesota that converted to dual eligible SNPs (including Blue Plus, UCare Minnesota, and Medica Health Plans). In addition, demonstration contracts in Wisconsin and those from Commonwealth Care Alliance also were reclassified in 2008 after previously being classified as "Other" contracts. These changes reflect a total of approximately 160,000 enrollees.

Table IV.1b. MA Enrollment Trends by Contract Type, URBAN Counties, United States, 2005-2008

Contracts by Type	March 2005	December 2005	November 2006	March 2007	March 2008	Net Change 2005-2008
Total Enrollees	5,189,804	5,523,185	6,514,650	6,989,737	8,035,025	+2,845,221
Local HMO, PSO, or PPO (formerly CCPs)	4,685,963	4,906,274	5,392,434	5,465,466	6,146,668	+1,460,705
Local HMO	4,513,681	4,656,433	5,014,027	5,080,075	5,650,875	+1,137,194
Local PPO (including PSO & PPO Demo)	172,282	249,841	378,407	385,391	495,793	+323,511
PFFS	53,728	136,099	548,465	924,219	1,409,793	+1,356,065
Regional PPO			75,199	97,503	190,697	+190,697
MSA				982	1,392	+1,392
Cost contracts	263,172	262,928	257,457	250,463	222,033	-41,139
HCPP	16,791	16,687	45,080	40,052	38,573	+21,782
PACE	9,866	10,865	12,116	12,180	13,539	+4,573
Other	160,284	190,332	183,899	198,872	12,330[a]	-147,954
MA Penetration Overall	15.3	16.3	19.3	20.7	23.7	
Local HMO/PPO Penetration	13.9	14.5	15.9	16.2	18.2	
Private FFS Penetration	0.2	0.4	1.6	2.7	4.2	

Source: MPR Analysis of files created from publicly available CMS data, selected months, and the data for March and December 2005 from the Geographic Service Area Reports. Data from 2006 forward are from the Monthly MA Enrollment by State/County/Contract files. SNP enrollment is included in the relevant contract type category.

[a]The significant decrease in "Other" contracts from March 2007 and March 2008 reflects the reclassification by CMS of former SHMOs from Scan, Elderplan, and several demonstrations for dual eligibles in Minnesota.

Table IV.1c. MA Enrollment Trends by Contract Type, RURAL Counties, United States, 2005-2008

Contracts by Type	March 2005	December 2005	November 2006	March 2007	March 2008	Net Change 2005-2008
Total Enrollees	234,607	304,259	617,074	775,015	1,091,535	+862,928
Local HMO, PSO, or PPO (formerly CCPs)	145,221	175,012	228,143	245,080	331,037	+185,816
Local HMO	139,935	165,302	202,489	214,439	273,944	+134,009
Local PPO (including PSO & PPO Demo)	5,286	9,710	25,654	30,641	57,093	+81,807
PFFS	25,644	62,963	270,606	405,048	622,750	+597,106
Regional PPO			14,194	20,527	62,517	+62,517
MSA				364	314	+314
Cost contracts	54,671	54,721	55,847	54,475	45,522	-949
HCPP	4,126	4,193	30,397	29,812	28,208	+24,082
PACE	0	0	0	0	0	0
Other	4,945	7,370	17,887	19,709	1,187	-3,758
MA Penetration Overall	2.6	3.3	6.8	8.5	11.9	
Local HMO/PPO Penetration	1.6	1.9	2.5	2.7	3.6	
Private FFS Penetration	0.3	0.7	3.0	4.4	6.8	

Source: MPR Analysis of files created from publicly available CMS data, selected months, and Geographic Service Area Reports. Data from 2006 forward are from the Monthly MA Enrollment by State/County/Contract files. SNP enrollment is included in the relevant contract type category.

Table IV.2. MA Enrollment by Region and State, 2005-2008

MA Region	State	Total Enrollment[a]				
		March 2005	December 2005	November 2006	March 2007	March 2008
United States		5,426,316	5,829,387	7,133,420	7,765,461	9,127,543
1	**Region**	**1,073**	**1,241**	**3,392**	**6,039**	**18,300**
	Maine	0	155	1,861	3,544	11,101
	New Hampshire	1,073	1,086	1,531	2,495	7,199
2	**Region**	**246,705**	**248,597**	**262,289**	**273,754**	**315,264**
	Connecticut	28,576	29,367	38,629	46,759	68,775
	Massachusetts	160,166	160,616	163,557	165,892	181,838
	Rhode Island	57,963	58,614	59,918	60,525	62,332
	Vermont	0	0	185	578	2,319
3	**Region**	**518,065**	**555,456**	**620,074**	**650,590**	**745,091**
	New York	518,065	555,456	620,074	650,590	745,091
4	**Region**	**95,877**	**100,497**	**109,093**	**111,536**	**121,335**
	New Jersey	95,877	100,497	109,093	111,536	121,335
5	**Region**	**33,861**	**37,003**	**43,064**	**45,860**	**58,530**
	Delaware	437	752	1,711	2,357	4,252
	District of Columbia	4,812	5,465	5,529	5,863	6,610
	Maryland	28,612	30,786	35,824	37,640	47,668
6	**Region**	**524,163**	**542,557**	**698,692**	**728,326**	**827,514**
	Pennsylvania	516,230	534,384	667,967	693,396	749,080
	West Virginia	7,933	8,173	30,725	34,930	78,434
7	**Region**	**81,996**	**110,072**	**211,751**	**246,087**	**324,450**
	North Carolina	66,636	89,596	141,405	162,329	209,783
	Virginia	15,360	20,476	70,346	83,758	114,667
8	**Region**	**22,175**	**46,045**	**111,818**	**146,015**	**216,016**
	Georgia	18,789	29,194	71,657	92,671	131,048
	South Carolina	3,386	16,851	40,161	53,344	84,968
9	**Region**	**578,172**	**631,686**	**706,106**	**752,564**	**831,639**
	Florida	578,172	631,686	706,106	752,564	831,639
10	**Region**	**136,879**	**170,438**	**234,726**	**261,681**	**319,215**
	Alabama	60,334	75,200	97,134	106,824	129,694
	Tennessee	76,545	95,238	137,592	154,857	189,521
11	**Region**	**21,726**	**28,759**	**85,084**	**203,130**	**321,350**
	Michigan	21,726	28,759	85,084	203,130	321,350
12	**Region**	**222,677**	**233,778**	**276,721**	**299,645**	**445,907**
	Ohio	222,677	233,778	276,721	299,645	445,907
13	**Region**	**31,461**	**38,039**	**104,049**	**148,363**	**198,867**
	Indiana	19,684	24,635	57,607	77,691	108,829
	Kentucky	11,777	13,404	46,442	70,672	90,038
14	**Region**	**139,588**	**169,964**	**245,149**	**284,408**	**350,301**
	Illinois	80,146	87,622	114,116	130,395	152,908
	Wisconsin	59,442	82,342	131,033	154,013	197,393
15	**Region**	**110,017**	**115,105**	**158,970**	**177,369**	**220,810**
	Arkansas	483	1,553	25,027	34,185	55,234
	Missouri	109,534	113,552	133,943	143,184	165,576
16	**Region**	**73,931**	**71,953**	**108,556**	**127,804**	**160,669**
	Louisiana	73,931	71,641	91,132	100,853	125,406
	Mississippi	0	312	17,424	26,951	35,263
17	**Region**	**194,781**	**227,611**	**314,711**	**355,833**	**441,447**
	Texas	194,781	227,611	314,711	355,833	441,447

Table IV.2 *(continued)*

MA Region	State	Total Enrollment[a]				
		March 2005	December 2005	November 2006	March 2007	March 2008
18	**Region**	**53,860**	**59,640**	**80,622**	**89,015**	**106,383**
	Kansas	11,370	13,357	23,881	27,497	33,959
	Oklahoma	42,490	46,283	56,741	61,518	72,424
19	**Region**	**143,799**	**174,621**	**268,367**	**306,002**	**363,846**
	Iowa	22,285	27,998	45,721	51,483	54,230
	Minnesota	108,100	128,920	181,791	202,683	241,376
	Montana	543	2,259	10,963	15,450	21,068
	Nebraska	10,929	12,682	19,696	22,203	26,835
	North Dakota	938	1,347	4,918	5,580	6,847
	South Dakota	176	583	2,679	5,811	10,470
	Wyoming	828	832	2,599	2,792	3,020
20	**Region**	**179,399**	**186,845**	**215,460**	**219,734**	**241,879**
	Colorado	137,554	142,798	159,620	161,593	178,303
	New Mexico	41,845	44,047	55,840	58,141	63,576
21	**Region**	**207,435**	**222,787**	**282,952**	**284,767**	**303,070**
	Arizona	207,435	222,787	282,952	284,767	303,070
22	**Region**	**83,493**	**85,487**	**88,847**	**92,022**	**97,809**
	Nevada	83,493	85,487	88,847	92,022	97,809
23	**Region**	**321,571**	**345,182**	**423,367**	**456,843**	**528,589**
	Idaho	19,162	21,859	32,264	37,726	48,106
	Oregon	171,365	179,320	203,749	211,352	227,462
	Utah	7,836	16,947	42,192	50,824	65,731
	Washington	123,208	127,056	145,162	156,941	187,290
24	**Region**	**1,343,615**	**1,365,048**	**1,412,789**	**1,431,184**	**1,499,016**
	California	1,343,615	1,365,048	1,412,789	1,431,184	1,499,016
25	**Region**	**59,997**	**60,976**	**66,758**	**66,848**	**70,115**
	Hawaii	59,997	60,976	66,758	66,848	70,115
26	**Region**	**0**	**0**	**13**	**42**	**131**
	Alaska	0	0	13	42	131

Source: MPR analysis of files created from publicly available CMS data. Data for March and December 2005 are from the Geographic Service Area Reports. Data from 2006 forward are from the Monthly MA Enrollment by State/County/Contract files.

[a] Includes all enrollees in all Medicare Advantage and related contracts. Excludes enrollees in Puerto Rico or the Territories.

Table IV.3. MA Penetration by Region and State, 2005-2008

		MA Penetration				
MA Region	State	March 2005	December 2005	November 2006	March 2007	March 2008
United States		12.6	13.6	16.6	18.1	21.2
1	**Region**	**0.2**	**0.3**	**0.8**	**1.4**	**4.2**
	Maine	0	0.1	0.8	1.5	4.6
	New Hampshire	0.6	0.6	0.8	1.3	3.7
2	**Region**	**13.5**	**13.6**	**14.4**	**15**	**17.3**
	Connecticut	5.3	5.4	7.1	8.6	12.7
	Massachusetts	15.9	15.9	16.2	16.5	18.1
	Rhode Island	32.6	33	33.7	34.1	35.1
	Vermont	0	0	0.2	0.6	2.3
3	**Region**	**18**	**19.3**	**21.5**	**22.6**	**25.9**
	New York	18	19.3	21.5	22.6	25.9
4	**Region**	**7.5**	**7.9**	**8.6**	**8.8**	**9.6**
	New Jersey	7.5	7.9	8.6	8.8	9.6
5	**Region**	**3.6**	**4**	**4.6**	**4.9**	**6.3**
	Delaware	0.3	0.6	1.3	1.8	3.2
	District of Columbia	6.2	7	7.1	7.6	8.5
	Maryland	4	4.3	5	5.2	6.6
6	**Region**	**20.5**	**21.2**	**27.3**	**28.5**	**32.4**
	Pennsylvania	23.6	24.4	30.5	31.7	34.2
	West Virginia	2.2	2.2	8.4	9.5	21.3
7	**Region**	**3.5**	**4.7**	**9**	**10.5**	**13.9**
	North Carolina	5.1	6.8	10.7	12.3	15.9
	Virginia	1.5	2	6.9	8.2	11.2
8	**Region**	**1.3**	**2.6**	**6.4**	**8.3**	**12.3**
	Georgia	1.7	2.7	6.7	8.6	12.2
	South Carolina	0.5	2.5	6	7.9	12.6
9	**Region**	**18.5**	**20.2**	**22.6**	**24**	**26.6**
	Florida	18.5	20.2	22.6	24	26.6
10	**Region**	**7.9**	**9.8**	**13.5**	**15.1**	**18.4**
	Alabama	7.7	9.6	12.4	13.7	16.6
	Tennessee	8	10	14.4	16.2	19.8
11	**Region**	**1.4**	**1.9**	**5.5**	**13.2**	**20.9**
	Michigan	1.4	1.9	5.5	13.2	20.9
12	**Region**	**12.3**	**12.9**	**15.3**	**16.5**	**24.6**
	Ohio	12.3	12.9	15.3	16.5	24.6
13	**Region**	**1.9**	**2.3**	**6.3**	**9**	**12.1**
	Indiana	2.1	2.6	6.2	8.3	11.6
	Kentucky	1.7	1.9	6.6	10	12.8
14	**Region**	**5.4**	**6.5**	**9.4**	**10.9**	**13.5**
	Illinois	4.6	5	6.5	7.5	8.7
	Wisconsin	7	9.6	15.3	18	23.1
15	**Region**	**7.7**	**8**	**11.1**	**12.4**	**15.4**
	Arkansas	0.1	0.3	5.1	7	11.3
	Missouri	11.6	12	14.2	15.2	17.6
16	**Region**	**6.6**	**6.5**	**9.7**	**11.5**	**14.4**
	Louisiana	11.5	11.1	14.2	15.7	19.5
	Mississippi	0	0.1	3.7	5.7	7.5
17	**Region**	**7.4**	**8.6**	**11.9**	**13.5**	**16.7**
	Texas	7.4	8.6	11.9	13.5	16.7
18	**Region**	**5.5**	**6.1**	**8.3**	**9.2**	**10.9**
	Kansas	2.8	3.2	5.8	6.7	8.2
	Oklahoma	7.6	8.3	10.1	11	12.9

Table IV.3 *(continued)*

MA Region	State	MA Penetration				
		March 2005	December 2005	November 2006	March 2007	March 2008
19	**Region**	**7.4**	**8.9**	**13.7**	**15.7**	**18.6**
	Iowa	4.4	5.6	9.1	10.2	10.8
	Minnesota	15	17.9	25.2	28.1	33.5
	Montana	0.4	1.5	7.2	10.1	13.7
	Nebraska	4.1	4.7	7.4	8.3	10
	North Dakota	0.9	1.3	4.6	5.2	6.4
	South Dakota	0.1	0.5	2.1	4.5	8.1
	Wyoming	1.1	1.1	3.5	3.8	4.1
20	**Region**	**21.9**	**22.8**	**26.3**	**26.8**	**29.5**
	Colorado	25.4	26.4	29.5	29.9	33
	New Mexico	15.1	15.9	20.1	20.9	22.9
21	**Region**	**25.3**	**27.2**	**34.6**	**34.8**	**37**
	Arizona	25.3	27.2	34.6	34.8	37
22	**Region**	**27**	**27.7**	**28.8**	**29.8**	**31.7**
	Nevada	27	27.7	28.8	29.8	31.7
23	**Region**	**17.4**	**18.6**	**22.8**	**24.7**	**28.5**
	Idaho	9.6	11	16.2	19	24.2
	Oregon	30.7	32.2	36.5	37.9	40.8
	Utah	3.2	6.9	17.2	20.7	26.8
	Washington	14.5	14.9	17	18.4	22
24	**Region**	**30.6**	**31.1**	**32.2**	**32.6**	**34.2**
	California	30.6	31.1	32.2	32.6	34.2
25	**Region**	**31.7**	**32.2**	**35.3**	**35.3**	**37**
	Hawaii	31.7	32.2	35.3	35.3	37
26	**Region**	**0**	**0**	**0**	**0.1**	**0.3**
	Alaska	0	0	0	0.1	0.3

Source: MPR analysis of files created from publicly available CMS data. Enrollment data for March and December 2005 are from the Geographic Service Area Reports. Data from 2006 forward are from the Monthly MA Enrollment by State/County/Contract files. To calculate penetration rates, MPR utilized CMS files from December 2005 data on the number of MA-eligible beneficiaries by county, because CMS did not release such updated counts until November 2006, and the update included changes in definitions that would, if used, make it appear that penetration dropped, when in fact it expanded.

Table IV.4. MA Penetration by Region and State, URBAN Counties Only, 2005-2008

		MA Penetration				
MA Region	State	March 2005	December 2005	November 2006	March 2007	March 2008
United States		15.3	16.3	19.2	20.7	23.7
1	**Region**	**0.4**	**0.5**	**1.1**	**1.8**	**5.2**
	Maine	0	0.1	1	1.8	5.8
	New Hampshire	1	1	1.3	1.9	4.4
2	**Region**	**14.5**	**14.6**	**15.4**	**16**	**18.3**
	Connecticut	5.8	6	7.7	9.2	13.3
	Massachusetts	16	16	16.3	16.5	18.1
	Rhode Island	32.6	33	33.7	34.1	35.1
	Vermont	0	0	0	0.3	1.3
3	**Region**	**19.2**	**20.5**	**22.7**	**23.7**	**26.7**
	New York	19.2	20.5	22.7	23.7	26.7
4	**Region**	**7.5**	**7.9**	**8.6**	**8.8**	**9.6**
	New Jersey	7.5	7.9	8.6	8.8	9.6
5	**Region**	**4**	**4.4**	**5.1**	**5.4**	**6.8**
	Delaware	0.4	0.7	1.4	2	3.6
	District of Columbia	6.2	7	7.1	7.6	8.5
	Maryland	4.3	4.6	5.4	5.6	7
6	**Region**	**24**	**24.8**	**31.1**	**32.2**	**35.5**
	Pennsylvania	26.1	26.9	33.4	34.5	36.8
	West Virginia	3.9	4	9.1	10.6	23
7	**Region**	**4.1**	**5.4**	**9.8**	**11.3**	**14.7**
	North Carolina	6.5	8.4	12.9	14.6	18.4
	Virginia	1.7	2.2	6.6	7.9	10.8
8	**Region**	**1.7**	**3.1**	**7.1**	**9.2**	**13.4**
	Georgia	2.3	3.3	7.4	9.5	13.3
	South Carolina	0.6	2.9	6.7	8.8	13.5
9	**Region**	**19.7**	**21.5**	**23.9**	**25.3**	**27.8**
	Florida	19.7	21.5	23.9	25.3	27.8
10	**Region**	**10.8**	**12.9**	**17.2**	**18.8**	**22.4**
	Alabama	11.2	12.8	16.5	17.6	20.6
	Tennessee	10.5	12.9	17.8	19.8	23.9
11	**Region**	**1.8**	**2.3**	**6.2**	**13.5**	**21.2**
	Michigan	1.8	2.3	6.2	13.5	21.2
12	**Region**	**15**	**15.7**	**17.9**	**19.1**	**26.9**
	Ohio	15	15.7	17.9	19.1	26.9
13	**Region**	**2.8**	**3.2**	**7.2**	**9.9**	**13.1**
	Indiana	2.5	3.1	6.3	8.5	11.6
	Kentucky	3.2	3.6	8.9	12.8	16.1
14	**Region**	**5.7**	**6.7**	**9.3**	**10.7**	**13**
	Illinois	5.2	5.7	7	7.9	9
	Wisconsin	6.8	9.5	15	17.8	22.9
15	**Region**	**11.8**	**12.3**	**15.1**	**16.5**	**19.4**
	Arkansas	0.2	0.5	5.8	8.1	12.5
	Missouri	16.5	17	18.8	19.8	22.1
16	**Region**	**11.5**	**11.1**	**14.8**	**16.5**	**20.1**
	Louisiana	16	15.4	18.6	20.2	24.2
	Mississippi	0	0.2	5.2	7.2	9.9
17	**Region**	**8.9**	**10.4**	**14.1**	**15.7**	**19.2**
	Texas	8.9	10.4	14.1	15.7	19.2
18	**Region**	**9.6**	**10.6**	**13.2**	**14.4**	**16.6**
	Kansas	4.9	5.7	9	10.3	12.6
	Oklahoma	13.1	14.1	16.3	17.3	19.6

Table IV.4 *(continued)*

MA Region	State	MA Penetration				
		March 2005	December 2005	November 2006	March 2007	March 2008
19	**Region**	**12.6**	**14.5**	**19.4**	**21.4**	**24.5**
	Iowa	7.3	8.9	13.3	14.5	15.1
	Minnesota	20.9	23.4	29.6	32.1	37
	Montana	0.5	2.2	9.8	13.4	17.3
	Nebraska	7.8	8.7	11	11.9	13.4
	North Dakota	0.6	1.2	5.2	6	7.7
	South Dakota	0.4	0.9	3.4	6.4	11
	Wyoming	2	2.1	5	5.1	5.1
20	**Region**	**27.6**	**28.6**	**32**	**32.7**	**35.8**
	Colorado	28.7	29.8	33	33.6	37
	New Mexico	24.6	25.6	29.4	30.4	32.7
21	**Region**	**29.2**	**30.8**	**37.7**	**38.1**	**40.2**
	Arizona	29.2	30.8	37.7	38.1	40.2
22	**Region**	**29.3**	**30**	**30.9**	**31.9**	**33.8**
	Nevada	29.3	30	30.9	31.9	33.8
23	**Region**	**20.3**	**21.5**	**25.9**	**27.7**	**31.6**
	Idaho	13.5	15.2	21	23.7	29.6
	Oregon	38.7	39.7	44.2	45.4	48.1
	Utah	3.6	7.6	18.2	21.9	28.3
	Washington	16.3	16.7	18.9	20.3	23.9
24	**Region**	**31.7**	**32.2**	**33.2**	**33.6**	**35.2**
	California	31.7	32.2	33.2	33.6	35.2
25	**Region**	**31.6**	**32.2**	**35.2**	**35.5**	**37.2**
	Hawaii	31.6	32.2	35.2	35.5	37.2
26	**Region**	**0**	**0**	**0**	**0.1**	**0.3**
	Alaska	0	0	0	0.1	0.3

Source: MPR analysis of files created from publicly available CMS data. Enrollment data for March and December 2005 are from the Geographic Service Area Reports. Data from 2006 forward are from the Monthly MA Enrollment by State/County/Contract files. To calculate penetration rates, MPR utilized CMS files from December 2005 data on the number of MA-eligible beneficiaries by county, because CMS did not release such updated counts until November 2006, and the update included changes in definitions that would, if used, make it appear that penetration dropped, when in fact it expanded.

Table IV.5. MA Penetration by Region and State, RURAL Areas Only, 2005-2008

		MA Penetration				
MA Region	State	March 2005	December 2005	November 2006	March 2007	March 2008
United States		2.6	3.3	6.8	8.5	11.9
1	**Region**	**0.0**	**0.0**	**0.4**	**0.8**	**3.0**
	Maine	0.0	0.0	0.5	1.1	3.2
	New Hampshire	0.0	0.0	0.2	0.5	2.8
2	**Region**	**0.0**	**0.1**	**0.9**	**1.5**	**4.0**
	Connecticut	0.0	0.1	1.9	2.9	6.3
	Massachusetts	0.0	0.0	0.0	0.0	0.0
	Rhode Island	NA	NA	NA	NA	NA
	Vermont	0.0	0.0	0.3	0.7	2.7
3	**Region**	**7.0**	**8.1**	**10.9**	**12.7**	**18.2**
	New York	7.0	8.1	10.9	12.7	18.2
4	**Region**	**NA**	**NA**	**NA**	**NA**	**NA**
	New Jersey	NA	NA	NA	NA	NA
5	**Region**	**0.0**	**0.1**	**0.5**	**0.8**	**1.7**
	Delaware	0.1	0.2	0.9	1.3	2.2
	District of Columbia	NA	NA	NA	NA	NA
	Maryland	0.0	0.0	0.2	0.4	1.4
6	**Region**	**8.1**	**8.6**	**13.9**	**15.3**	**21.2**
	Pennsylvania	11.7	12.5	16.9	18.5	22.0
	West Virginia	0.3	0.4	7.6	8.4	19.7
7	**Region**	**2.1**	**3.1**	**7.2**	**8.7**	**11.9**
	North Carolina	2.6	4.0	7.0	8.4	11.6
	Virginia	0.8	1.2	7.8	9.3	12.6
8	**Region**	**0.2**	**1.3**	**4.5**	**6.0**	**9.6**
	Georgia	0.2	1.1	4.7	6.1	9.1
	South Carolina	0.2	1.5	4.1	5.8	10.4
9	**Region**	**2.3**	**2.5**	**5.6**	**7.9**	**11.0**
	Florida	2.3	2.5	5.6	7.9	11.0
10	**Region**	**2.0**	**3.7**	**6.1**	**7.5**	**10.3**
	Alabama	0.7	3.2	4.3	5.7	8.5
	Tennessee	3.1	4.1	7.5	8.9	11.7
11	**Region**	**0.0**	**0.4**	**3.3**	**12.2**	**19.8**
	Michigan	0.0	0.4	3.3	12.2	19.8
12	**Region**	**2.0**	**2.2**	**5.2**	**6.6**	**15.8**
	Ohio	2.0	2.2	5.2	6.6	15.8
13	**Region**	**0.4**	**0.7**	**4.8**	**7.5**	**10.3**
	Indiana	0.9	1.4	5.8	7.9	11.6
	Kentucky	0.1	0.2	4.2	7.2	9.5
14	**Region**	**4.2**	**5.8**	**9.8**	**11.6**	**14.9**
	Illinois	1.7	2.2	4.5	5.7	7.4
	Wisconsin	7.2	10.0	16.0	18.5	23.4
15	**Region**	**0.9**	**1.1**	**4.6**	**5.8**	**9.0**
	Arkansas	0.0	0.1	4.4	5.8	10.0
	Missouri	1.6	1.8	4.8	5.8	8.2
16	**Region**	**0.3**	**0.4**	**3.1**	**4.8**	**6.9**
	Louisiana	0.7	1.0	3.6	4.9	8.3
	Mississippi	0.0	0.0	2.8	4.8	6.0
17	**Region**	**1.3**	**1.5**	**3.2**	**4.2**	**6.8**
	Texas	1.3	1.5	3.2	4.2	6.8
18	**Region**	**0.3**	**0.4**	**2**	**2.5**	**3.6**
	Kansas	0.1	0.2	1.7	2.1	2.7
	Oklahoma	0.5	0.7	2.2	2.7	4.3

Table IV.5 *(continued)*

MA Region	State	MA Penetration				
		March 2005	December 2005	November 2006	March 2007	March 2008
19	**Region**	**2.1**	**3.4**	**8.1**	**10.0**	**12.8**
	Iowa	1.9	2.6	5.4	6.5	7.0
	Minnesota	4.8	8.4	17.7	21.2	27.4
	Montana	0.3	1.1	5.8	8.5	12.0
	Nebraska	0.9	1.4	4.2	5.2	7.1
	North Dakota	1.0	1.3	4.3	4.8	5.7
	South Dakota	0.0	0.2	1.3	3.3	6.4
	Wyoming	0.7	0.7	2.9	3.2	3.7
20	**Region**	**3.6**	**4.0**	**8.1**	**8.5**	**9.8**
	Colorado	7.5	7.8	11.0	11.2	12.3
	New Mexico	0.2	0.6	5.6	6.1	7.6
21	**Region**	**2.3**	**5.8**	**15.8**	**15.0**	**17.8**
	Arizona	2.3	5.8	15.8	15.0	17.8
22	**Region**	**12.2**	**13.1**	**15.2**	**16.2**	**18.2**
	Nevada	12.2	13.1	15.2	16.2	18.2
23	**Region**	**7.5**	**9.0**	**12.7**	**14.5**	**18.2**
	Idaho	3.6	4.3	8.6	11.5	15.6
	Oregon	12.6	14.9	19	20.7	24.1
	Utah	0.7	3.1	11.5	14.1	18.4
	Washington	5.4	5.9	7.7	9.0	12.4
24	**Region**	**1.3**	**1.5**	**4.8**	**5.0**	**6.3**
	California	1.3	1.5	4.8	5.0	6.3
25	**Region**	**31.9**	**32.2**	**35.3**	**34.7**	**36.6**
	Hawaii	31.9	32.2	35.3	34.7	36.6
26	**Region**	**0.0**	**0.0**	**0.0**	**0.0**	**0.2**
	Alaska	0.0	0.0	0.0	0.0	0.2

Source: MPR analysis of files created from publicly available CMS data. Enrollment data for March and December 2005 are from the Geographic Service Area Reports. Data from 2006 forward are from the Monthly MA Enrollment by State/County/Contract files. To calculate penetration rates, MPR utilized CMS files from December 2005 data on the number of MA-eligible beneficiaries by county, because CMS did not release such updated counts until November 2006, and the update included changes in definitions that would, if used, make it appear that penetration dropped, when in fact it expanded.

NA = Not Applicable, no rural counties.

Table IV.6. Distribution of MA Enrollees by 2004 County Payment Type and MA County Benchmark

	Medicare Beneficiaries, December 2005		Number of MA Enrollees[a]					Percent of MA Enrollees				
	N	%	March 2005	December 2005	November 2006	March 2007	March 2008	March 2005	December 2005	November 2006	March 2007	March 2008
2004 County Payment Type[b]												
All	42,983,823	100	5,426,316	5,829,387	7,133,420	7,765,461	9,127,543	100	100	100	100	100
Rural floor	7,556,084	17.6	214,111	282,274	566,735	697,300	964,893	3.9	4.8	7.9	9.0	10.6
Urban floor	12,171,352	28.3	1,461,087	1,622,581	2,158,834	2,393,025	2,901,930	26.9	27.8	30.3	30.8	31.8
100% FFS	16,152,647	37.6	2,208,680	2,328,091	2,679,551	2,893,330	3,317,037	40.7	39.9	37.6	37.3	36.3
Blend	1,774,709	4.1	391,439	402,663	431,715	445,472	483,588	7.2	6.9	6.1	5.7	5.3
Minimum Increase	5,329,031	12.4	1,149,094	1,191,835	1,294,889	1,335,625	1,459,085	21.2	20.4	18.2	17.2	16.0
Under $625[c]	8,969,621	20.9	246,987	321,929	557,109	0	0	4.6	5.5	7.8	0.0	0.0
$625 - $699	18,829,260	43.8	2,283,378	2,482,411	2,505,450	759,187	916,527	42.1	42.6	35.1	9.8	10.0
$700 - $749	5,152,096	12.0	786,793	840,628	1,051,725	2,745,789	185,699	14.5	14.4	14.7	35.4	2.0
$750 - $799	3,507,281	8.2	755,146	783,191	799,954	1,080,250	3,478,984	13.9	13.4	11.2	13.9	38.1
$800 - $849	3,159,092	7.3	558,644	574,679	734,428	848,553	1,142,585	10.3	9.9	10.3	10.9	12.5
$850 or more	3,366,473	7.8	793,463	824,606	1,483,058	2,330,973	3,402,765	14.6	14.1	20.8	30.0	37.3

Source: MPR analysis of files created from publicly available CMS data. Data for March and December 2005 are from the Geographic Service Area Reports. Data for 2006 forward are from the monthly MA Enrollment by State/County/Contract files.

[a]Includes a small number of enrollees whose county rates could not be identified. The numbers from 2005-2008 were 1,905; 1,943; 1,696; 709; and 983, respectively.

[b]Counties are in the same category for each year, based on their 2004 status.

[c]Categories are constant. Rates change each year. The absence of enrollees in the under $625 category is explained by the fact that the floor minimums increase each year.

Table IV.7. Percentage of MA Enrollees by Contract Type and County Payment Type, 2005-2008

County Rate Type[a]	All	HMO	Local PPO	RPPO	PFFS	All Others
March 2005						
Rural Floor	3.9	2.4	3.3	NA	40.6	12.6
Urban Floor	26.9	26.6	17.3	NA	41.9	30.9
100% FFS (2004)	40.7	40.2	69.6	NA	12.2	39.3
All Others	28.4	30.8	9.9	NA	5.2	17.2
December 2005						
Rural Floor	4.8	2.6	4.3	NA	38.9	12.3
Urban Floor	27.8	27.1	21.0	NA	48.5	30.1
100% FFS (2004)	39.9	40.1	60.0	NA	7.4	40.7
All Others	27.4	30.2	14.8	NA	5.2	16.9
November 2006						
Rural Floor	7.9	2.8	6.7	7.6	36.1	15.2
Urban Floor	30.3	27.3	33.3	26.7	48.7	29.4
100% FFS (2004)	37.6	41.2	40.8	51.9	9.5	39.8
All Others	24.2	28.7	19.2	13.8	5.7	15.5
March 2007						
Rural Floor	9.0	2.9	7.7	12.5	30.4	15.3
Urban Floor	30.8	27.2	37.5	26.6	44.2	29.2
100% FFS (2004)	37.3	41.1	39.9	46.8	19.1	39.9
All Others	22.9	28.8	14.9	14.0	6.4	15.6
March 2008						
Rural Floor	10.6	3.4	10.8	17.5	29.5	16.9
Urban Floor	31.8	26.7	43.9	25.9	42.4	41.3
100% FFS (2004)	36.3	41.6	35.5	42.7	21.2	31.9
All Others	21.3	28.3	9.8	13.9	6.9	9.9

Source: MPR analysis of files created from publicly available CMS data. Data for March and December 2005 are from the Geographic Service Area Reports. Data for 2006 forward are from the monthly MA Enrollment by State/County/Contract files.

[a]Counties are in the same category for each year, based on their 2004 status.

Table IV.8. Distribution of Enrollment by Product, County Benchmark, 2005-2008

	Total MA Enrollees		HMO		Local PPOs[a]		PFFS		Other[b]	
	N	%	N	%	N	%	N	%	N	%
March 2005 by 2005 Rates										
Total[c]	5,426,316	100.0	4,655,406	100.0	177,594	100.0	79,372	100.0	513,944	100.0
$592 (rural floor)	203,597	3.8	110,840	2.4	3,844	2.2	32,232	40.6	56,681	11.0
Between rural & urban floor	64,372	1.2	27,654	0.6	3,368	1.9	2,735	3.4	30,615	6.0
$654 (urban floor)	1,441,992	26.6	1,225,740	26.3	30,082	16.9	33,106	41.7	153,064	29.8
Urban floor - $800	2,362,343	43.5	2,073,148	44.5	76,699	43.2	10,380	13.1	202,116	39.3
$801-$900	816,590	15.0	720,511	15.5	42,504	23.9	767	1.0	52,808	10.3
$901 and above	535,517	9.9	495,723	10.6	21,071	11.9	152	0.2	18,571	3.6
November 2006 by 2006 Rates										
Total[c]	7,133,420	100.0	5,218,069	100.0	404,076	100.0	819,098	100.0	692,177	100.0
$620 (rural floor)	552,623	7.7	145,091	2.8	23,719	5.9	293,509	35.8	90,304	13.0
Between rural & urban floor	130,490	1.8	45,623	0.9	8,871	2.2	36,124	4.4	39,872	5.8
$686 (urban floor)	2,141,501	30.0	1,411,796	27.1	134,008	33.2	397,044	48.5	198,653	28.7
Urban floor - $800	2,089,664	29.3	1,759,457	33.7	80,802	20.0	70,334	8.6	179,071	25.9
$801-$900	1,362,682	19.1	1,099,287	21.1	91,948	22.8	20,445	2.5	151,002	21.8
$901 and above	854,764	12.0	755,262	14.5	64,713	16.0	1,615	0.2	33,174	4.8
March 2007 by 2007 Rates										
Total[c]	7,765,461	100.0	5,295,129	100.0	416,047	100.0	1,329,296	100.0	724,989	100.0
$662 (rural floor)	666,963	8.6	151,172	2.9	28,461	6.8	390,335	29.4	96,995	13.4
Between rural & urban floor	182,589	2.4	50,312	1.0	9,977	2.4	80,252	6.0	42,048	5.8
$732 (urban floor)	2,327,373	30.0	1,409,063	26.6	153,028	36.8	569,877	42.9	195,405	27.0
Urban floor - $800	1,419,474	18.3	1,115,716	21.1	60,037	14.4	137,501	10.3	106,220	14.7
$801-$900	1,604,576	20.7	1,255,648	23.7	65,929	15.8	100,692	7.6	182,307	25.1
$901 and above	1,563,777	20.1	1,312,603	24.8	98,600	23.7	50,610	3.8	101,964	14.1
March 2008 by 2008 Rates										
Total[c]	9,127,543	100.0	5,925,682	100.0	552,901	100.0	2,032,587	100.0	616,373	100.0
$699 (rural floor)	916,527	10.0	195,086	3.3	48,348	8.7	574,132	28.2	98,961	16.1
Between rural & urban floor	274,861	3.0	62,393	1.1	27,749	5.0	138,213	6.8	46,506	7.5
$773 (urban floor)	2,815,751	30.8	1,545,103	26.1	237,373	42.9	835,810	41.1	197,465	32.0
Urban floor - $800	576,067	6.3	370,565	6.3	56,725	10.3	101,034	5.0	47,743	7.7
$801-$900	2,023,286	22.2	1,587,790	26.8	85,410	15.4	214,890	10.6	135,196	21.9
$901 and above	2,520,068	27.6	2,163,882	36.5	97,281	17.6	168,464	8.3	90,441	14.7

Source: MPR analysis of files created from publicly available CMS data. Data for March and December 2005 are from the Geographic Service Area Reports. Data for 2006 forward are from the monthly MA Enrollment by State/County/Contract files.

[a]Local PPOs includes PSO as well. Regional PPOs are included with "Other."

[b]Includes Regional PPOs, MSAs, Cost, HCCPP, Pace and "Other" (largely demonstrations).

[c]Totals include a small number of enrollees whose county rates could not be identified. The numbers from 2005-2008 were 1,905; 1,696; 709; and 983, respectively.

V. MA CONTRACT OFFERINGS AND ENROLLMENT BY SPONSOR

In this chapter, we analyze the role played by selected major firms in MA, their enrollment, and how offerings and enrollment have changed during the 2005 through 2008 period. The analysis builds on our prior work in coding contracts to support analysis of national firms. Historically, since 1999, we have distinguished by name seven firms or affiliates—Aetna, Cigna, Health Net, Humana, Kaiser, UnitedHealthcare/Secure Horizons,[1] and Blue Cross-Blue Shield affiliates.[2] In 2005, we began to distinguish Blue Cross-Blue Shield-branded offerings through WellPoint versus other affiliated organizations, because the merger of WellPoint with Anthem BCBS meant that the successor WellPoint organization included a substantial share of BCBS-covered lives nationwide. For this report, we identify four additional firms previously included in the "other" category—Coventry, HealthSpring, WellCare, and non-Blues branded WellPoint under the UniCare license.

A. MA CONTRACTS AND AVAILABLE PLANS, BY SPONSOR

In MA, a relatively small share of firms and affiliated organizations account for a large share of the contracts in MA despite some dimunition in concentration with the MMA. In 2005, the firms named above accounted for half of all contracts (Table V.1). Three of the firms alone—Aetna, Humana, and UnitedHealthcare—had 77 contracts, or 31 percent of the total. In 2008, concentration remained high, but was somewhat reduced. Aetna, Humana and UnitedHealthcare/ Secure Horizons had more contracts—116—but accounted for only 24 percent of the expanded number of contracts. Among the named sponsors, BCBS-affiliated sponsors held almost twice as many contracts in 2008 than 2005. Coventry expanded from 6 to 18 contracts, and WellCare from 2 to 16. The net result was that, in 2008, the named sponsors accounted for 45 percent of MA contracts. This compares to 59 percent in early 2005.

The nearly national scope of some major MA sponsors is worthy of note (Table V.2). By 2008, Humana and, Coventry, each had at least one contract available to 84-86 percent of beneficiaries. The combined UnitedHealthcare/Secure Horizons offerings and the WellCare and WellPoint offerings were available to 69-71 percent of beneficiaries. The expansion of PFFS offerings contributed extensively to national coverage among these firms. Coventry in particular offer only limited local HMOs or PPOs and so does Universal American (not shown) despite the fact that both companies' PFFS offerings are broadly available across the nation.[3] Although Humana has HMO and local PPO offerings, they still were available to only 24 percent of

[1] PacifiCare and UnitedHealthcare were coded separately until their merger in 2006. We use the term "UnitedHealthcare-Secure Horizons" to refer to the firm post-merger because the "Secure Horizons" brand was used for many of their offerings. (This may be changing in 2008, because AARP entered into an agreement with UnitedHealthcare to allow its brand to be used for most of the coordinated care plans offered by the firm.)

[2] While BCBS affiliates are separately owned companies, they share in authority to use the BCBS trademark and other characteristics which make them of interest to policymakers as a group.

[3] Universal American has PFFS available to 97 percent of beneficiaries though its HMOs are only available to 2 percent (data not shown).

beneficiaries in 2008. Among firms broadly available across the nation, UnitedHealthcare/Secure Horizons appears to have the most widely available diversified offerings, with an HMO or local PPO available to about two-fifths of all beneficiaries nationwide. Aetna also is diversified, but its availability is less extensive, though expanding. (Aetna reduced its offerings substantially under MA's predecessor program, and is just beginning to expand again.)

Kaiser Permanente is unique among MA sponsors in the stability of its offerings over time. With its network based extensively upon an integrated delivery system, Kaiser has served a consistent 15 percent of all Medicare beneficiaries in private plans from 2005 through 2008, most of whom are in HMO contracts. The remainder are in plans paid as cost contracts, although in delivery systems similar to those used by Kaiser for its HMO product.

Blue Cross-Blue Shield affiliates also have seemingly unique attributes, although this may only reflect the variation across affiliated firms. Perhaps because their commercial products are long-standing and broad-based provider networks, Blue Cross-Blue Shield affiliated firms appear less likely to offer PFFS plans than some other firms, and when they do, they tend to offer them in areas where local HMOs or PPOs also are offered. Only a small share of beneficiaries is added when availability is expanded beyond HMOs and local PPOs to PFFS. Blues' affiliate WellPoint does offer extensive PFFS products, but appears to do so most often under its UniCare license than through Blues-branded products (WellPoint also offers its most widely available MSA through the UniCare license).

B. MA ENROLLMENT BY FIRM

Enrollment is even more concentrated than are contracts within the named firms than are contracts (Table V.3). About two-thirds of all MA enrollees were within the named firms, a share relatively consistent between 2005 and 2008. Over this time period, there have been some shifts in the dominance of particular firms. In March 2005, three firms or affiliates—PacifiCare/ UnitedHealthcare, Kaiser, and the Blues affiliates—accounted for 52 percent of MA enrollment. Humana's share was only 7 percent, whereas Coventry, HealthSpring, WellCare, and WellPoint (Blues or non-Blues) had less than 1 percent each of the market. UnitedHealthcare/Secure Horizons, Kaiser, and Blues affiliates are still dominant players, and together they account for 40 percent of enrollment. Kaiser however, has experienced only moderate growth and accounts for less than 10 percent of the market. Meanwhile, Humana has expanded substantially, so that it has 13 percent of the market as of 2008. Other named firms also have increased their market share, although none has as much as 5 percent of the market.

In Table V.4, we show changes in the distribution of enrollment across contract types from 2005 through 2008 for the four largest firms.

- UnitedHealthcare/Secure Horizons, the market leader, retains predominance in the HMO sector, although its share of total firm enrollment from this sector decreased from 96 percent in 2005 to 82 percent in 2008, reflecting expansions in other types of contracts and a small overall decline in the firm's HMO enrollment.
- Among BCBS affiliates (the second largest enrollment segment), HMO enrollment has grown slowly, with local PPOs and PFFS plans accounting for a disproportionate

share of the enrollment growth. Although HMOs made up 93 percent of the total enrollment in Blues-branded contracts in 2005, they comprised only 56 percent in 2008, with PFFS accounting for 20 percent and local PPOs for 17 percent.

- After the MMA, Humana expanded the most rapidly among these firms. PFFS enrollment drove most of the expansion. In March 2005, Humana had approximately 358,000 HMO enrollees, a figure that grew to about 392,000 in 2008. In contrast, PFFS enrollment grew from 32,000 to 658,000 over this same time period, constituting 56 percent of the firm's 2008 enrollment. While the largest jump in PFFS enrollment occurred in 2006, Humana continued to expand its PFFS enrollment substantially in 2007 and 2008. While Humana is the dominant offeror of regional PPOs nationally, the firm had only 61,000 enrollees in March 2008—about 5 percent of its total enrollment. This percentage is increasing slowly, however, as is Humana's enrollment in local PPOs, which is at about the same level as 2005.

As noted previously, Kaiser remains a dominant HMO company, and its enrollment has grown only moderately over the period from 2005 through 2008. Readers interested in the same kind of data for additional selected large firms—Aetna, Cigna, Coventry, Health Net, and WellPoint—will find them in Table V.5. In general, the data show that, to date:

- CIGNA remains a very small player in the market, with a mainly HMO enrollment. Cigna has expanded its MA offerings to 18 percent of the MA market in 2008, but this is not yet reflected in major enrollment growth.

- Aetna experienced a more than threefold growth in MA enrollment from 2005 through 2008, with PFFS offerings new to the firm accounting for 186,000 of the net increase of 236,000 enrollees, and with most of the rest coming from the HMO sector. Once very active in Medicare+Choice (MA's predecessor), Aetna had reduced its enrollment dramatically, but now appears to be expanding again in the market.

- Coventry has become a much more substantial player in the market, with 277,000 enrollees, or 3 percent of the total. While Coventry had a small number of HMO and local PPO enrollees in 2005 (approximately 21,000), its enrollment grew nearly fivefold by 2008 (98,000). The firm also moved aggressively into PFFS (available to 86 percent of beneficiaries in 2006) to build an enrollment from that source, which is now almost twice as large as in its base HMO and local PPO market.

- Health Net, one of the major firms in the Medicare market in earlier years, has continued to concentrate its efforts on HMO enrollment, which accounted for 83 percent of enrollment in 2008, compared to 93 percent in 2005. However, Health Net now has a more diversified set of products (e.g., PPOs, PFFS) that contribute to its enrollment growth.

- WellPoint, a composite of a number of now-merged firms, had a very small enrollment in MA in 2005 (around 32,000) but it has expanded to 344,000, now accounting for 3-4 percent of the market. To a large extent, this growth appears to reflect decisions that became operational mainly in 2007 or 2008. In each of those years, WellPoint used its non-Blues branded UniCare license to offer PFFS and MSA

plans widely across the country, although enrollment was only about 140,000 in such products in 2008. The largest jump in Blues-branded MA enrollment occurred in 2008, and appears to reflect growth across a variety of contract types.

Table V.1. MA Contracts by Sponsor and Type, 2005-2008

Selected Firms or Affiliations	Total Contracts[a] 2005[b]	2006	2007	2008
All Sponsors	**249**	**364**	**395**	**489**
Selected Firms	**135**	**178**	**186**	**220**
Aetna	10	26	31	38
Cigna	2	2	3	5
Health Net	8	9	8	9
Humana	16	24	25	32
Kaiser	10	8	7	8
UnitedHealthcare/Secure Horizons[c]	51	55	53	46
Blue Cross and Blue Shield Affiliates	28	54	59	82
WellPoint	2	41	47	55
Other	26	13	12	27
Selected Newer Entrants				
Coventry	4	4	14	18
Health Spring	4	5	5	5
WellCare	2	6	7	16
WellPoint (non-BCBS)[d]	0	0	2	2
All Other Sponsors	114	171	181	228

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. 2007 data are from a file created from the November 2006 release of the Plan Finder, and 2008 data are compiled from the MA Landscape files. Firm coding by MPR staff.

[a]Excludes HCPP, PACE, and other (largely demonstration) contracts. Also excludes SNP-only contracts and employer-only contracts, because they are not universally available for individual enrollment.

[b]2005 data are for March 2005.

[c]In 2006, includes nine PacifiCare contracts, because the two are now merged as one company.

[d]These are non-Blues branded products, generally offered under the "UniCare" license.

Table V.2. Selected Measures of Scope of MA Plan Offerings Nationally, Selected Firms or Affiliates, 2005-2008

	Percent of Beneficiaries with a Choice of At Least One Firm Product				Percent of Beneficiaries, by Selected Contract Type							
					Local HMO/PPO Only				Any Local MA (HMO, PPO, or PFFS)			
	2005	2006	2007	2008	2005	2006	2007	2008	2005	2006	2007	2008
All Sponsors	93	100	100	100	66	79	81	85	84	99	100	100
Selected Firms	71	99	100	100	57	69	72	77	69	98	100	100
Aetna	17	19	29	46	17	18	24	29	17	18	28	46
Cigna	1	1	2	18	1	1	2	2	1	1	2	18
Health Net	17	18	24	32	17	17	14	15	17	17	23	31
Humana	27	69	84	84	11	18	19	24	27	69	84	84
Kaiser	15	15	15	15	12	12	12	12	12	12	12	12
UnitedHealthcare/Secure Horizons	43	69	69	69	40	41	45	39	41	64	64	60
BCBS Affiliates	29	58	64	80	27	40	40	51	28	45	48	68
WellPoint	6	21	22	31	6	12	8	15	6	14	11	25
Other	27	42	46	53	26	33	36	40	26	36	41	48
Selected Newer Entrants												
Coventry	1	1	75	86	1	1	11	9	1	1	75	86
HealthSpring	4	5	6	6	4	5	6	6	4	5	6	6
WellCare	3	12	35	70	3	12	12	21	3	12	35	70
WellPoint (non-BCBS)	0	0	69	71	0	0	0	0	0	0	25	49
All Others	86	79	100	100	45	56	62	68	67	77	100	100

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. 2007 data are from a file created from the November 2006 release of the Plan Finder, and 2008 data are compiled from the MA Landscape files. Beneficiary data are for December 2005, and are from the Market Penetration Report. Firm coding by MPR staff.

Table V.3. Total MA Enrollment by Firm, 2005-2008

	March 2005		December 2005		November 2006		March 2007		March 2008	
Selected Firm/Affiliate	N	%	N	%	N	%	N	%	N	%
All Sponsors	5,426,316	100	5,829,387	100	7,133,420	100	7,765,461	100	9,127,543	100
Selected Firms	3,641,984	67.1	3,873,540	66.4	4,777,014	67.0	5,340,497	68.8	6,171,478	67.6
Aetna	99,841	1.8	101,213	1.7	120,070	1.7	166,947	2.1	335,899	3.7
Cigna	57,357	1.1	56,570	1.0	56,127	0.8	56,236	0.7	58,388	0.6
Health Net	191,127	3.5	199,357	3.4	217,800	3.1	202,386	2.6	262,829	2.9
Humana	392,195	7.2	471,455	8.1	910,822	12.8	1,013,338	13.0	1,170,275	12.8
Kaiser	859,604	15.8	879,299	15.1	882,437	12.4	869,888	11.2	872,241	9.6
UnitedHealthcare/Secure Horizons	1,074,843	19.8	1,165,142	20.0	1,411,473	19.8	1,357,244	17.5	1,189,497	13.0
Blue Cross-Blue Shield Affiliated	895,647	16.5	902,603	15.5	1,058,622	14.8	1,178,081	15.2	1,543,897	16.9
WellPoint	32,090	0.6	30,802	0.5	60,537	0.8	68,272	0.9	204,057	2.2
Other	863,557	15.9	871,801	15.0	998,085	14.0	1,109,809	14.3	1,339,840	14.7
Selected Newer Entrants										
Coventry	20,654	0.4	20,823	0.4	22,478	0.3	169,772	2.2	276,819	3.0
Health Spring	47,608	0.9	69,835	1.2	78,535	1.1	118,571	1.5	124,470	1.4
WellCare	3,108	0.1	7,243	0.1	18,650	0.3	110,355	1.4	196,914	2.2
WellPoint (non-BCBS)	NA	0.0	NA	0.0	NA	0.0	97,679	1.3	140,249	1.5
All Others	1,784,332	32.9	1,955,847	33.6	2,356,406	33.0	2,424,964	31.2	2,956,065	32.4

Source: MPR analysis of files created from publicly available CMS data. Data for March and December 2005 are from the Geographic Service Area Reports. Data from 2006 forward are from the Monthly MA Enrollment by State/County/Contract files. Firm coding by MPR staff.

Table V.4. MA Enrollment by Contract Type, Leading Firms and Affiliates, 2005-2008

	BCBS Affiliations (all)		Humana		Kaiser		UnitedHealthcare/Secure Horizons	
	N	%	N	%	N	%	N	%
Mar-05								
Total	895,647	100.0	392,195	100.0	859,604	100.0	1,074,843	100.0
HMO	830,276	92.7	357,678	91.2	788,882	91.8	1,036,019	96.4
PPO	7,985	0.9	2,089	0.5	0	0.0	34,074	3.2
RPPO	NA	NA	NA	NA	NA	NA	NA	NA
PFFS	195	0.0	32,428	8.3	0	0.0	809	0.1
Other	57,191	6.4	0	0.0	70,722	8.2	3,941	0.4
Dec-05								
Total	902,603	100.0	471,455	100.0	879,299	100.0	1,165,142	100.0
HMO	798,656	88.5	365,271	77.5	809,396	92.1	1,103,703	94.7
PPO	46,096	5.1	6,722	1.4	0	0.0	43,374	3.7
RPPO	NA	NA	NA	NA	NA	NA	NA	NA
PFFS	4,890	0.5	99,462	21.1	0	0.0	12,468	1.1
Other	52,961	5.9	0	0.0	69,903	7.9	5,597	0.5
Nov-06								
Total	1,058,622	100.0	910,822	100.0	882,437	100.0	1,411,473	100.0
HMO	838,617	79.2	378,442	41.5	814,526	92.3	1,137,280	80.6
PPO	117,370	11.1	34,610	3.8	0	0.0	61,446	4.4
RPPO	0	0.0	29,706	3.3	0	0.0	33,651	2.4
PFFS	34,161	3.2	468,064	51.4	0	0.0	176,810	12.5
Other	46,931	4.4	0	0.0	67,911	7.7	2,286	0.2
Mar-07								
Total	1,178,650	100.0	1,016,890	100.0	869,888	100.0	1,357,244	100.0
HMO	746,733	63.4	381,202	37.5	804,166	92.4	1,144,257	84.3
PPO	145,468	12.3	29,005	2.9	0	0.0	56,221	4.1
RPPO	0	0.0	31,073	3.1	0	0.0	36,988	2.7
PFFS	163,500	13.9	571,830	56.2	0	0.0	102,064	7.5
Other	84,631	7.2	3,780	0.4	65,722	7.6	17,714	1.3
Mar-08								
Total	1,543,897	100.0	1,170,275	100.0	872,241	100.0	1,189,497	100.0
HMO	860,928	55.8	391,886	33.5	820,115	94.0	980,641	82.4
PPO	254,140	16.5	58,596	5.0	0	0.0	60,949	5.1
RPPO	0	0.0	61,020	5.2	0	0.0	54,780	4.6
PFFS	314,990	20.4	657,939	56.2	0	0.0	88,625	7.5
Other	46,967	3.0	834	0.1	52,126	6.0	4,502	0.4

Source: MPR analysis of files created from publicly available CMS data. Data for March and December 2005 are from the Geographic Service Area Reports. Data from 2006 forward are from the Monthly MA Enrollment by State/County/Contract files. Firm coding by MPR staff.

Table V.5. MA Enrollment by Contract Type, Selected Other MA Firms, 2005-2008

	Aetna		CIGNA		Coventry		Health Net		WellPoint					
									All		BCBS Affiliates		Other	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Mar-05														
Total	99,841	100.0	57,357	100.0	20,654	100.0	191,127	100.0	32,090	100.0	32,090	100.0	0	0.0
HMO	84,628	84.8	57,357	100.0	13,470	65.2	178,038	93.2	31,895	99.4	31,895	99.4	0	0.0
PPO	15,213	15.2	0	0.0	7,184	34.8	13,089	6.8	0	0.0	0	0.0	0	0.0
RPPO	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
PFFS	0	0.0	0	0.0	0	0.0	0	0.0	195	0.6	195	0.6	0	0.0
Other	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Dec-05														
Total	101,213	100.0	56,570	100.0	20,823	100.0	199,357	100.0	30,802	100.0	30,802	100.0	0	0.0
HMO	85,736	84.7	56,570	100.0	12,893	61.9	182,420	91.5	28,951	94.0	28,951	94.0	0	0.0
PPO	15,477	15.3	0	0.0	7,930	38.1	16,937	8.5	0	0.0	0	0.0	0	0.0
RPPO	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
PFFS	0	0.0	0	0.0	0	0.0	0	0.0	1,851	6.0	1,851	6.0	0	0.0
Other	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Nov-06														
Total	120,070	100.0	56,127	100.0	22,478	100.0	217,800	100.0	60,537	100.0	60,537	100.0	0	0.0
HMO	99,174	82.6	56,127	100.0	10,822	48.1	197,286	90.6	35,226	58.2	35,226	58.2	0	0.0
PPO	20,111	16.7	0	0.0	11,656	51.9	19,040	8.7	1,774	2.9	1,774	2.9	0	0.0
RPPO	785	0.7	0	0.0	0	0.0	1,474	0.7	20,775	34.3	20,775	34.3	0	0.0
PFFS	0	0.0	0	0.0	0	0.0	0	0.0	2,762	4.6	2,762	4.6	0	0.0
Other	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Mar-07														
Total	166,947	100.0	56,236	100.0	169,772	100.0	208,692	100.0	165,951	100.0	68,272	100.0	97,679	100.0
HMO	108,617	65.1	56,115	99.8	69,475	40.9	183,274	87.8	33,567	20.2	33,567	49.2	0	0.0
PPO	19,872	11.9	121	0.2	24,604	14.5	18,911	9.1	2,298	1.4	2,298	3.4	0	0.0
RPPO	881	0.5	0	0.0	0	0.0	2,249	1.1	26,339	15.9	26,339	38.6	0	0.0
PFFS	37,064	22.2	0	0.0	75,613	44.5	4,245	2.0	102,401	61.7	5,998	8.8	96,403	98.7
Other	513	0.3	0	0.0	80	0.0	13	0.0	1,346	0.8	70	0.1	1,276	1.3
Mar-08														
Total	335,899	100.0	58,388	100.0	276,819	100.0	262,829	100.0	344,306	100.0	204,057	100.0	140,249	100.0
HMO	126,118	37.5	56,825	97.3	77,294	27.9	219,000	83.3	110,259	32.0	110,259	54.0	0	0.0
PPO	21,863	6.5	291	0.5	20,935	7.6	21,054	8.0	12,113	3.5	12,113	5.9	0	0.0
RPPO	1,010	0.3	0	0.0	0	0.0	3,880	1.5	43,901	12.8	43,901	21.5	0	0.0
PFFS	186,233	55.4	1,272	2.2	178,424	64.5	18,895	7.2	176,208	51.2	37,081	18.2	139,127	99.2
Other	675	0.2	0	0.0	166	0.1	0	0.0	1,825	0.5	703	0.3	1,122	0.8

Source: MPR analysis of files created from publicly available CMS data. Data for March and December 2005 are from the Geographic Service Area Reports. Data from 2006 forward are from the Monthly MA Enrollment by State/County/Contract files. Firm coding by MPR staff.

VI. MA CONTRACTS THAT OFFER SNPs

In this chapter, we describe what can be learned from public data on MA contracts about whether the latter include one or more Special Needs Plans (SNPs), as well as the share of enrollment in SNPs as a whole within the MA program and its diverse types of contracts. Because available public data that allow matching MA contracts to SNP offerings have changed over time, we focus on analysis for 2007 and 2008 only, the years that most easily lend themselves to this form of analysis. (SNPs were first authorized in the MMA, but few were approved prior to late 2005; hence, the main gap is in data for 2006, a year of transition in which MA enrollment data was not publicly available until November 2006. (For additional detail on SNPs, see Verdier et al. (2008); Milligan and Woodcock 2008).

A. AVAILABILITY OF SNPs

Under the MMA, SNPs are a type of plan, not contract. Such plans may be offered only as part of coordinated care contracts. Some of what now are designated as SNPs began earlier under CMS's demonstration authority. As shown in Table VI.1, 222 MA contracts offered an SNP in 2007 and 325 did in 2008. This number represents 38 percent of all MA contracts in 2007 and 45 percent in 2008 (Figure VI.1).[1] When SNPs are offered through an MA contract, they are twice as likely to be offered as part of a contract that also includes regular MA plans as they are to be offered in a contract that also includes SNP. Thirteen percent of MA contracts in 2007 and 16 percent in 2008 offered SNP contracts *only*.

SNPs are disproportionately HMO-type plans. In 2007, 76 percent of SNPs were under an MA HMO contract (169 out of 222), and 83 percent in 2008 (269 out of 325; see Table VI.1). The shift appears mainly to be explained by CMS's reclassification of about 10 contracts offering SNPs that were considered "demonstrations" in 2007, but HMOs in 2008. While HMOs are the dominant form of SNP, some MA sponsors also offer SNPs as part of local or regional PPO contracts. In 2007, 19 percent of local PPO contracts offered an SNP, while 23 percent did in 2008 (statistics calculated from Table VI.1). Approximately half of regional PPO contracts offer an SNP. There also are some local and regional PPOs that offer *only* SNPs.

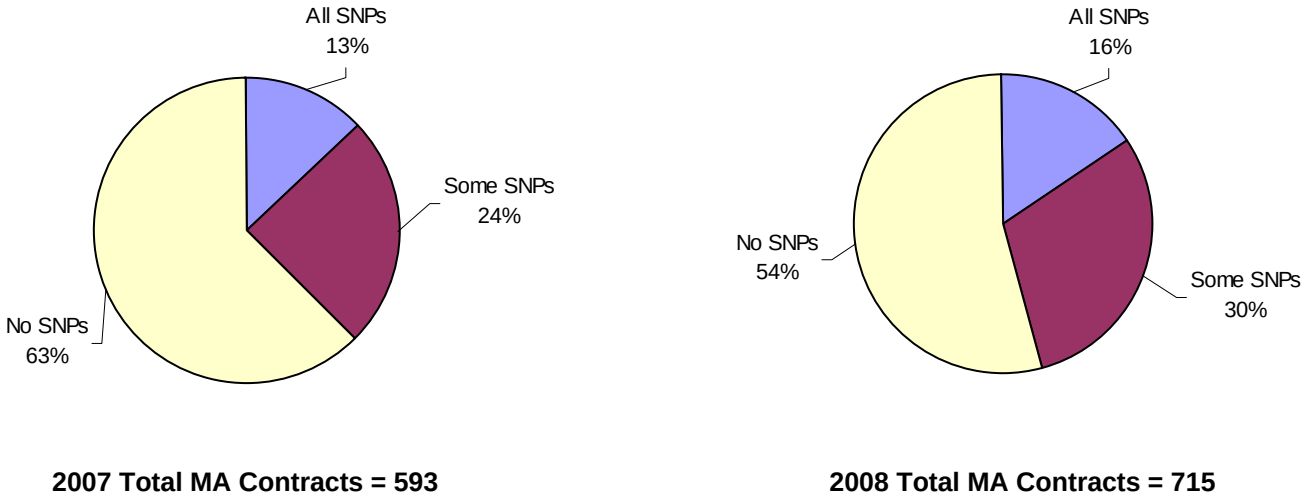
B. ENROLLMENT IN SNPs

Nine percent of MA enrollees were in SNPs in July 2007, increasing to 10.5 percent by March 2008.[2] Because MA enrollment was also growing over this period, this reflects a net increase of about 220,000 SNP enrollees over the nine months. As with other offerings, HMOs

[1] The composite share of plans with some or all SNPs shown in Figure VI.1 is 37 percent in 2007 but this is because of rounding. See Table VI.1.

[2] We show enrollment for July 2007 instead of March 2007 because CMS did not release public data on SNP enrollment in March 2007 and we wanted to use consistent data for SNPs and overall enrollment.

Figure VI.1. MA Contracts by Their SNP Offerings, 2007-2008



2007 Total MA Contracts = 593 **2008 Total MA Contracts = 715**

Source: MPR analysis for ASPE of CMS' publicly available MA data (see Table V1.1).

dominate SNP enrollment. Sixty-eight percent of SNP enrollees in 2007 were in HMOs, and most of the rest were in demonstrations similar to HMOs (statistics calculated from Table VI.1). With many such demonstrations reclassified as HMOs in 2008, 85 percent of SNP enrollees were counted by CMS as under an MA HMO contract. Although SNP enrollment is dominated by HMO enrollment, SNPs offered under local PPO contracts are about equally likely to attract enrollment adjusting for their lesser penetration in the marketplace. In fact, SNPs offered as regional PPOs have a disproportionate share of regional PPO enrollment—34 percent in 2007 and 30 percent in 2008. This is influenced, to a considerable extent by Care Improvement Plus' use of regional PPO contracts to offer chronic care SNPs exclusively.

C. SNP ENROLLMENT BY FIRM

The firms that dominate MA enrollment overall do not necessarily play as dominant a role in the SNP market (Table VI.3a and VI.3b.). The main exception is UnitedHealthcare/Secure Horizons, whose share of the SNP market was 17 percent in 2007 and 20 percent in 2008. Kaiser Permanente also has a substantial share of SNP enrollees (8 percent in 2007 and 6 percent in 2008), but the share is below that of Kaiser's overall presence in the MA market. Humana, in contrast, has only a limited presence in the SNP market, as do BCBS affiliates. A recent analysis by Verdier and Fleming (April 2008) highlights the role played in the SNP market by firms such as SCAN (in California and Arizona), Care Improvement Plus (multiple states), Managed Health Inc. (New York), as well as national firms such as WellCare and HealthSpring. To a significant extent, however, SNP sponsors are not as consolidated as they are in MA overall. Whether this reflects the unique nature of SNPs, or the early stages in the evolution of this market, remains to be seen.

D. SNP ENROLLMENT BY STATE

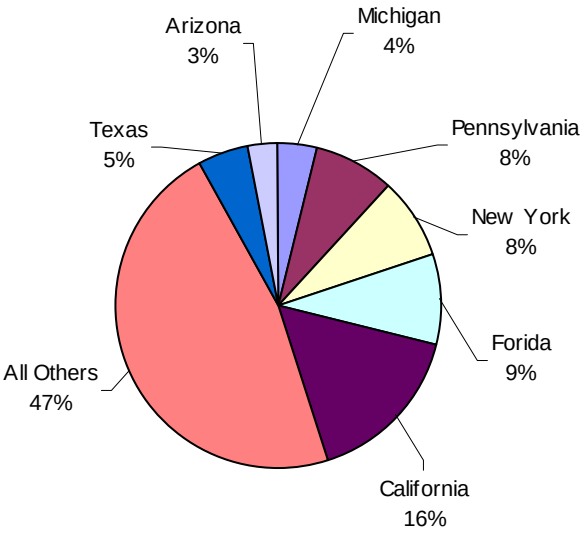
There is some SNP enrollment in most states; the main exceptions are those that had little if any overall enrollment in MA coordinated care contracts in 2007 and 2008 (Table VI.4).[3] In neither year was there any SNP enrollment in Alaska, Montana, New Hampshire, Vermont, West Virginia, or Wyoming. Kansas had no SNP enrollees in 2007, but had a small number in 2008. In contrast, North Dakota had a very small number of SNP enrollees in 2007, but none in 2008.

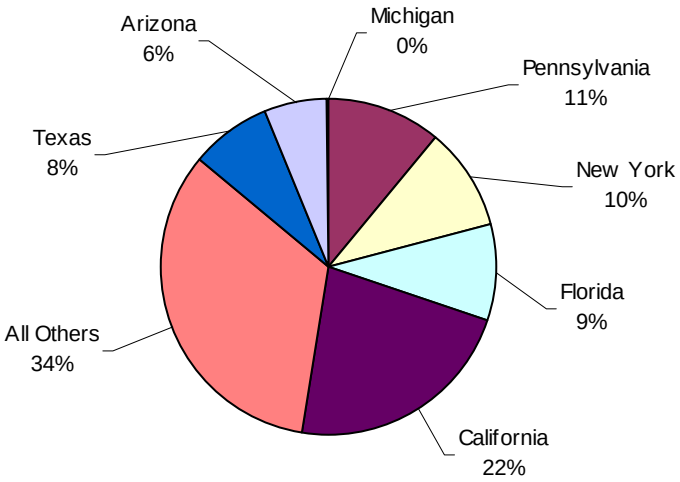
Variation across states in SNP enrollment reflects a combination of state beneficiary size (total number of beneficiaries), overall attractiveness of MA (general penetration of MA in the state), and other state characteristics that have particular influence on the SNP share of the market. The most obvious of these variations relates to the state's history of Medicaid in managed care, because dually eligible enrollees are the largest share of the population in SNPs, and states vary in how aggressively they have sought to enroll such individuals in managed care, either through Medicaid alone or through demonstrations (see Verdier et al. 2008). States with SNPs comprising a disproportionate share of their MA enrollment are South Dakota (36 percent in 2007 and 40 percent in 2008), Maryland (22 percent in 2007 and 24 percent in 2008), Arizona (17 percent in 2007 and 19 percent in 2008), Tennessee (17 percent in 2007 and 16 percent in 2008), and Minnesota (17 percent in 2007 and 15 percent in 2008). In 2008, SNP enrollment grew, and was particularly high in Texas (16 percent), Arkansas (18 percent), and Georgia (20 percent). Although Puerto Rico is excluded from our analysis, it is worth noting its disproportionate share of SNP enrollees—about a quarter of all SNP enrollees nationwide (about 240,000).

In 2008, six states in the nation had more than 300,000 Medicare beneficiaries enrolled in MA, and one (Arizona) had nearly 300,000. We show in Figure VI.2 how total MA enrollment and SNP enrollment are distributed among these and other states. Forty-one percent of total MA enrollment is in California, Florida, New York, and Pennsylvania, and 53 percent is in these states combined with Texas, Michigan, and Arizona. Among the seven states, one—Michigan—has a disproportionately smaller enrollment in SNPs than MA overall. Florida has about the same share of the SNP market as it does the MA market. The other five states all have disproportionately more SNP enrollees. Because California accounts for so large a share of the MA market, the fact that it has disproportionately more SNP enrollees (16 percent versus 22 percent in MA) means that the top four states in MA enrollment account for more than half of SNP enrollment (52 percent). The seven states with the largest MA enrollment in aggregate account for 66 percent of SNP enrollment in 2008, which is higher than their share of total MA enrollment that same year (53 percent).

[3] Most SNPs operate only in a single state, but some operate in a service area that includes more than one state. CMS does not provide public data that can be used to allocate enrollment in plans within a service area. Public data show only enrollment at the county level for a contract. For purposes of this analysis, we distributed SNP enrollment across states when they served more than one service area by applying the same proportions in which total MA enrollment for that contract was allocated. In 2007, 40,604 SNP enrollees, or 4 percent, had to be allocated across states. In 2008, 57,365, or 5 percent of enrollees, had to be allocated across states. States (and DC) with more than approximately half of their enrollees in SNPs based on allocations are the District of Columbia, Delaware, Georgia, Louisiana, Maryland, Missouri, and South Carolina. (For additional information on allocation, see Appendix A.5.)

Figure V1.2. MA Enrollment and SNP Enrollment by State, 2008





MA Total Enrollment = 8.1 million

SNP Total Enrollment = 0.9 million

Source: MPR analysis for ASPE of CMS' publicly available MA data (see Table VI.4).

Note: States with Total MA enrollment of close to 300,000, or 300,000 or more are named. The rest are included in "All Others." Excludes Puerto Rico and The Territories.

Table VI.1. SNP Contracts Within MA Contracts, 2007-2008

					MA Contracts with SNPs					
	Total MA Contracts		MA (without SNPs)		Total		Some SNPs		SNP-Only Contracts	
	2007	2008	2007	2008	2007	2008	2007	2008	2007	2008
Total	**593**	**715**	**371**	**390**	**222**	**325**	**142**	**212**	**80**	**113**
Local HMO	291	367	122	98	169	269	117	178	52	91
Local PPO	113	137	92	106	21	31	10	17	11	14
PFFS	46	76	46	76	0	0	0	0	0	0
RPPO	14	14	8	6	6	8	3	5	3	3
Demonstration	40	19	18	6	22	13	9	10	13	3
Other	89	102	85	98	4	4	3	2	1	2

Source: MPR analysis of CMS Monthly data from the MA State/County/Contract file, 2007 Plan Finder, and 2008 Landscape File.

Note: This table lists more contracts that we otherwise show nationally (Table II.1) because the Puerto Rico exclusion was handled differently (see Appendix B.3). Because we were using enrollment files for tables in this chapter, the Puerto Rico exclusion was based on FIPS codes rather than on the Plan Finder/Landscape file as we did for the other work on availability. Table VI.1 shows 715 contracts in 2008 versus 697 (see Appendix Table B.4) and 593 versus 575 in 2007 (see Appendix Table B.3). The other reason that counts aren't the same as in Table II.1 is because this analysis includes all MA plans and does not exclude SNP-only group, HCPP, PACE, and demonstration contracts.

Table VI.2. Contract Enrollment by Contract Type, 2007-2008

	July 2007			March 2008		
	Total MA Enrollment	Total SNP Enrollment in MA Contracts	Total SNP Enrollment as Percentage of Total MA Enrollment	Total MA Enrollment	Total SNP Enrollment in MA Contracts	Total SNP Enrollment as Percentage of Total MA Enrollment
Total	**8,211,106**	**738,061**	**9.0%**	**9,127,543**	**957,894**	**10.5%**
Local HMO	5,381,813	505,320	9.4%	5,925,682	810,639	13.7%
Local PPO	450,235	42,495	9.4%	552,901	69,215	12.5%
PFFS	1,608,809	0	0	2,032,587	0	0
RPPO	159,614	37,626	23.6%	253,214	75,666	29.9%
Demonstration	213,164	152,602	71.6%	3,979	1,956	49.2%
Other	397,471	18	0.0%	359,180	418	0.1%

Source: MPR analysis of CMS Monthly data from the MA contracts file and the SNP Comprehensive Reports for July 2007 and March 2008.

Table VI.3a. SNP Enrollment by Selected MA Firms, by Overall Size of MA Enrollment, 2007

	Total MA Enrollment		SNP Enrollment	
Firm Name of Affiliation	N	%	N	%
Total Enrollment	**8,557,623**	**100.0**	**738,061**	**100.0**
Blue Cross/Blue Shield Affiliate	1,250,273	14.6	13,418	1.8
UnitedHealthcare/Secure Horizons	1,362,694	15.9	124,968	16.9
Humana	1,079,619	12.6	7,836	1.1
Kaiser Permanente	870,263	10.2	56,148	7.6
Health Net	228,596	2.7	8,746	1.2
Aetna	180,728	2.1	0	0.0
WellCare	122,525	1.4	23,087	3.1
Other	3,462,925	40.5	503,458	68.2

Source: MPR analysis of CMS Monthly MA Contract Enrollment file, July 2007, SNP Comprehensive Report, July 2007.

Note: Numbers may not be identical to standard SNP reports because of merging challenges and discrepancies between general MA and SNP data.

Table VI.3b. SNP Enrollment by Selected MA Firms, by Overall Size of MA Enrollment, 2008

	Total MA Enrollment		SNP Enrollment	
Firm Name of Affiliation	N	%	N	%
Total Enrollment	9,492,114	100.0	957,894	100.0
Blue Cross/Blue Shield Affiliate	1,566,563	16.5	15,121	1.6
UnitedHealthcare/Secure Horizons	1,189,497	12.5	190,007	19.8
Humana	1,186,031	12.5	14,634	1.5
Kaiser Permanente	872,252	9.2	58,342	6.1
Health Net	262,829	2.8	13,249	1.4
Aetna	335,899	3.5	1,055	0.1
WellCare	196,914	2.1	29,061	3.0
Other	3,882,129	40.9	636,425	66.4

Source: MPR analysis of CMS Monthly MA Contract Enrollment file, July 2007, SNP Comprehensive Report, July 2007.

Note: Numbers may not be identical to standard SNP reports because of merging challenges and discrepancies between general MA and SNP data.

Table VI.4. Total MA and Total SNP Enrollment, by State, July 2007 and March 2008

State	2007			2008		
	SNP Enrollment	Total MA Enrollment	SNP Enrollment as a Percent of Total July MA Enrollment	SNP Enrollment	Total MA Enrollment	SNP Enrollment as a Percent of Total July MA Enrollment
National[a]	**716,466**	**8,211,118**	**8.7%**	**889,286**	**9,127,555**	**9.7%**
Alaska	0	63	0.0	0	131	0.0
Alabama	17,132	114,732	14.9%	19,979	129,694	15.4%
Arkansas[b,c]	5,780	45,556	12.7%	10,054	55,234	18.2%
Arizona	50,175	288,904	17.4%	56,116	303,070	18.5%
California[b]	182,939	1,453,104	12.6%	194,316	1,499,016	13.0%
Colorado	8,633	166,668	5.2%	10,463	178,303	5.9%
Connecticut	3,716	54,789	6.8%	6,113	68,775	8.9%
District of Columbia[b,c]	419	6,470	6.5%	876	6,610	13.3%
Delaware[c]	315	3,302	9.5%	430	4,252	10.1%
Florida	45,692	769,567	5.9%	81,038	831,639	9.7%
Georgia[b,c]	14,907	109,152	13.7%	26,041	131,048	19.9%
Hawaii	1,013	67,922	1.5%	1,663	70,115	2.4%
Iowa[b,c]	40	55,175	0.1%	528	54,230	1.0%
Idaho	410	41,734	1.0%	1,495	48,106	3.1%
Illinois[b,c]	5,023	139,158	3.6%	6,831	152,908	4.5%
Indiana	381	88,332	0.4%	894	108,829	0.8%
Kansas[c]	0	29,684	0.0	549	33,959	1.6%
Kentucky	9,652	76,660	12.6%	9,449	90,038	10.5%
Louisiana[b]	1,908	109,712	1.7%	4,149	125,406	3.3%
Massachusetts	13,968	171,353	8.2%	17,132	181,838	9.4%
Maryland[b,c]	9,028	41,453	21.8%	11,456	47,668	24.0%
Maine	181	5,499	3.3%	752	11,101	6.8%
Michigan[b]	1,445	225,880	0.6%	2,946	321,350	0.9%
Minnesota[b]	35,813	214,321	16.7%	35,962	241,376	14.9%
Missouri[b,c]	3,585	150,043	2.4%	9,004	165,576	5.4%
Mississippi[b]	1,144	32,102	3.6%	2,696	35,263	7.6%
Montana	0	17,847	0.0	0	21,068	0.0
Nebraska[b,c]	156	24,099	0.6%	196	26,835	0.7%
New Hampshire	0	4,123	0.0	0	7,199	0.0
New Jersey	2,379	115,212	2.1%	3,473	121,335	2.9%
New Mexico[b,c]	681	59,826	1.1%	1,161	63,576	1.8%

Table VI.4 *(continued)*

State	2007 SNP Enrollment	2007 Total MA Enrollment	2007 SNP Enrollment as a Percent of Total July MA Enrollment	2008 SNP Enrollment	2008 Total MA Enrollment	2008 SNP Enrollment as a Percent of Total July MA Enrollment
Nevada	69	93,486	0.1%	579	97,809	0.6%
New York	72,735	682,522	10.7%	85,842	745,091	11.5%
North Carolina	4,611	185,886	2.5%	14,890	209,783	7.1%
North Dakota[b]	56	6,269	0.9%	0	6,847	0.0
Ohio[b]	5,228	315,548	1.7%	8,448	445,907	1.9%
Oklahoma	480	66,132	0.7%	877	72,424	1.2%
Oregon[c]	17,469	219,409	8.0%	18,275	227,462	8.0%
Pennsylvania	102,490	708,092	14.5%	101,925	749,080	13.6%
Rhode Island	3,808	60,989	6.2%	4,842	62,332	7.8%
South Carolina[b,c]	6,626	65,162	10.2%	17,471	84,968	20.6%
South Dakota	2,581	7,110	36.3%	4,217	10,470	40.3%
Tennessee	28,307	167,150	16.9%	29,686	189,521	15.7%
Texas[b,c]	46,439	386,689	12.0%	71,926	441,447	16.3%
Utah	2,021	54,556	3.7%	2,979	65,731	4.5%
Virginia[c]	155	96,739	0.2%	637	114,667	0.6%
Vermont	0	1,272	0.0	0	2,319	0.0
Washington[c]	1,652	168,635	1.0%	3,633	187,290	1.9%
Wisconsin	5,224	168,905	3.1%	7,059	197,393	3.6%
West Virginia	0	71,332	0.0	38	78,434	0.0%
Wyoming	0	2,781	0.0	0	3,020	0.0

Source: MA enrollment counts are from MPR analysis of the CMS MA Monthly State/County/Contract file, July 2007 and March 2008; CMS July 2007 and March 2008 SNP Comprehensive Reports; and CMS 2007 and 2008 Plan Finders.

Note: Totals for SNPs differ from those in Tables VI.2 and VI.3 because the Puerto Rico exclusion in the latter was based on Plan Geographic Names from the SNP Comprehensive Report. This file does not show the split in enrollment across SNPs by state. In this table, we used the FIPS code applied to contracts and allocated SNP enrollment across states where it was relevant in proportion to the split in total MA enrollment.

[a]Excludes Puerto Rico and The Territories. In July 2007, there were an additional 241,088 SNP enrollees in Puerto Rico—70 percent of Puerto Rico's 346,505 total MA enrollment. In 2008, there were 235,466 SNP enrollees in Puerto Rico, 65 percent of Puerto Rico's total of 364,559. Total SNP enrollment, including Puerto Rico, was 957,554 in 2007 and 1,124,552 in 2008.

[b]Some portion of the 2007 SNP enrollment was allocated to the state.

[c]Some portion of the 2008 SNP enrollment was allocated to the state.

VII. MA PLAN BENEFITS AND PREMIUMS

In this chapter, we review characteristics and trends in MA plan premiums and benefits from 2006 through 2008. This analysis is based on the public file from Medicare Options Compare, and differs in a number of respects from the analysis in the previous chapter.

First, this analysis is by plan rather than contract, because benefits and premiums can differ across plans offered under the same contract. Within a contract, plans may be offered in only part of a contract's total service area. In addition, more than one plan may serve the same county.

Second, the contracts whose plans we examine here include Puerto Rico (excluded in the prior analyses) but they otherwise are a subset of all the contracts examined in the prior chapters. Specifically, we focus on contracts formally authorized as part of the MA program—HMOs, local PPOs (and provider sponsored plans that we include with them), regional PPOs, PFFS plans, and MSAs.[1] Within this spectrum of contracts, we include in this analysis all of the plans offered, with two caveats. SNP plans and those offered under SNP-only contracts are included, but are defined as their own "type" due to the nature of their target population, such as dual eligibility or institutional status. Totals *exclude* SNPs because of their unique nature, and to avoid double-counting lowest premium plans. Group plans are *excluded* from the analysis entirely, both because they are unique and because the Plan Finder does not include them.

Third, this analysis describes more fully what plans offer than what enrollees get, the latter of which is influenced by beneficiary response to the options available to them and which plans they select. Each provides important information but the two kinds of statistics may not be the same because of the wide variation in enrollment levels across plans. As discussed in Chapter I, CMS historically provided a single annual release of enrollment data for plans within contracts but it did not show enrollment at the county level, which limited the ability to analyze individual enrollment in plans whose details differed across the service area of a contract.[2] Given this constraint, the analysis for the most part is not weighted by enrollment. Because enrollment is so important, however, we do provide a limited weighted analysis of "lowest premium MA-PDs" offered under contract segments, in the last section of this chapter which examines trends from 2006-2008. This analysis makes the assumption that *all* of a given contract's MA enrollment in those counties is in the lowest premium plan available for general enrollment.[3]

We begin this chapter by describing what we learned from constructing the analysis about the number and types of plans offered under MA contracts from 2006 to 2008. We then present data from the most recent year, 2008, on the characteristics of benefits and premiums. Finally,

[1] Other types of contracts either are excluded from the Plan Finder upon which this analysis is based, or have unique requirements influencing the benefits offered and premiums charged.

[2] In May 2008, after we completed our analysis, CMS released what they say will be a monthly file with enrollment at the contract-county-plan level, though cells with fewer than 10 enrollees are not reported.

[3] This is analogous to the assumptions we have made historically in looking at benefits and premiums within "basic plans." The main difference is that there are now more plans offered under individual contracts, and enrollment may be more dispersed.

we discuss trends in benefits and premiums during 2006-2008. For this purpose, we focus on the lowest premium plans, and provide weighted and unweighted data for a selected number of variables. In Appendix C, readers will find full tables for 2007. (The 2006 results have been published previously in Gold et al. 2006 but this analysis uses updated data so estimates from that source and this are not identical, especially when weighted since 2006 enrollment data were not available for the earlier analysis.[4]).

Users of this analysis should recognize the constraints inherent in our use of these public files. The Plan Finder is a text file on the public Medicare website (www.medicare.gov) developed to support beneficiary choice. We have manipulated the text file to create "variables" that aim to distill the nature of benefits offered and cost sharing applied. These variables are limited both in the detail and in their consistency over time. The variables also may be influenced by errors in specific plan listings. We have provided caveats in several places where the data appear potentially problematic.

A. NUMBER AND TYPE OF MA PLANS OFFERED, 2006-2008

Table VII.1 shows the number of MA plans offered in 2006, 2007, and 2008, by type. There are many more plans than there are MA contracts (Figure VII.1). Among the types of contracts we include in this chapter, there were 346 in 2006, 375 in 2007, and 473 in 2008.[5] In contrast, there were an average of 5.4 regular MA plans per contract in 2006, excluding SNPs; there were 7.5 in 2007 and 7.0 in 2008 (statistics calculated from Figure VII.1). There are many reasons why more than one plan would be offered, and it is possible, by analyzing these data, to see the effects of some of these reasons.

MA-PD versus MA only. Beneficiaries voluntarily choose Part D benefits. For this reason, sponsors often offer plans both with and without such a benefit under MA if they are able to.[6] There are far more MA-PD than MA-only plans, although still more of the latter than applicable MA contracts. From 2006 to 2008, the number of MA-PD plans increased from 1,349, to 2,086, to 2,232 (Table VII.1). In each year, 67 percent or more of MA plans were of this type (from 2006-2008, 72 percent, 74 percent, and 67 percent, respectively). In PFFS contracts (which have the option to offer prescription drugs or not), 63 percent of plans did so in 2006, 69 percent in 2007, and 53 percent in 2008 (statistics calculated from Table VII.1).

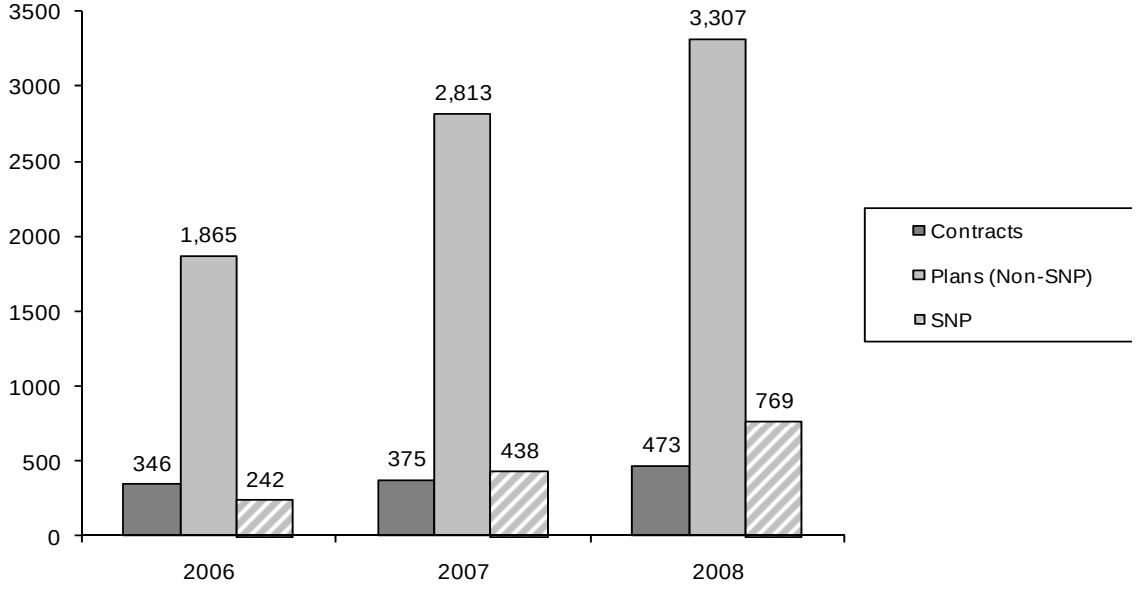
Segmenting the Service Area. Except for regional PPOs, MA contracts choose their service areas by county (with some regulatory restrictions in place to prevent abuse). HMOs and other coordinated care plans often secure different MA contracts for the diverse markets they

[4] To be consistent with the rest of the analysis, we combine PSO plans with local PPOs here. As a result, the 2006 data presented here may differ slightly for HMOs and local PPOs from that previously published (Gold et al. 2006). Other inconsistencies may exist because we use here an updated 2006 file.

[5] Numbers here are from Table II.1, but exclude cost, HCPP, PACE, and other contracts.

[6] Under MA, HMOs and local PPOs must offer at least one PD plan under their contracts, and beneficiaries who enroll in MA under these types of contracts may *not* enroll in a free-standing prescription drug plan. Regional PPOs *must* offer only MA-PD plans, although the data seem to show that some MA-only plans have been approved under this contract. PFFS plans have the option to offer an MA-PD plan or not. MSA may *not* offer an MA-PD.

Figure VII.1. Number of Contracts and Plans, 2006-2008



Source: MPR analysis for ASPE of publicly available CMS data from Medicare Options Compare. Excludes group plans (see Tables II.1 and VII.1).

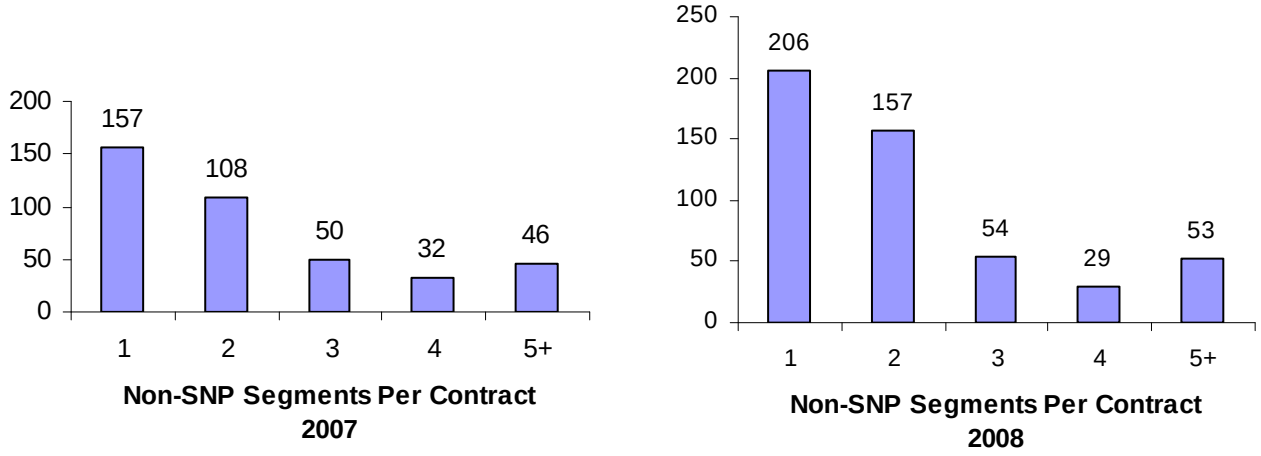
Note: Includes HMO, Local PPO, PSO, Regional PPO, PFFS, and MSA contracts only.

serve, because of their history and the role state licensure plays in their operation. With less history and fewer state licensure restrictions (for network-based offerings), PFFS contracts tend to have large service areas. Except for regional PPOs, which are precluded from this practice, firms take into account differences in capitation rates and medical care costs within their service areas in structuring the geographical scope of their plans, and the specific benefits and premiums that apply to each. To support them in this, CMS allows firms to "segment" a service area into more than one non-overlapping unit, and to offer different plans within each. It appears that most contracts take advantage of this. The count of lowest premium MA-PDs (excluding SNPs) is a close equivalent to the number of contract segments; and the numbers of segments for each year are much higher than the number of contracts.[7]

Among contracts that offer non-SNP plans, about 60 percent do some segmentation of the service area in their contract to define the benefit packages they will offer in diverse plans (Figure VII.2). Most use only 2 or 3 segments, but some use many more (a maximum of 86 in 2007, and 83 in 2008). Segmentation is less likely in SNPs; 76 percent and 73 percent in 2007 and 2008, respectively had only one geographic segment upon which their benefit packages were designed (data not presented).

[7] The main source of error is the exclusion from this count of segments in which MA-only plans are offered. Because of the statute, the exclusions mostly are PFFS plans and MSAs, all of which are MA-only plans.

Figure VII.2. Number of Contract Segments (for Non-SNP plans), 2007-2008



Source: MPR analysis for ASPE of CMS' publicly available data from Medicare Options Compare. Excludes group plans.

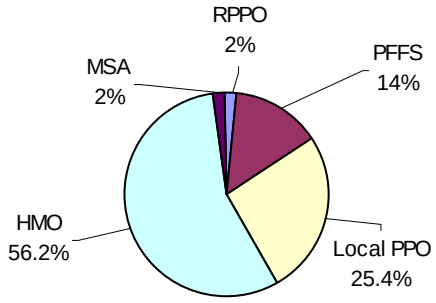
Note: Includes only contracts for HMOs, Local PPOs, Regional PPOs, PFFS, and MSAs. In 2007, there were 393 such contracts. In 2008, there were 499.

Multiple MA-PDs within Segments. Firms may want to reach different beneficiaries by offering a range of plans that allow them to trade off premium for richness of cost sharing. In 2007, 73 percent of MA-PD plans offered in contract segments represented "lowest premium" plans, which means that fewer than a quarter offered two or more plans within the segments (statistics calculated from Table VII.1).[8] This share declined to 59 percent in 2007 and went back up slightly, to 62 percent in 2008. Multiple plan offerings to the same population are less common in SNPs.

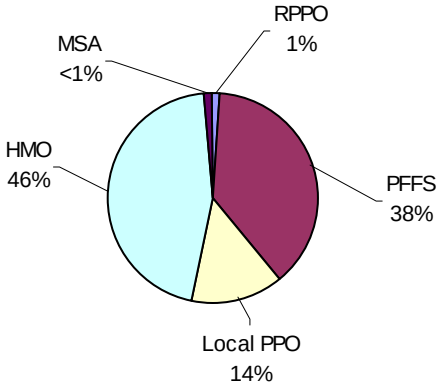
Type of Contract. Figure VII.3 seeks to summarize the variations in how contracts of different types structure their plans, and how this influences the share of plans contributed by contracts of that type. In 2008, HMOs accounted for 56 percent of all the MA contracts of the type we examine here, and they had a roughly equivalent share of the lowest premium MA-PDs; however, they were only 35 percent of MA-only contracts. In contrast, PFFS comprise only 14 percent of total contracts, but account for a much larger share of plans—25 percent of lowest premium MA-PDs and 56 percent of MA-only plans. In percentage terms, local PPOs contribute a small share of all MA plans (14 percent) compared to contracts (25 percent). MSAs are limited to MA-only plans, and such plans now constitute only a small percentage of all this type. Because we know that MSAs were available to all beneficiaries in 2008, this means that the plans must be offered on a relatively uniform basis across the country. All of these figures exclude plans approved for group enrollment, since they are excluded from the analysis and not displayed in the Plan Finder.

[8] Some firms may offer more than two plans, so the number with only a single segment cannot be determined from the data in Table VII.1.

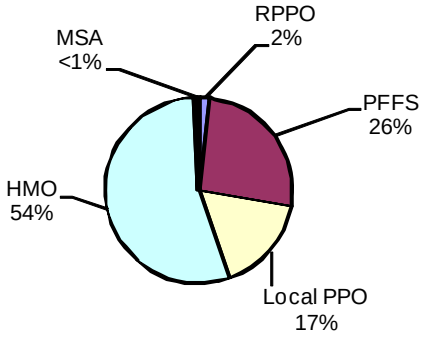
Figure VII.3. MA Plans by Type, Various Definitions, 2008



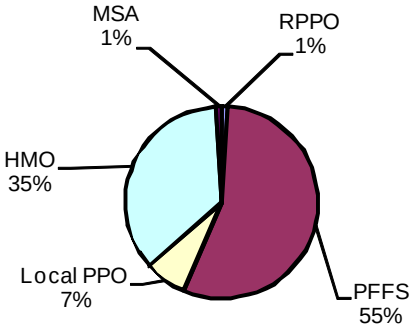
Total Contracts = 473[a]



All MA Plans = 3,307



Lowest Premium MA-PDs = 1,387



MA Only = 1,075

Source: MPR analysis for ASPE of publicly available data from Medicare Options Compare. Excludes group plans (see Table VII.1).

Note: Includes only HMO, Local PPO, Regional PPO, PFFS and MSA contracts.

[a]Total contracts are for MA, and exclude SNP-only contracts (from Table I.4).

B. 2008 BENEFITS AND PREMIUMS

Here, we review various features of the benefits and premiums offered by MA plans in 2008. Because MA-PDs account for most plans and a large share of enrollment, particularly of individuals,[9] we make these our focus, but provide a review of the characteristics of MA-only plans at the end of this section. (Identical tables for 2007 are in Appendix C.) The data shown in this section are unweighted and hence reflect what MA firms offer, not necessarily what beneficiaries receive based on their enrollment decisions.

1. MA-PD Benefits Premiums

Table VII.2 provides information on MA-PD premiums by contract type, and for lowest premium and "other" plans. These premiums are the total premiums plans charge beneficiaries who enroll, as shown in Medicare Options Compare. They include both the core MA premium (Part C) and the prescription drug (Part D) premium, taking into account plan rebates. The MA-PD premiums are in addition to beneficiary monthly premiums paid directly to Medicare for the Part B benefit ($96.40 in 2008, and more for beneficiaries with higher incomes). In 2008, the mean premium a plan charged was $23 per month in lowest premium plans and $45 across all plans. HMO premiums, on average, are substantially lower than for other generally available plans (Figure VII.4). Of lowest premium plans, the average premium is only $12 per month, and 76 percent offered their plans for no additional premiums (including 15 percent that provided a rebate for all or some of the Part B premium). SNPs, the majority of which are HMOs, also have low premiums, although a smaller share of them offers such plans for no premium at all. (Because SNPs include a diverse mix of plans targeted at those who are dually eligible, or with institutional, and chronic care needs, it is difficult to interpret their data without additional information on the plans.) Among other plan types, local and regional PPOs tend to have the highest average premiums, and PFFS lower ones.

We do not know, of course, which plans are being chosen, and to what extent those enrolling are choosing more expensive plan options when the same company also offers a similar lower premium plan. Among lowest premium plans, a larger share of local PPOs price their premiums at $100 or more per month (15 percent) compared to other types. Forty-two percent of lowest premium local PPOs cost $50 or more per month, as do 50 percent of regional PPOs and 23 percent of PFFS plans. Firms probably differ in the target populations they seek, and this may vary both by MA contract type and by company. A premium of $100 per month may be high for a price-sensitive shopper, but low if the person otherwise would purchase a Medigap plan. When firms offer plans beyond their lowest premium product, they typically seem to do so to provide beneficiaries the choice of a much richer benefit package. Very few of these plans have zero premiums, and most have premiums of $50 per month or more (SNPs being an exception).

[9] The April 2008 CMS Monthly Summary Report (which includes some plans excluded here) shows that 83 percent of all MA enrollees are in MA-PDs, and the rest in MA-only plans. We believe, from what we learned in the discussions with firms, that some of the MA-only individuals are enrolled through group plans that maintain the subsidy for their own Part D benefit. If so, more than 83 percent of beneficiaries in plans included here (since group plans are excluded) are in MA-PDs.

Figure VII.4. MA-PD Monthly Premiums, Unweighted by Plan Type, 2008

Source: MPR analysis for ASPE of CMS' publicly available data from Medicare Options Compare (see Table VII.2). Excludes group plans. Premiums are the combined regular MA and the Part D premium after rebates, as shown in Medicare Options Compare. Amounts shown are plan averages, without weights for enrollment.

2. Prescription Drug Premiums and Benefit Design

Tables VII.3a-c provide information on the Part D share of the MA-PD premium, and also on the way benefits are structured. If firms can provide Medicare Part A and B benefits for less than they are paid by Medicare, they can use the difference, not just to offset the costs of that coverage (or its associated premium), but also the Part D plan benefit. (We discuss this issue further at the end of the chapter.) Table VII.3a shows results for all MA-PDs, 3b for lowest premium plans only, and 3c for "other" plans. Among lowest premium MA-PDs, the average premium charged for Part D coverage is under $5 per month for HMOs (76 percent of which offer it for no additional premium (see Table VII.3b)). Each of the other plan types average premiums between $13 and $18, although more than a third of them (except regional PPOs) have zero premium plans. Part D premiums are substantially higher among all plan types for "other" packages; presumably, the difference includes lower cost sharing and/or more expansive formularies or tiering, although we do not have the information to assess that.

Most plans, regardless of their type, waive the initial deductible and use fixed dollar and tiered copayments, rather than coinsurance, in designing their drug plan. This is true across MA-PDs, whether they are lowest premium or not. Coverage in the "gap" remains less pervasive. Among lowest premium plans, 62 percent offer no such coverage, 15 percent offer coverage for generic only, and 23 percent offer some brand coverage.[10] Gap coverage is more likely in

[10] The Plan Finder is not sufficiently detailed to allow easy assessment of which drugs are covered. Most of those noted as covering "brand and generic" in fact provide coverage tied to certain tiers in the formulary.

"other" plans, although only 63 percent of them offer it at all, and 26 percent offer this coverage only for generic (Table VII.3c). HMOs do not appear to differ as much from other plans on these characteristics as they do on premiums. In 2008, regional PPOs stand out among lowest premium plans for their greater likelihood of offering gap coverage (only 39 percent of RPPOs do not offer gap coverage—Table VII.3b); however, this is a very consolidated market, so we do not know if the offering reflects a single firm's decision.

3. Cost Sharing for Physician and Hospital Services

Tables VII.4a-c show the copayments and other out-of-pocket charges for selected physician and hospital services. Rates for lowest premium plans (Table VII.4b) are most relevant to the price-sensitive shopper, although this may vary with their health status. Although their premiums were lowest in 2008, HMOs still tend to have less cost sharing than other plan types. The average HMO copayment for a primary care visit was $7 in 2008; 35 percent charged nothing at all, and others varied copayments for different types of visits. HMOs charge higher copayments for specialist visits—the average is $22 per visit—and 37 percent charge more than $25. Coinsurance is almost never applied to either type of visit.

Other plan types also appear to vary the copayment level for primary care versus specialty visits, but they charge more, on average, than HMOs. We have had more difficulty now in interpreting data from the Plan Finder file about cost sharing in and out of network in PPOs than when we last analyzed data in 2006 (Gold et al. 2006).[11] In 2006, few lowest premium plans used coinsurance for in-network benefits, although most had copayments. In contrast, local and regional PPOs commonly appear to use both in 2008, particularly local PPOs. We do not know whether this reflects errors in the way such data are presented in the Plan Finder (or at least in the analysis file to which we have access) or whether it reflects reality, possibly because the use of copayments versus coinsurance depends on the type of service.[12]

Among lowest premium plans using copayments, the mean copayment charged for primary care visits is $7 for HMOs, $11 for local PPOs, $16 for PFFS, and $11 for regional PPOs. For a specialist visit, it is $22 for HMOs, $24 for local PPOs, $29 for PFFS, and $28 for regional

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Additional detail on prescription drug formularies is discussed later in this chapter, and is available in MedPAC 2008a.

[11] Earlier versions of the file were clearer about what cost sharing applied to in- and out-of-network benefits. The tables make the following assumptions: (1) If both a copay and coinsurance amount are given and neither is explicitly stated as in- or out-of-network, we assume that the copay is for in-network and that the coinsurance is for out-of-network; (2) If only one copay or only one coinsurance amount is given and no network is stated, we assume that amount applies to both in and out-of-network; and (3) If two different copay amounts are given, we assume the lower is for in-network and the higher is for out-of-network.

[12] An example of the kind of text language on the Plan Finder File is as follows: NO REFERRAL REQUIRED FOR NETWORK DOCTORS, SPECIALISTS, AND HOSPITALS. YOU MAY HAVE TO PAY A SEPARATE COPAY FOR CERTAIN DOCTOR OFFICE VISITS. SEE "ROUTINE PHYSICAL EXAMS," FOR MORE INFORMATION. $30 COPAY FOR EACH PRIMARY CARE DOCTOR VISIT FOR MEDICARE COVERED BENEFITS $30 COPAY FOR EACH SPECIALIST VISIT FOR MEDICARE COVERED BENEFIT; S30% FOR EACH PRIMARY CARE DOCTOR VISIT; 30% FOR EACH SPECIALIST VISIT.

PPOs. Copayments are rarer for SNPs, and almost never apply to primary care; this may reflect the influence of dual eligibility.

Within all plan types, except perhaps SNPs, cost sharing for hospital inpatient and outpatient services is typical. This also is true for radiology services, but is somewhat less extensively applied to laboratory services.

Using the crude data available here, we cannot see striking differences in the cost sharing applied to lowest premium versus all plans.

4. Out-of-Pocket Limit on Spending

As out-of-pocket charges for MA-PDs have grown over time, more plans have put in place a limit on such spending for Part A and Part B services, at least within the network. Sixty-four percent of all lowest premium plans have such a limit, as do 70 percent of "other" MA-PDs (Table VII.5). Such limits are required of regional PPOs, but not of other plans.[13] HMOs still make much less use of such limits in 2008 than other plan types—only about 45 percent of both lowest premium and other MA-PDs of this type use them. The absence of such limits could reflect HMOs' historical base in limited cost sharing that presumably obviated the need for such a limit. (This assumption may no longer apply, although it depends on the particular plan.) Out-of-pocket limits typically exceed $2,500 per year, but rarely $5,000, except in regional PPOs. Among lowest premium plans, a higher share of local PPOs than PFFS plans have limits of more than $4,000 (31 percent vs. 26 percent). HMOs that use limits tend to set them below this amount.

5. Additional Insight on Cost Sharing in PPOs and PFFS

Local and Regional PPOs. Table VII.6 shows the out-of-pocket cost sharing that applies to local and regional PPOs. As noted previously, these data are not consistent with those of 2006, and we suspect that the 2008 Plan Finder made changes that complicate the differentiation of cost sharing for in-network versus out-of-network services.

Both local and regional PPOs commonly use a separate out-of-network deductible for physician services, although this practice is much more common in regional PPOs than in local ones (73 percent and 44 percent, respectively have such a practice). These data are consistent with those for 2006. In 2008, copayments rather than coinsurance appear typical both for physician and hospital services, but we cannot determine whether this is true or just an artifact of the data.

PFFS. Given their considerable growth in enrollment, there is great interest in gaining a better understanding of how PFFS plans handle cost sharing. These plans are not required to offer a prescription drug benefit, so our presentation of lowest premium plans includes all lowest premium PFFS as well as only the lowest premium MA-PDs (Table VII.7). Fixed-dollar

[13] In recent years, in its annual call letter, CMS has encouraged the use of such limits or other provisions to limit excessive out-of-pocket costs.

copayments are more common than coinsurance. Among lowest premium plans, copayments for specialty visits are more than $25 per visit in about three-quarters of the plans. Among lowest premium PFFS plans, inpatient cost sharing also tends to favor a copayment structure rather than Medicare's emphasis on first-day deductibles. About two-thirds of lowest premium PFFS plans charge copayments per day. Copayments of between $101 and $200 per day are somewhat more common than those over $200 per day in 2008, although each range is applied frequently. Copays change by day 10. Although Medicare limits the number of days of care covered in a year, only about a quarter of lowest premium PFFS plans have such a limit. More than 90 percent of lowest premium PFFS plans also have maximums for out-of-pocket and annual spending, something absent from the Medicare benefit package. Such limits typically are more than $2,500 per year. Approximately one-quarter of plans set them higher than $4,000 per year.

6. Estimated Annual Per Capita Out-of-Pocket Cost for Hospital and Physician Services

In Table VII.8, we apply the out-of-pocket cost sharing for physician and hospital services in each plan to calculate a rough estimate of what the benefit and cost sharing structure in lowest premium MA-PD plans would imply about the costs enrollees with different types of needs may face annually for such services. As described in Appendix A, the calculations involve use assumptions for physician visits and hospitalizations for each of three categories of beneficiaries that differ in likely health need, with the overall average reflecting a standard composite across beneficiary types using the same weights for each plan type. The weights draw upon data from the Medicare Current Beneficiary Survey. Averages assume that beneficiaries remain in network. The out-of-pocket costs examined do not include those associated with the Part D benefit.

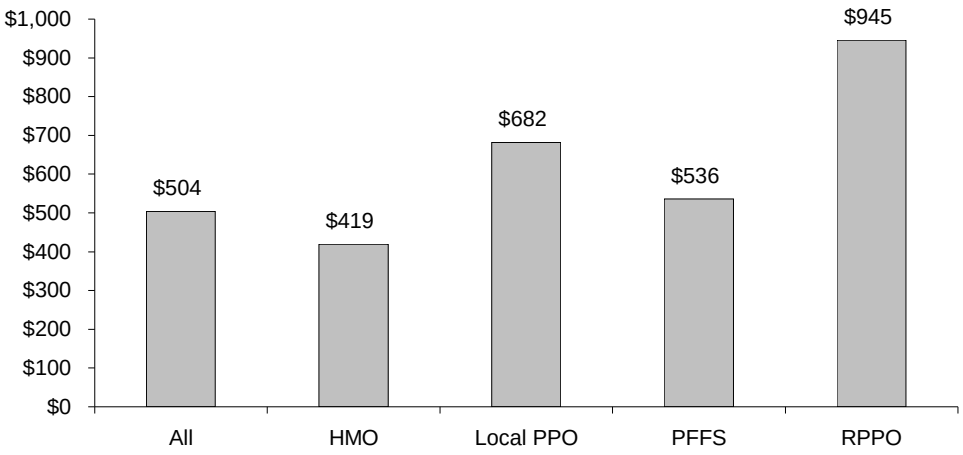
As shown in Figure VII.5, the benefit structure of the average lowest premium MA-PD (unweighted) would mean a beneficiary would have $504 out-of-pocket costs for such services. Such costs are lowest in HMOs ($419), followed by PFFS ($536), and local PPOs ($682). They are highest in regional PPOs ($945). Out-of-pocket costs are substantially higher for those who are likely to use more care, despite the use of out-of-pocket limits (Figure VII.6). A relatively healthy beneficiary would have lowest costs in the average PFFS MA-PD plan ($78), followed by an HMO ($124). The sickest beneficiaries with chronic needs would pay, on average, substantially more across all types of plans ($2,268 annually on average). However, they would do better in a local HMO ($1,951) or local PPO ($2,326) than in a PFFS plan ($2,842) or regional PPO ($3,311).

SNP estimates overstate out-of-pocket costs because they reflect only the structure of Medicare benefits, and most SNP enrollees are dually eligible for Medicaid.

7. Supplemental Benefits

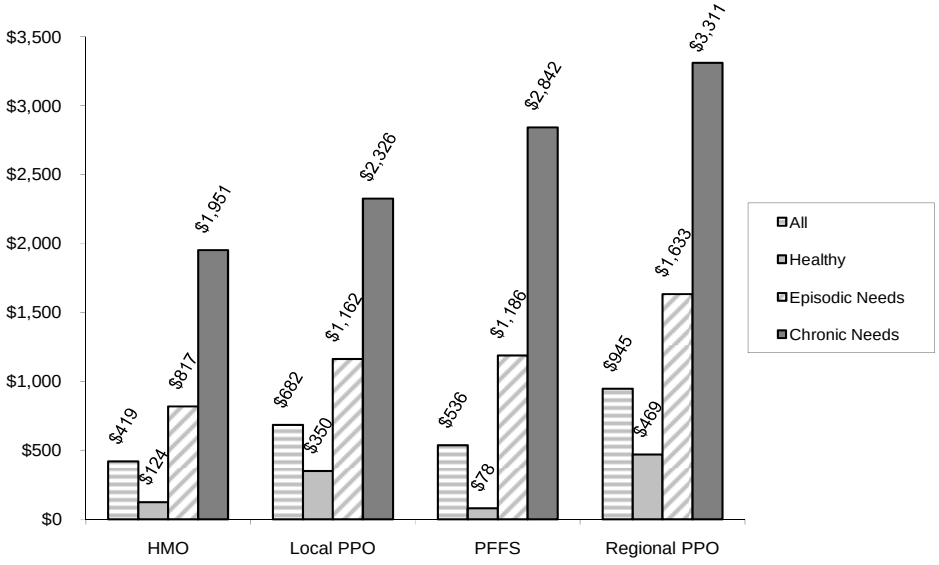
Given current payment rates, there is virtually no variation within or across type in the supplemental benefits offered. They almost universally include preventive dental, vision, hearing, podiatry, and chiropractic benefits (Table VII.9). The structure and scope of such benefits likely varies across plans, but not in ways amenable to analysis here.

Figure VII.5. Estimated Average Per Capita Out-of-Pocket Costs for Hospital and Physician Services in Lowest Premium MA-PDs, Unweighted by Plan Type, 2008



Source: MPR analysis for ASPE from CMS' public data from Medicare Options Compare using HealthMetrix methods (see Table VII.8). Estimates are unweighted for plan enrollment and include only costs associated with the noted services (e.g., Part D cost sharing would be additional).

Figure VII.6. Estimated Annual Per Capita Out-of-Pocket Costs for Beneficiaries with Different Needs in Diverse MA Plans, Unweighted, 2008



Source: MPR analysis for ASPE from CMS' public data from a filed based on Medicare Options Comparer using HealthMetrix methods (see Table VII.8). Estimates are unweighted for plan enrollment and include only costs associated with hospital and physician services (e.g., Part D cost sharing would be additional).

8. Benefits and Premiums in MA-Only Plans

The previous tables have focused mainly on MA-PDs, the type of plan in which most Medicare beneficiaries are enrolled. However, some Medicare beneficiaries may not want Part D coverage, either because it is available to them elsewhere, or because they perceive it is not worth the costs they would incur in purchasing it. As we described at the outset of this chapter, MA contracts not precluded from doing so often offer MA-only plans to provide an option that may interest such beneficiaries, whether aging into Medicare or already enrolled in the program. Monthly premiums for all MA-only plans average $22 per month, ranging from $18 for HMOs and $22 for PFFS, to $44 for local PPOs (Table VII.10). Almost three-fifths of MA-only plans charged no premiums in 2008, including 64 percent of HMOs and 58 percent of PFFS. (Sixty-nine percent of local PPOs charged a premium.) In general, the structure of cost sharing for physician and hospital services does not appear different to that offered by MA-PDs.

MSAs are a new and unique form of plan, first offered in 2007. MSAs all are MA-only, since by statute they are not allowed to cover prescription drugs (although beneficiaries may purchase a free-standing PDP alongside the MA-only plan). On the Plan Finder, the MSAs indicate that they are zero-premium plans with a deductible, after which no cost sharing applies. Because these plans mostly are offered by WellPoint's UniCare and Anthem units, we obtained the summary of 2008 benefits from their websites. In effect, the MSA offerings for these jointly owned companies appear similar. All of the MSAs appear to limit coverage solely to Medicare-covered benefits, applying the same limits as does Medicare. Enrollees face a substantial deductible, after which no additional cost sharing applies to the Medicare-covered benefits. Enrollees are provided an account with a stipulated sum that they can use to offset a portion of the deductible. (See box on the next page for detail.)

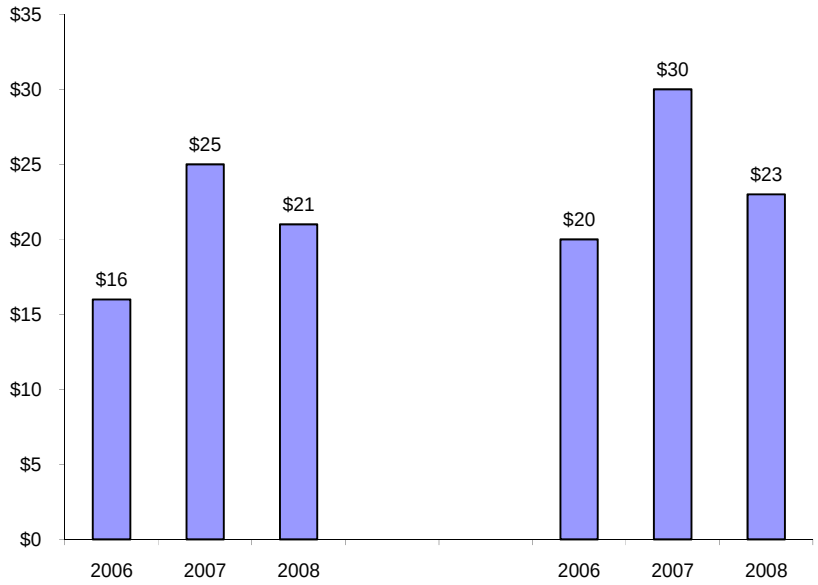
C. TRENDS IN BENEFITS AND PREMIUMS, 2006-2008

Table VII.11 summarizes the trends in key indicators of MA-PD premiums and benefits from 2006-2008. The analysis focuses on lowest premium MA-PDs of each type and shows both unweighted statistics and those weighted by enrollment for March of each year. *As noted previously, the weighting assumes that the entire enrollment for a given contract in the counties within the segment is in the lowest premium plans.* The first set of rows on Table VII.11 show the findings for all contract types; the table also provides results on the same variables for HMOs, local PPOs, regional PPOs, and PFFS. (We do not include SNPs in this analysis). Because most MA enrollment is in HMOs and PFFS, the discussion focuses most extensively on the findings for all MA-PDs, and for these two types.

1. Monthly Premiums

The MA market appears to be very sensitive to premium price, at least for the average enrollee. While average monthly premiums among all lowest premium MA-PDs increased from 2006 to 2008 (Figure VII.7), enrollees are likely to select from among the lower premiums offered each year. Most strikingly, approximately three-fifths of all enrollees are in MA-PDs that charge no premium, and this share was markedly persistent from 2006 through 2008 (Table VII.11).

Figure VII.7. Trends in Mean MA-PD Monthly Premiums, Lowest Premium Only, Weighted and Unweighted, 2006-2008



Source: MPR analysis for ASPE of CMS from a file based on Medicare Options Compare (see Table VII.11). Excludes group plans. Includes only HMO, Local PPO, Regional PPO, PFFS, and MSA plans.

[a]The percent of enrollees in zero premium plans was 62 percent in 2006, 60 percent 2007, and 59 percent in 2008.

In 2006, PFFS plans in particular appear to have capitalized on this price sensitivity—the average PFFS premium, weighted by enrollment, was $7.50 (Figure VIII.8), far lower than the average premium unweighted by enrollment ($27). Since then, mean PFFS premiums have increased but it was not until 2008 that the average, weighted by enrollment, exceeded that for HMOs ($23 versus $18). In 2008, however, 46 percent of PFFS enrollees were in zero-premium plans, versus 64 percent of HMO enrollees (Table VII.11). Even though mean local PPO premiums (weighted by enrollment) increased from 2006 through 2008 ($32 to $46), the share in zero-premium products actually has increased (from 37 percent in 2006 to 48 percent in 2008).

Only a small share of MA-PDs use savings to offer a rebate on the Part B premium for beneficiaries, although this share has grown over time (from 3.3 percent to 5.7 percent for all lowest premium MA-PDs, weighted by enrollment). This percentage is lower than that of MA-PDs unweighted by enrollment (6.4 percent in 2006; 11.3 percent in 2008). However, this difference largely reflects HMO experience. This lack of application to the Part B premium may reflect a firm's preference for using any savings to offset the Part D premium, thus presenting a seemingly more competitive product, although this is speculation.

2008 MSAs under UniCare/Anthem ("Smart Saver MSA")

Essential Elements under all contracts

- Zero premium (beyond Part B).
- Medicare deposits $XX in bank account.
- $YY yearly deductible, after which 100 percent is covered.
- No cost sharing for Medicare benefits once the yearly deductible is reached.
- Coverage limited to Medicare benefits. (Medicare lifetime reserve day limit applies, as does 190-day limit for psychiatric services, the three-day covered hospital stay requirement before starting skilled nursing benefits, and limit to services in U.S., including preventive care).
- Any provider that participates in Medicare and accepts the plans' terms and conditions can be used.

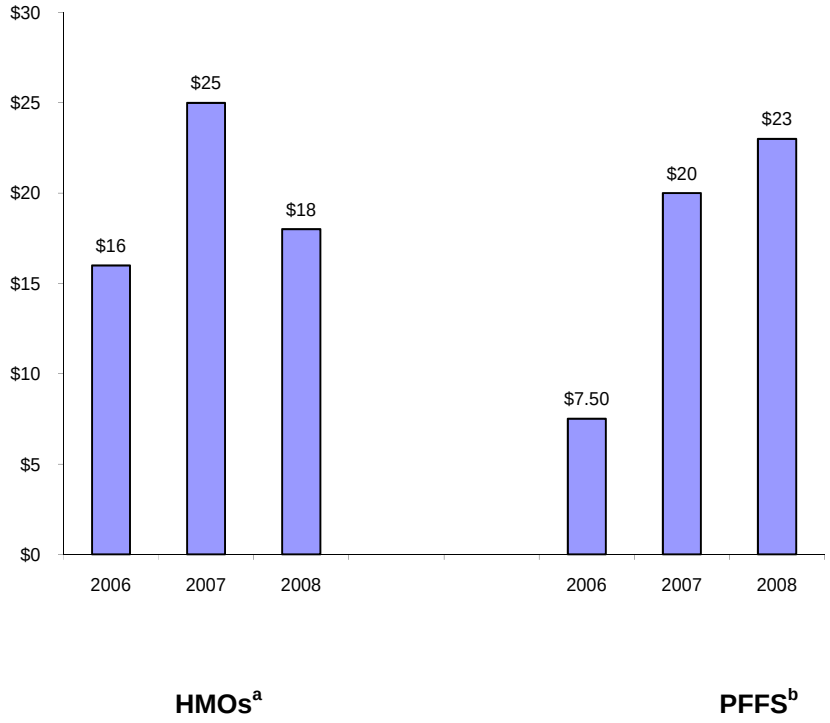
WellPoint's UniCare affiliate offers an MSA in select counties in more than 30 states. UniCare offers three plans, none of which have a premium. These plans structure accounts (XX) and deductibles (YY) as follows:

- Plan I: $1,250 paid into account; $2,750 deductible
- Plan II: $1,375 paid into account, $4,000 yearly deductible
- Plan III: $1,575 into account $5,000 yearly deductible

Anthem's "Smart Saver Medical Savings Account" is offered in selected counties in Colorado, Connecticut, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio, Virginia, and Wisconsin. Benefits described in the booklet for all states except Connecticut, Nevada, and New Hampshire include a $1,300 deposit into bank account and $3,000 yearly deductible

Source: www.unicare.com/wps/portal/chpmedicare; www.anthem.com/wps/portal/ahpmedicare

Figure VII.8. Trends in Mean MA-PD Monthly Premiums, Lowest Premium HMOs and PFFS, Weighted by Enrollment, 2006-2008



Source: MPR analysis for ASPE of CMS public data from Medicare Options Compare (see Table VII.11). Excludes group plans.

[a]The share of HMO enrollees in zero premium plans was 63 percent in 2006, 62 percent in 2007, and 6.5 percent in 2008.

[b]The share of PFFS enrollees in zero premium plans was 64 percent in 2006, 58 percent in 2007, and 56 percent in 2008.

2. Cost Sharing for Part A and Part B Benefits

Between 2006 and 2008, the average copayment for a primary care physician visit in a lowest premium MA-PD (weighted by enrollment) increased from $10 to $11, and the average copayment for a specialist visit increased from $20 to $23 (Figure VII.9). PFFS copays, which started out higher than HMOs, increased less over the period for specialist care (Table VII.9). In 2006, 89 percent of MA-PDs were in plans that had some cost sharing for hospital services, a statistic that rose to 95 percent by 2008.

Out-of-pocket limits are more prevalent in 2008 than they were in 2006, when 56 percent of enrollees in lowest premium MA-PDs were in plans without such a limit (at least using the assumptions employed for this analysis; Table VII.11 and Figure VII.10). By 2008, this declined to 45 percent. HMOs remain least likely to use such a limit, although the share without one declined from 61 percent to 57 percent in the period 2006 to 2008.

The annual limit level also increased over the period, however, from $3,188 on average in 2006 to $3,752 in 2008 (Table VII.11, weighted figures).

Given the changes in the structure of cost sharing for physician and hospital services, we estimate (using the HealthMetrix methods) that annual out-of-pocket costs for the average beneficiary in a lowest premium plan actually decreased from 2006 to 2008, from $498 to $471, weighted by enrollment (Figure VII.11). In 2008, HMOs had the lowest estimated out-of-pocket costs of any plan type, and the amount declined from $482 to $412. Out-of-pocket costs in PFFS plans declined from $640 to $546, moving them ahead of local PPOs. Regional PPOs continued in 2008 to have the highest estimated out-of-pocket costs in 2008 ($1,010) and they are the only type showing no reduction in such costs (all of these estimates assume in-network use). For the most part, the decline reflects a drop between 2006 and 2007. Weighted by enrollment, average out-of-pocket spending declined from $498 to $458 from 2006 to 2007, and then increased to $471 in 2008. For HMOs, the average however continued to decline in 2008 ($422 to $412). These estimates rely on relatively simplified assumptions; Part D cost sharing would be additional.

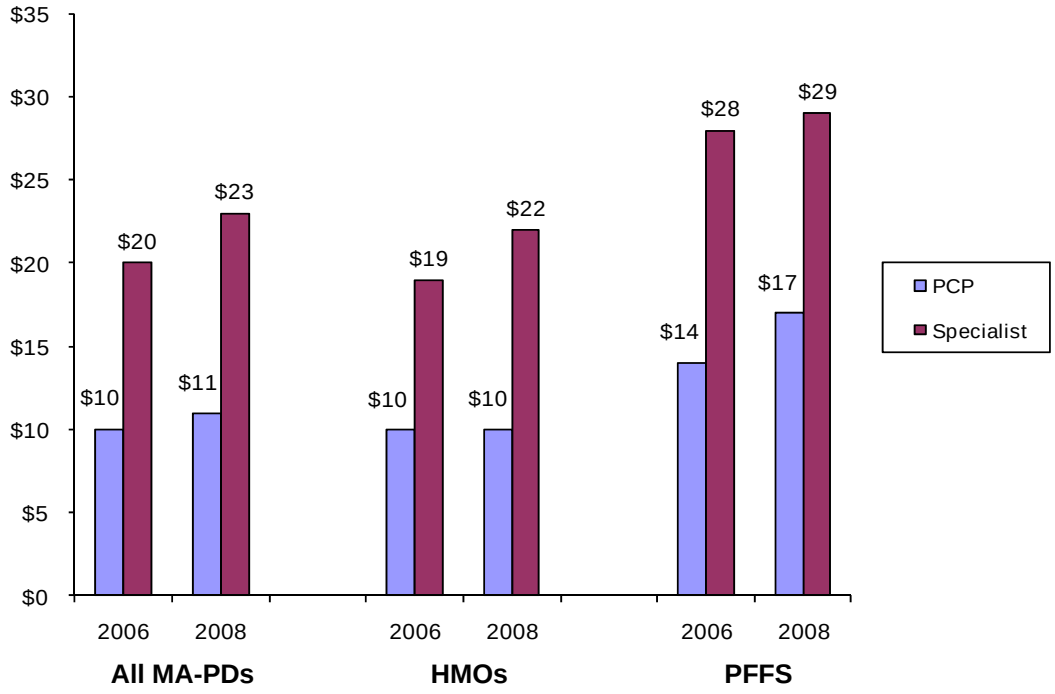
3. Part D Premiums and Benefits

The average Part D premium among lowest premium MA-PDs (weighted by enrollment) decreased from $10 per month in 2006 to $7.46 in 2008. As with total premiums, the weighted figures are lower than the unweighted. Among plan types, the only exceptions were PFFS plans; their average premiums increased from $7.20 in 2006 to $10.68 in 2008.

A larger share of enrollees in 2008 than in 2006 appeared to be in MA-PDs that provide coverage in the "gap"—27 percent in 2006 and 47 percent in 2008 (unweighted).[14] This increase masks the fact that the percentage actually declined to 18 percent in 2007. Such coverage is hard

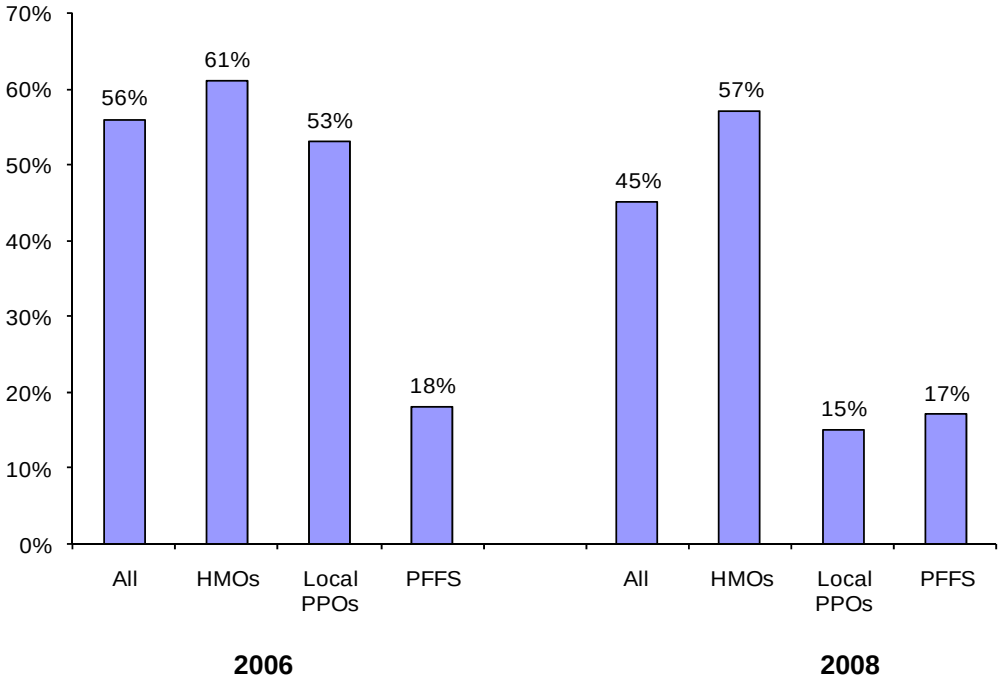
[14] In 2008, Medicare's standard prescription drug benefit had a $275 deductible (up from $250 in 2006) and then paid 25 percent up to an initial coverage limit of $2,510 (up from $2,250 in 2006). Beneficiaries then paid all costs until they reached the true out-of-pocket limit, which was $4,050 in 2008 ($2,510 in 2006). After that, there is nominal cost sharing only. Many PDPs and most MA-PDs modify this cost-sharing structure on an actuarially equivalent basis, or provide enhanced benefits (MedPAC 2008a).

Figure VII.9. Average Copayment Primary Care and Specialist Visit, Lowest Premium in MA-PD, 2006 and 2008 (Weighted by Enrollment)



Source: MPR analysis for ASPE from CMS' public data from Medicare Options Compare using HealthMetrix methods (see Table VII.8). Excludes group plans.

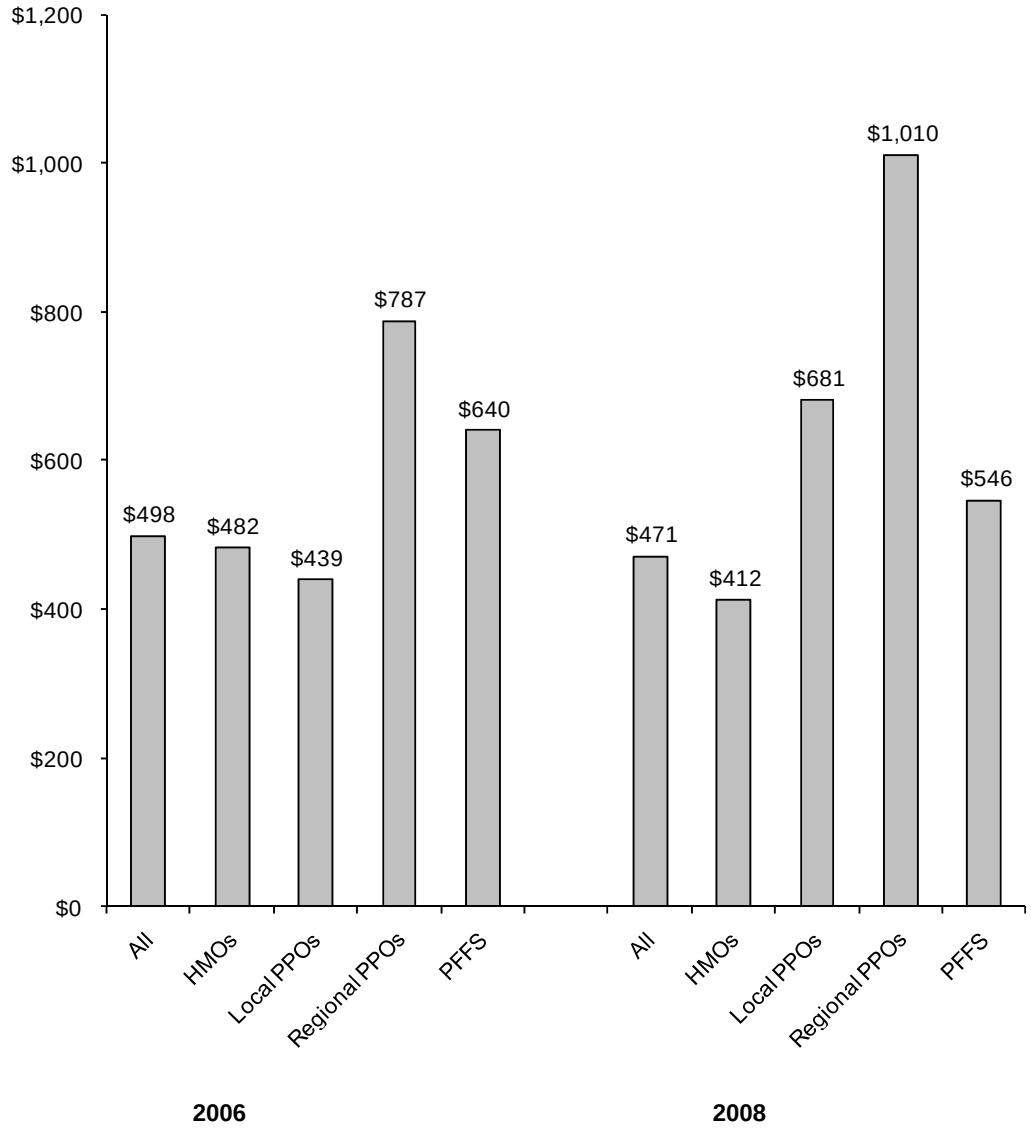
Figure VII.10. Percent Without Limit in Out-of-Pocket Costs, Lowest Premium, Local MA-PDs, by Type, 2006-2008 (Weighted by Enrollment)



Source: MPR analysis for ASPE of publicly available CMS data from Medicare Options Compare (see Table VII.11). Excludes group plans.

Note: Regional PPOs not shown because all are required to have such a limit.

Figure VII.11. Estimated Average Annual Per Capita Out-of-Pocket Costs for Physician and Hospital Cost Stay, Lowest Premium MA-PDs by Type, 2006-2008 (Weighted by Enrollment)



Source: MPR analysis for ASPE of publicly available data from the Plan Finder (see Table VII.11). Excludes group plans. Estimates use HealthMetrix use assumptions by enrollee health status category; the total assumes a standardized distribution by category for each plan type based on community residents in the Medicare Current Beneficiary Survey. Out-of-pocket costs do not include those associated with Part D.

to interpret without detail on inclusions and exclusions. For the most part, gap coverage appears to reflect coverage for generic drugs only. Some plans specify coverage in terms of tiers (e.g., tiers 1 and 2 only).

MedPAC (2008a) provides additional analysis of the way formularies are structured in MA-PDs, and what this means for the coverage of their enrollees.[15] This analysis indicates that 87 percent of MA-PD enrollees were in plans with "three-tiered" formularies in 2007, up from 73 percent in 2006. Such a formulary distinguishes generic drugs and preferred and preferred drug benefits. In 2007, 94 percent of MA-PDs also used a "specialty tier," which CMS defined as drugs exceeding $500 per month ($600 per month in 2008). According to MedPAC's analysis, copays for the median enrollee in an MA-PD with a three-tiered formulary were $5 per 30-day prescription drug for generic, $29 for preferred brand names, and $60 for nonpreferred brands. The median plan applied coinsurance of 25 percent to specialty tiers. As we found, however, benefits vary by plan.

Using the plan bid data, MedPAC estimates that, in 2008, 38 percent of enrollees were in plans that offer no coverage in the gap, 37 percent were in plans that provide coverage for generic only, and 25 percent had coverage for some generic and some brand name drugs. (The equivalent distributions for plans were 49 percent, 34 percent, and 17 percent, indicating that enrollees tend to prefer plans with coverage in the gap.) As does our analysis, MedPAC shows a marked increase from 2007 to 2008 in some form of gap coverage, with 67 percent of beneficiaries having no gap coverage in 2007 and 25 percent covered for generic drugs only. Their estimates for 2008 assume that beneficiaries will stay in the same plan in which they were enrolled in 2007.

4. Relationship Between MA Payment Policy and Trends

Since 2006, MA plan payment has been determined by the relationship between the plan bid for Medicare benefits and the benchmark. For Part A/B services, the benchmark is either what CMS estimates it costs them for a beneficiary within that county in the traditional program, or a higher figure reflecting historical efforts to encourage MA growth in rural areas (rural floor), underserved urban areas (urban floor), and selected other changes.[16] If plan bids are above the benchmark, the beneficiary pays the difference in a higher premium for enrolling in the MA plan. If it is below the benchmark, CMS gets 25 percent of the savings and firms are required to use the remainder to increase benefits, lower cost sharing, or lower premiums.

Using data from the plan bids, MedPAC (2008a) shows that the average MA benchmark was 116 percent (excluding Puerto Rico), relative to spending in the traditional program in 2008. Such benchmarks lead to higher payments relative to the traditional program—112 percent in 2008 (excluding Puerto Rico), up from 111 percent in 2006. Higher payments help MA sponsors enhance the benefits offered in MA plans and/or reduce their premiums.

[15] MedPAC's analysis is based on all plans, not just lowest premium plans. MedPAC has access to bid data that is not publicly available.

[16] Regional benchmarks are for regions, not counties, and take into account the actual plan bids.

Because of their location relative to counties eligible for floor payments, benchmarks were higher in PFFS (120 percent) and local PPOs (122 percent) than in HMOs (117 percent) or regional PPOs (115 percent). This is also true for payments relative to the traditional program (119 percent in local PPOs and 117 percent in PFFS, versus 112 percent in HMOs and regional PPOs). MedPAC's analysis shows that HMO bids show lower costs than other plan types for the core Medicare Part A and B benefit package, with bids of 99 percent of traditional Medicare program costs versus 103 percent for other plan types. (PFFS and local PPO bids are especially high relative to traditional Medicare, at 108 percent.) While these other plans may cost more for Part A and B services than traditional Medicare, they are also paid more, because of MA policy and their locations. This discrepancy may help to explain why there is not more of a difference in plan generosity between HMOs and other plan types.

Table VII.1. Number of Medicare Advantage Plans with Prescription Drug Benefits (MA-PDs) and without (MA-Only), Offered by Segment, by Contract Type, 2006-2008

	All MA			MA-PDs									MA-Only		
				All			Lowest Premium			Other					
	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008
Total Plans, excluding SNPs[a]	1,865	2,813	3,307	1,349	2,086	2,232	981	1,227	1,387	368	859	845	516	727	1,075
Health Maintenance Organization	1,228	1,392	1,517	892	1,064	1,138	650	668	769	242	396	369	336	328	379
Local Preferred Provider Organization[b]	367	377	462	284	298	384	203	189	238	81	109	146	83	79	78
Private Fee-for-Service	201	996	1,271	126	690	676	102	344	354	24	346	322	75	306	595
Regional Preferred Provider Organization	69	42	43	47	34	34	26	26	26	21	8	8	22	8	9
Medical Savings Account	NA	6	14	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	6	14
Total Special Needs Plans	242	438	769	242	438	769	193	337	526	49	101	243	NA	NA	NA

Source: MPR analysis of publicly available data from CMS's 2006-2008 Medicare Options Compare files. Excludes group plans.

[a]Data were segmented separately for SNP and non-SNP plans, with the lowest premium assigned separately for SNP and non-SNP plans.

[b]The Local PPO count includes 23 PSOs in 2006, 30 in 2007, and 34 in 2008.

Table VII.2. Total Premiums for Lowest Premium and Other MA-PDs, Unweighted by Type of Plan, 2008

	All MA-PD Plans						Lowest Premium MA-PD Plans						Other MA-PD Plans					
	All MA-PD Plans	HMO	Local PPO	PFFS	Regional PPO	SNP[a]	All Types[a]	HMO	Local PPO	PFFS	Regional PPO	SNP[a]	All Other MA-PD Plans	HMO	Local PPO	PFFS	Regional PPO	SNP[a]
Mean Total Premium	$45.18	$36.15	$62.57	$49.60	$62.79	$25.85	$23.12	$12.28	$45.56	$29.78	$48.04	$19.23	$81.38	$85.91	$90.31	$71.40	$110.75	$40.18
Mean if Premium More than Zero	$70.37	$74.26	$79.83	$61.08	$73.62	$62.39	$54.55	$51.03	$69.96	$46.44	$59.48	$51.10	$81.38	$85.91	$90.31	$71.40	$110.75	$72.97
Distribution																		
Zero	35.8	51.3	21.6	18.8	14.7	24.2	57.6	75.9	34.9	35.9	19.2	35.4	0.0	0.0	0.0	0.0	0.0	0.0
Includes Reduced Part B Premium	7.5	10.0	4.2	5.5	0.0	5.1	11.3	14.6	6.7	8.2	0.0	6.1	1.2	0.5	0.0	2.5	0.0	2.9
$1 to $19	4.2	2.8	4.4	6.4	2.9	18.7	5.7	2.7	5.9	12.1	3.8	18.6	1.7	3.0	2.1	0.0	0.0	18.9
$20 to $49.99	21.3	16.3	19.3	30.9	20.6	45.9	17.1	11.3	17.6	28.5	26.9	39.5	28.2	26.6	21.9	33.5	0.0	59.7
$50 to $99.99	25.7	19.9	29.9	32.1	44.1	8.2	14.9	8.3	26.5	19.2	42.3	5.1	43.6	44.2	35.6	46.3	50.0	14.8
$100 or more	13.0	9.7	24.7	11.8	17.6	3.0	4.8	1.7	15.1	4.2	7.7	1.3	26.6	26.3	40.4	20.2	50.0	6.6
Number of Contract Segments	2,232	1,138	384	676	34	769	1,387	769	238	354	26	526	845	369	146	322	8	243

Source: MPR analysis of publicly available data from CMS's 2008 Medicare Options Compare file. Premiums are the combined Part C (MA) and Part D (prescription drug) premium after rebates have been applied. Group plans excluded.

[a]Data were segmented separately for SNP and non-SNP plans, with lowest premium assigned separately for SNP and non-SNP plans. The "all types" column excludes SNPs to avoid double-counting plans within the same contract, where both SNP and non-SNP are offered.

Table VII.3a. Prescription Drug Coverage in All MA-PD Plans, Unweighted, by Type of Plan, 2008

		All MA-PD Plans				
	All Types[a]	HMO	Local PPO	PFFS	Regional PPO	SNP
Mean Drug Premium	$17.72	$13.05	$24.95	$21.31	$20.91	$18.80
Distribution						
Zero	38.2	54.0	24.2	20.9	14.7	26.1
Under $20	13.8	12.6	15.6	13.0	52.9	19.9
$20 to $29.99	24.2	15.0	25.3	39.6	14.7	35.8
$30 to $39.99	13.3	9.8	14.3	19.2	0.0	14.3
$40 to $49.99	5.6	5.4	8.6	4.3	2.9	2.1
$50 or more	4.8	3.3	12.0	3.0	14.7	1.8
Initial Deductible						
None	86.7	88.5	84.1	85.2	88.2	52.0
Reduced	2.2	2.2	3.9	1.2	0.0	11.4
Standard Amount ($275)	11.1	9.3	12.0	13.6	11.8	36.5
Tiered Copayments						
Yes	95.5	95.3	96.9	95.0	100.0	73.7
No	4.5	4.7	3.1	5.0	0.0	26.3
Benefits in Coverage Gap						
None	52.8	52.1	47.7	57.5	36.7	70.5
Generic Only	19.3	23.1	26.8	9.0	10.0	14.2
Generic/Brand	28.0	24.8	25.5	33.5	53.3	15.3
Percent with Mail Order	30.6	25.4	31.3	36.7	76.5	32.4
Number of Contract Segments	2,232	1,138	384	676	34	769

Source: MPR analysis of publicly available data from CMS's 2008 Medicare Options Compare file. Group plans excluded.

[a]Data were segmented separately for SNP and non-SNP plans, with lowest premium assigned separately for SNP and non-SNP plans. The "all types" column excludes SNPs to avoid double-counting plans within the same contract, where both SNP and non-SNP are offered.

Table VII.3b. Prescription Drug Coverage in Lowest-Premium MA-PD Plans, Unweighted, by Type of Plan, 2008

		Lowest Premium MA-PD Plans				
	All Types[a]	HMO	Local PPO	PFFS	Regional PPO	SNP
Mean Drug Premium	$9.42	$4.69	$17.56	$13.94	$13.39	$15.25
Distribution						
Zero	59.6	77.3	37.8	38.7	19.2	36.3
Under $20	14.9	10.5	13.9	21.2	65.4	20.2
$20 - $29.99	17.0	8.3	27.7	28.8	15.4	31.2
$30 - $39.99	5.5	3.1	9.2	8.5	0.0	11.4
$40 - $49.99	1.8	0.5	6.7	1.7	0.0	0.4
$50 or more	1.2	0.3	4.6	1.1	0.0	0.6
Initial Deductible						
None	85.4	88.4	76.9	84.5	88.5	44.9
Reduced	2.8	2.5	5.5	2.0	0.0	13.3
Standard Amount ($275)	11.8	9.1	17.6	13.6	11.5	41.8
Tiered Copayments						
Yes	96.0	96.7	96.2	93.8	100.0	70.2
No	4.0	3.3	3.8	6.2	0.0	29.8
Benefits in Coverage Gap						
None	62.4	56.8	60.9	76.9	39.1	67.3
Generic Only	14.9	20.9	15.0	2.8	0.0	17.4
Generic/Brand	22.7	22.3	24.0	20.2	60.9	15.3
Percent with Mail Order	32.3	29.5	37.8	30.8	84.6	27.9
Number of Contract Segments	1,387	769	238	354	26	526

Source: MPR analysis of publicly available data from CMS's 2008 Medicare Options Compare file. Group plans excluded.

[a]Data were segmented separately for SNP and non-SNP plans, with lowest premium assigned separately for each. The "all types" column excludes SNPs to avoid double-counting plans within the same contract, where both SNPs and non-SNPs are offered.

Table VII.3c. Prescription Drug Coverage in "Other" MA-PD Plans, Unweighted, by Type of Plan, 2008

		"Other" MA-PD Plans				
	All Types[a]	HMO	Local PPO	PFFS	Regional PPO	SNP
Mean Drug Premium	$31.33	$30.46	$37.01	$29.41	$45.34	$26.50
Distribution						
Zero	3.2	5.4	2.1	1.2	0.0	4.1
Under $20	12.2	16.8	18.5	4.0	12.5	19.3
$20 to $29.99	36.1	29.0	21.2	51.6	12.5	45.7
$30 to $39.99	26.1	23.8	22.6	31.1	0.0	20.6
$40 to $49.99	11.6	15.4	11.6	7.1	12.5	5.8
$50 or more	10.8	9.5	24.0	5.0	62.5	4.5
Initial Deductible						
None	88.9	88.6	95.9	86.0	87.5	67.5
Reduced	1.1	1.6	1.4	0.3	0.0	7.4
Standard Amount ($275)	10.1	9.8	2.7	13.7	12.5	25.1
Tiered Copayments						
Yes	94.8	92.1	97.9	96.3	100.0	81.5
No	5.2	7.9	2.1	3.7	0.0	18.5
Benefits in Coverage Gap						
None	37.1	42.3	26.4	36.0	28.6	77.4
Generic Only	26.4	27.6	45.8	15.8	42.9	7.4
Generic/Brand	36.6	30.1	27.8	48.3	28.6	15.2
Percent with Mail Order	27.8	16.8	20.5	43.2	50.0	42.0
Number of Contract Segments	845	369	146	322	8	243

Source: MPR analysis of publicly available data from CMS's 2008 Medicare Options Compare file. Group plans excluded.

[a]Data were segmented separately for SNP and non-SNP plans, with lowest premium assigned separately for SNP and non-SNP plans. The "all types" column excludes SNPs to avoid double-counting plans within the same contract, where both SNP and non-SNP are offered.

Table VII.4a. Copayments for Medical and Hospital Services in All MA-PD Plans, Unweighted, by Type of Plan, 2008

		All MA-PD Plans by Type				
	All Types[a]	HMO	Local PPO[b]	PFFS	Regional PPO[b]	SNP[a]
Primary Care Physician						
Mean Copayment	$10.54	$7.90	$10.76	$14.81	$11.03	$0.00
None	19.3%	31.0%	14.6%	3.4%	0.0%	83.7%
Less than $5	10.5	12.8	14.6	4.6	2.9	3.7
$5.01 to $10	29.0	32.5	35.2	16.9	85.3	7.5
$10.01 to $15	25.5	17.1	17.8	45.2	2.9	2.5
$15.01 to $25	14.8	5.7	15.9	29.8	8.8	2.7
$25.01 or more	0.9	1.0	1.8	0.1	0.0	0.0
Varies	30.2	21.4	20.8	48.8	55.9	32.9
Coinsurance	17.0	67.4	67.4	15.7	32.4	20.5
Specialist Visit						
Mean Copayment	$22.96	$20.73	$22.18	$27.04	$25.29	$0.00
None	6.4%	9.5%	4.2%	2.7%	0.0%	61.9%
Less than $5	2.8	3.3	4.4	1.2	0.0	1.3
$5.01 to $10	6.9	9.3	7.0	2.4	14.7	9.1
$10.01 to $15	8.4	8.4	11.5	7.0	0.0	5.1
$15.01 to $25	34.0	39.4	43.9	19.4	32.4	15.0
$25.01 or more	41.6	30.1	29.0	67.4	52.9	7.5
Varies	1.4	0.6	2.3	2.2	0.0	16.1
Coinsurance	12.5	0.4	67.4	0.6	32.4	22.9
Emergency Room (%)						
None	3.4	3.0	5.2	3.2	0.0	39.5
Less than $20	0.0	0.0	0.0	0.0	0.0	0.4
$20.01 to $40	5.4	3.0	1.8	12.9	0.0	5.4
$40.01 to $50	91.2	94.0	93.0	84.0	100.0	54.6
$50.01 to $74.01	0.0	0.0	0.0	0.0	0.0	0.0
$75 or more	0.0	0.0	0.0	0.0	0.0	0.0
Coinsurance	0.0	0.0	0.0	0.0	0.0	0.0
Any Cost Sharing (%)						
Hospital Admission	89.9	85.3	94.8	94.4	100.0	57.6
Hospital Outpatient	87.9	82.9	89.8	95.3	88.2	54.7
X-ray	82.6	75.7	78.6	95.6	100.0	52.3
Lab	52.8	50.4	50.3	56.7	85.3	42.1
Number of Contract Segments	2,232	1,138	384	676	34	769

Source: MPR analysis of publicly available data from CMS's 2008 Medicare Options Compare file. Group plans excluded.

[a]Data were segmented separately for SNP and non-SNP plans, with lowest premium assigned separately for SNP and non-SNP plans. The "all types" column excludes SNPs to avoid double-counting plans within the same contract, where both SNP and non-SNP are offered.

[b]In PPOs, cost sharing is described for in-network benefits, to the extent feasible. The 2008 Plan Finder is not clear as to the circumstances in which copayments vs. coinsurance, or both, apply.

Table VII.4b. Copayments for Medical and Hospital Services in Lowest Premium MA-PD Plans, Unweighted, by Type of Plan, 2008[a]

		Lowest Premium MA-PD Plans, by Plan Type				
	All Types[a]	HMO	Local PPO[b]	PFFS	Regional PPO[b]	SNP[a]
Primary Care Physician						
Mean Copayment	$10.22	$7.44	$11.16	$15.55	$11.35	$0.00
Distribution (%)						
None	21.9	35.0	11.8	2.0	0.0	82.9
Less than $5	12.7	14.5	17.7	6.2	3.8	4.8
$5.01 - $10	24.2	26.8	32.5	8.8	80.8	8.8
$10.01 - $15	25.1	16.7	18.6	49.4	3.8	2.2
$15.01 - $25	15.0	6.1	16.9	33.3	11.5	1.3
$25.01 or more	1.0	0.9	2.5	0.3	0.0	0.0
Varies	28.9	26.7	27.3	31.6	73.1	28.9
Coinsurance	17.8	0.3	66.0	23.4	19.2	19.6
Specialist Visit						
Mean Copayment	$24.10	$21.55	$24.24	$29.22	$28.27	$0.0
Distribution (%)						
None	6.0	9.4	3.4	0.8	0.0	53.7
Less than $5	2.7	3.5	3.4	0.6	0.0	2.0
$5.01 - $10	6.7	10.1	4.2	1.1	3.8	11.3
$10.01 - $15	6.5	6.8	8.9	4.8	0.0	4.0
$15.01 - $25	29.6	33.0	42.6	13.6	26.9	19.5
$25.01 or more	48.6	37.2	37.6	79.1	69.2	9.5
Varies	1.5	0.7	2.1	3.1	0.0	10.6
Coinsurance	12.3	0.7	66.0	0.8	19.2	21.7
Emergency Room (%)						
None	2.3	2.7	2.5	1.1	0.0	39.2
Less than $20	0.0	0.0	0.0	0.0	0.0	0.2
$20.01 - $40	2.9	3.8	2.5	0.7	0.0	3.8
$40.01 - $50	94.8	93.5	94.9	98.1	100.0	56.7
$50.01 - $74.01	0.0	0.0	0.0	0.0	0.0	0.0
$75 or more	0.0	0.0	0.0	0.0	0.0	0.0
Coinsurance	0.0	0.0	0.0	0.0	0.0	0.0
Any Cost Sharing (%)						
Hospital Admission	92.8	88.7	95.8	99.2	100.0	53.8
Hospital Outpatient	88.7	83.7	91.6	97.2	92.3	52.9
X-Ray	84.9	79.5	82.8	97.2	100.0	53.0
Lab	60.6	57.7	57.1	66.9	92.3	43.2
Number of Contract Segments	1,387	769	238	354	26	526

Source: MPR analysis of publicly available data from CMS's 2008 Medicare Options Compare file. Group plans excluded.

[a]Data were segmented separately for SNPs and non-SNPs, with lowest premium assigned separately for each. The "all types" column excludes SNPs to avoid double-counting plans within the same contract, where both SNPs and non-SNPs are offered.

[b]In PPOs, cost sharing is described for in-network benefits, to the extent feasible. The 2008 Plan Finder is not clear as to the circumstances in which copayments vs. coinsurance, or both, apply.

Table VII.4c. Copayments for Medical and Hospital Services in "Other" MA-PD Plans, Unweighted, by Type of Plan, 2008

		"Other" MA-PD Plans by Type				
	All Types[a]	HMO	Local PPO[b]	PFFS	Regional PPO[b]	SNP[a]
Primary Care Physician						
Mean Copayment	$11.05	$8.87	$10.12	$14.00	$10.00	$0.00
None	15.0%	22.5%	19.2%	5.0%	0.0%	85.2%
Less than $5	6.9	9.5	9.6	2.8	0.0	1.3
$5.01 to $10	37.0	44.2	39.7	25.9	100.0	4.9
$10.01 to $15	26.1	17.9	16.4	40.5	0.0	3.1
$15.01 to $25	14.5	4.9	14.4	25.9	0.0	5.4
$25.01 or more	0.6	1.1	0.7	0.0	0.0	0.0
Varies	32.2	10.6	10.3	67.7	0.0	41.6
Coinsurance	15.6	0.3	69.9	7.1	75.0	22.6
Specialist Visit						
Mean Copayment	$21.09	$19.03	$18.84	$24.63	$15.63	$0.00
None	7.0%	9.8%	5.5%	4.7%	0.0%	79.2%
Less than $5	3.1	3.0	6.2	1.9	0.0	0.0
$5.01 to $10	7.2	7.6	11.6	3.7	50.0	4.6
$10.01 to $15	11.4	11.7	15.8	9.3	0.0	7.4
$15.01 to $25	41.2	52.6	45.9	25.9	50.0	5.6
$25.01 or more	30.1	15.4	15.1	54.5	0.0	3.2
Varies	1.2	0.5	2.7	1.2	0.0	28.0
Coinsurance	12.9	0.0	69.9	0.3	75.0	25.5
Emergency Room (%)						
None	5.1	3.5	9.6	5.0	0.0	40.1
Less than $20	0.0	0.0	0.0	0.0	0.0	0.9
$20.01 to $40	9.4	1.4	0.7	23.7	0.0	8.6
$40.01 to $50	85.5	95.1	89.7	71.2	100.0	50.4
$50.01 to $74.01	0.0	0.0	0.0	0.0	0.0	0.0
$75 or more	0.0	0.0	0.0	0.0	0.0	0.0
Coinsurance	0.0	0.0	0.0	0.0	0.0	0.0
Any Cost Sharing (%)						
Hospital Admission	85.2	78.3	93.2	89.1	100.0	65.8
Hospital Outpatient	86.6	81.0	87.0	93.2	75.0	58.8
X-ray	78.7	67.8	71.9	93.8	100.0	50.6
Lab	39.9	35.0	39.0	45.3	62.5	39.9
Number of Contract Segments	845	369	146	322	8	243

Source: MPR analysis of publicly available data from CMS's 2008 Medicare Options Compare file. Group plans excluded.

[a]Data were segmented separately for SNP and non-SNP plans, with lowest premium assigned separately for SNP and non-SNP plans. The "all types" column excludes SNPs to avoid double-counting plans within the same contract, where both SNP and non-SNP are offered.

[b]In PPOs, cost sharing is described for in-network benefits, to the extent feasible. The 2008 Plan Finder is not clear as to the circumstances in which copayments vs. coinsurance, or both, apply.

Table VII.5. Percent of MA-PDs with an Out-of-Pocket Annual Limit on Spending, Unweighted, by Plan Type, 2008

	All MA-PDs		HMO		Local PPOs		PFFS[a]		Regional PPOs	
	Lowest Premium	Other	Lowest Premium	Other	Lowest Premium	Other	Lowest Premium	Other	Lowest Premium	Other
No Limit	36.0%	30.1%	54.9%	54.7%	18.9%	7.5%	9.3%	12.7%	0.0%	0.0%
$1,000 or less	0.6	2.1	0.7	2.4	0.4	2.7	0.6	1.6	0.0	0.0
$1,001-$2,500	7.2	20.7	8.7	21.7	11.3	20.6	1.7	19.9	0.0	12.5
$2,501-$4,000	39.4	39.0	29.9	19.0	38.7	49.3	62.4	57.5	15.4	37.5
$4,001-$5,000	13.8	7.1	4.4	1.1	21.0	19.9	26.0	8.4	61.5	0
Over $5,000	2.9	0.9	1.4	1.1	9.7	0.0	0.0	0.0	23.1	50.0
Number of contract segments	1,387	845	769	369	238	146	354	322	26	8

Source: MPR's analysis of publicly available data from CMS's 2008 Medicare Option Compare file. Group plans excluded.

Note: Limit may apply only to in-Network benefits. (If out-of-network benefits exist, they typically have a higher limit, if there is a limit.)

[a]Among lowest premium MA-only PFFS plans, 2.6% have no limit, 0.0% have a limit of $1,000 or less, 10.3% have a limit between $1,001 and $2,500, and 87.2% have a limit between $2,501 and $5,000.

Table VII.6. Out-of-Network Cost-Sharing Requirements in Local and Regional PPOs, 2008 (Lowest Premium MA-PDs Plans, Unweighted)

	Local PPOs	Regional PPOs
Separate Out-of-Network Deductible for Physician Care		
None	55.5%	26.9%
$150 or less	12.3	0.0
$151 - $250	15.1	5.3
$251 - $999	48.1	89.5
$1,000 or more	24.5	5.3
Primary Care Visits		
Copayment	97.3	100.0
Coinsurance		
20 percent	0.9	0.0
25 percent	0.0	0.0
30 percent	1.3	0.0
Other	0.4	0.0
Specialist Visits		
Copayment	98.7	100.0
Coinsurance		
20 percent	0.9	0.0
25 percent	0.0	0.0
30 percent	0.0	0.0
Other	0.4	0.0
Hospital In-Patient Services		
No cost sharing	61.8	26.9
Deductible	0.8	0.0
Copayment		
Per day	0.0	0.0
Per stay	16.0	57.7
Both	0.0	0.0
Coinsurance only	5.9	3.8
20 percent	27.5	0.0
25 percent	2.0	0.0
30 percent	68.6	50.0
Other	2.0	50.0
Coinsurance and Copay	15.5	11.5
Number of Contract Segments	238	26

Source: MPR analysis of publicly available data from CMS's 2008 Medicare Options Compare file. Group plans excluded.

Table VII.7. Cost Sharing in PFFS Plans, Unweighted, by Type, 2008

		Lowest Premium PFFS Plans	
Cost Sharing	All PFFS Plans	All PFFS Plans	MA-PD Only
Primary Care Physician Visit			
None	5.2%	3.1%	2.0%
Deductible	5.8	0.0	0.0
Coinsurance			
Less than 20%	0.0	0.0	0.0
Exactly 20%	8.3	21.1	23.4
20% or More	0.0	0.0	0.0
Copayment			
$10 or Less	9.8	5.1	4.0
$11 - $15	11.8	21.9	23.2
$16 - $25	16.0	16.3	16.1
More than $25	0.1	0.3	0.3
Varies	43.0	32.3	31.1
Specialist Physician Visit			
None	2.4	0.8	0.8
Deductible	6.1	0.8	0.0
Coinsurance			
Less than 20%	0.0	0.0	0.0
Exactly 20%	0.6	0.8	0.8
20% or More	0.0	0.0	0.0
Copayment			
$10 or Less	7.9	2.0	1.7
$11 - $15	6.4	3.8	3.7
$16 - $25	19.3	13.5	11.9
More than $25	54.8	74.0	78.2
Varies	2.6	4.3	2.8
Hospital Inpatient Stay			
None	7.2	2.0	0.8
Deductible	6.4	0.0	0.0
Coinsurance	0.0	0.0	0.0
Copayment Per Stay			
$1 - $150	1.7	0.3	0.0
$150 or Higher	27.1	29.8	31.1
Copayment Per Day	57.6	67.9	68.1
$100 or less (Day 1)	9.7	1.9	1.2
$101 - $200 (Day 1)	56.3	57.7	55.6
$201 or more (Day 1)	34.0	40.4	43.2
Different Copay Day 2	0.0	0.0	0.0
Different Copay Day 10	87.7	82.0	83.4
Limit on Days	29.3	25.7	28.0
Percentage With an Out-of-Pocket Maximum on Total Out-of-Pocket Spending Per Year			
$1000 or Less	1.6	0.5	0.6
$1001 to $2500	13.2	2.5	1.7
$2501 to $4000	59.3	61.8	62.4
$4001 to $5000	10.9	26.5	26.0
More than $5000	0.0	0.0	0.0
Percentage with No Out-of-Pocket Maximum	15.0	8.7	9.3
Number of Contract Segments	1,271	393	354

Source: MPR analysis of publicly available data from CMS's 2008 Medicare Options Compare file. Excludes group plans.

Table VII.8. Estimated Out-of-Pocket Costs for Hospital and Physician Services in Lowest Premium and Other MA-PD Plans, Unweighted, by Plan Type, 2008

Estimated Out-of-Pocket Costs for Hospital and Physician Services by Health	All (except SNP)	HMO	Local PPO	PFFS	Regional PPO	SNP[a]
l MA-PD						
All	$454	$384	$612	$462	$823	174[b]
Healthy	149	124	332	74	410	39
Episodic Needs	878	734	1,016	1,012	1,447	363
Chronic Needs	2,000.00	1,732	2,000	2,410	2,825	855
Lowest Premium MA-PDs						
All	$504	$419	$682	$536	$945	197[b]
Healthy	157	124	350	78	469	44
Episodic Needs	986	817	1,162	1,186	1,633	411
Chronic Needs	2,268	1,951	2,326	2,842	3,311	966
"Other" MA-PDs						
All	$371	$311	$498	$380	$429	125[b]
Healthy	136	125	304	70	218	28
Episodic Needs	701	562	779	822	841	261
Chronic Needs	1,559	1,274	1,467	1,936	1,245	615
Number of Contract Segments						
All	2,232	1,138	384	676	34	769
Lowest Premium	1,387	769	238	354	26	526
Other	845	369	146	322	8	243

Source: MPR analysis of public data from CMS's 2008 Medicare Options Compare file. Excludes group plans.

Note: This analysis uses methodology from HealthMetrix Inc. to calculate out-of-pocket costs estimates for each of the three categories of enrollees (Part D costs are not included). Estimates involve use assumptions for physician services and hospitalizations within each health need category that are applied to the structure of the plan's benefits and cost sharing. Previous to 2005, HealthMetrix called the three categories "good," "fair," and "poor" health. The "all" estimate is a standardized weighted composite of the three categories of beneficiaries, with weights drawn from the Medicare Current Beneficiary Survey (community residing beneficiaries). The "all" figure assumes 71.51 percent are "healthy," 19.04 percent have "episodic needs," and 8.90 percent have "chronic needs." (CMS 2003, Table II.7). Using weights that are beneficiary rather than enrollee based is a change to reflect the extensive growth in MA that is not reflected yet in MCBS data. The change affects only the "All" row.

[a]Data were segmented separately for SNP and non-SNP plans, with lowest premium assigned separately for SNP and non-SNP plans. The "all types" column excludes SNPs to avoid double-counting plans within the same contract, where both SNP and non-SNP are offered. Most SNP enrollees are dually eligible, something that is not factored into the out-of-pocket estimates.

[b]No data are available on the distribution of such enrollees by type.

Table V11.9. Supplemental Benefits in Lowest Premium and "Other" MA-PD Plans, Unweighted, by Type of Plan, 2008

	All MA-PD Plans						Lowest Premium MA-PD Plans						Other MA-PD Plans					
			Local		Regional				Local		Regional				Local		Regional	
	All[a]	HMO	PPO	PFFS	PPO	SNP[a]	All[a]	HMO	PPO	PFFS	PPO	SNP[a]	All Other	HMO	PPO	PFFS	PPO	SNP[a]
Percent With																		
Preventive dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0 %	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Vision benefits	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hearing benefits	98.6	98.6	97.4	99.4	100.0	83.9	97.9	97.9	95.8	99.2	100.0	89.4	99.6	99.5	100.0	99.7	100.0	72.0
Physical exam	99.4	99.2	99.3	99.7	100.0	88.9	99.1	99.0	98.7	99.7	100.0	84.7	99.8	99.7	100.0	99.7	100.0	97.9
Podiatry benefits	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Chiropractic benefits	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of Contract Segments	2,232	1,138	384	676	34	769	1,387	769	238	354	26	526	845	369	146	322	8	243

Source: MPR analysis of public data from CMS 2008 Medicare Options Compare file. Group plans excluded.

[a]Data were segmented separately for SNP and non-SNP plans. Basic flags were assigned separately for SNP and non-SNP plans. SNPs are not included in the "All" column.

Table VII.10. Overview of Premiums and Benefits, All MA-Only Plans, Unweighted, by Plan Type, 2008 (SNP Plans Excluded)

	All MA-Only	HMO	Local PPO	PFFS	Regional PPO	MSA
Average Monthly Premium	$21.78	$18.30	$44.63	$21.70	$9.11	$0.0
Distribution						
Zero	58.9%	64.1%	29.5%	58.0%	88.9%	100.0
$1 - $49	21.8	19.3	28.2	23.4	0.0	0.0
$50 or more	19.3	16.6	42.3	18.7	11.1	0.0
Percent with Cost Sharing for Hospital Admissions[a]						
None	11.2	16.1	5.1	9.1	0.0	0.0
Deductible	7.5	0.8	1.3	12.8	0.0	100.0
Coinsurance	4.2	3.4	39.7	0.0	11.1	0.0
Deductible and coinsurance	0.1	0.3	0.3	0.0	0.0	0.0
Copayment	76.9	79.4	53.8	78.2	88.9	0.0
Cost Sharing for Primary Care Visits[a]						
None	14.0	24.8	16.7	7.2	0.0	0.0
Deductible	14.0	4.5	46.2	12.9	66.7	100.0
Coinsurance	10.4	0.3	46.2	12.4	11.1	0.0
Copayment	77.3	74.9	76.9	80.3	100.0	0.0
Cost Sharing for Specialist Visits[a]						
Requires Referral	100%	100%	100%	0%	110.0	0.0
Deductible	14.0	4.5	46.2	12.9	66.7	100.0
Coinsurance	10.7	0.3	46.2	12.9	11.1	0.0
Copayment	86.3	89.4	92.3	85.4	100.0	0.0
Percent that Cover						
Preventive dental	100.0	100.0	100.0	100.0	100.0	NA
Vision benefits	100.0	100.0	100.0	100.0	100.0	NA
Hearing benefits	98.0	99.2	97.4	99.5	100.0	NA
Physical exam	99.7	99.5	100.0	99.8	100.0	NA
Podiatry benefits	100.0	100.0	100.0	100.0	100.0	NA
Chiropractic benefits	100.0	100.0	100.0	100.0	100.0	NA
Percent with Any Out-of-pocket Limit	64.6	36.9	84.6	80.3	100.0	100.0
Number of Contract Segments	1,075	379	78	595	9	14

Source: MPR analysis of publicly available data from CMS's 2008 Medicare Options Compare file. Group plans excluded. Premiums are after rebates have been applied. Group plans excluded.

[a]In-network benefits are described in instances where out-of-network benefits are offered.

Table VII.11. Selected MA Premium and Benefit Trends, Enrollment Weighted and Unweighted, Lowest Premium MA-PDs, 2006-2008

	Weighted[a]			Unweighted		
	2006	2007	2008	2006	2007	2008
All Contract Types						
Mean Combined Premium (C and D)	$15.94	$25.21	$21.16	$19.89	$29.79	$23.12
Mean Part D Premium	$10.09	$8.46	$7.46	$13.67	$10.44	$9.42
Percent Zero Premium	61.8%	59.9%	58.60%	49.6%	53.5%	57.6%
with Reduced Part B	3.3	4.1	5.7	6.4	8.6	11.3
without Reduced Part B	58.5	55.8	52.9	43.2	44.9	46.3
Mean PCP Copay	$10.38	$11.67	$11.40	$9.52	$10.11	$10.22
Mean Specialist Copay	$20.21	$22.88	$23.34	$21.45	$24.82	$24.24
Any Hospital Cost Sharing	89.1%	92.3%	94.8%	89.8%	95.0%	92.8%
Limit on Out-of-Pocket						
None	55.8%	51.7%	44.5%	56.4%	45.6%	36.0%
$2,500 or less	10.2	4.9	7.9	15.3	6.0	7.8
$2,501-$3,999	24.3	30.1	33.4	17.2	35.0	39.4
$4,000-$4,999	9.7	12.4	12.4	10.7	11.0	13.9
$5,000 or more	0.1	0.9	1.9	0.4	2.4	2.9
Mean	$3,187.91	$3,756.11	$3,752.11	$3,200.98	$8,254.23[d]	$3,717.58
Average Per Capita Out-of-Pocket Costs for Hospital and Physician Services[b]						
All	$498.03	$457.88	$471.01	$532.93	$508.51	$504.04
Healthy	$104.70	$119.18	$110.32	$129.17	$150.71	$157.28
Episodic Needs	$1,122.58	$926.18	$969.40	$1,150.05	$1,001.39	$985.65
Chronic Needs	$2,332.46	$2,184.90	$2,310.59	$2,466.81	$2336.69	$2,268.39
Any Coverage in Part D Gap[c]	26.8%	18.4%	46.5%	26.7%	20.9%	38.6%
HMOs						
Mean Combined Premium (C and D)	$15.89	$24.67	$18.02	$13.05	$16.46	$12.28
Mean Part D Premium	$9.88	$7.91	$5.65	$10.36	$5.81	$4.69
Percent Zero Premium	63.4%	61.8%	63.6%	62.2%	71.9%	75.9%
with Reduced Part B	3.2	3.0	4.9	8.5	14.7	14.6
without Reduced Part B	60.2	58.8	58.7	53.7	57.2	61.3
Mean PCP Copay	$10.05	$11.26	$10.01	$8.28	$7.91	$7.44
Mean Specialist Copay	$19.46	$22.01	$22.18	$20.00	$21.49	$21.55
Any Hospital Cost Sharing	88.5%	90.9%	93.1%	88.0%	92.5%	88.7%`

Table VII.II *(continued)*

	Weighted[a]			Unweighted		
	2006	2007	2008	2006	2007	2008
Limit on Out-of-Pocket						
None	61.0%	60.5%	56.5%	64.2%	63.6%	54.9%
$2,500 or less	10.6	4.9	6.2	16.8	7.6	9.4
$2,501-$3,999	26.3	31.7	32.8	16.9	25.6	29.9
$4,000-$4,999	2.1	2.9	3.9	2.2	3.1	4.4
$5,000 or more	0.0	0.0	0.6	0.0	0.0	1.4
Mean	$2,814.04	$3,370.78	$3,440.24	$2,646.78	$3,095.37	$3,244.38
Average Per Capita Out-of-Pocket Costs for Hospital and Physician Cost Sharing[b]						
All	$481.75	$422.81	$411.77	$515.63	$414.11	$419.37
Healthy	$105.79	$106.54	$83.60	$141.26	$114.70	$123.62
Episodic Needs	$1,086.14	$846.37	$849.93	$1,088.70	$822.10	$816.97
Chronic Needs	$2,219.47	$2,064.45	$2,117.97	$2,306.94	$1,953.47	$1,951.37
Any Coverage in Part D Gap[c]	29.6%	21.2%	46.7%	31.2%	29.8%	44.0%
Local PPOs						
Mean Combined Premium (C and D)	$32.42	$45.67	$45.65	$36.00	$54.17	$45.56
Mean Part D Premium	$18.69	$15.19	$16.69	$22.22	$18.00	$17.56
Percent Zero Premium	36.9%	41.9%	47.5%	24.6%	25.9%	34.9%
with Reduced Part B	10.6	17.8	17.1	3.9	3.7	6.7
without Reduced Part B	26.3	24.1	30.4	20.7	22.2	28.2
Mean PCP Copay	$8.58	$10.70	$10.44	$10.68	$12.30	$11.16
Mean Specialist Copay	$17.67	$19.84	$19.80	$22.14	$23.57	$24.24
Any Hospital Cost Sharing	79.1%	88.4%	95.9%	89.7%	94.7%	95.8%
Limit on Out-of-Pocket						
None	52.9%	47.7%	14.7%	54.7%	50.8%	18.9%
$2,500 or less	23.5	19.4	32.4	19.7	11.6	11.8
$2,501-$3,999	19.8	29.8	31.0	18.7	25.9	38.7
$4,000-$4,999	2.4	2.0	13.8	4.9	6.9	21.0
$5,000 or more	1.3	1.0	8.1	2.0	4.8	9.7
Mean	$2,516.56	$2,682.75	$3,496.08	$3,032.83	$35,591.94[e]	$4,096.63

Table VII.II *(continued)*

	Weighted[a]			Unweighted		
	2006	2007	2008	2006	2007	2008
Average Per Capita Out-of-Pocket Costs Hospital and Physician Services[b]						
All	$439.42	$592.99	$680.87	$526.48	$679.60	$681.71
Healthy	$84.01	$319.91	$348.57	$104.34	$369.72	$350.11
Episodic Needs	$1,006.77	$1,051.66	$1,206.81	$1,186.06	$1,144.23	$1,161.99
Chronic Needs	$2,090.64	$1,813.52	$2,234.36	$2,517.96	$2,182.90	$2,326.28
Any Coverage in Part D Gap[c]	33.8%	30.3%	33.6%	27.6%	27.5%	40.3%
Regional PPO						
Mean Combined Premium (C and D)	$10.41	$26.70	$25.32	$38.13	$60.05	$48.04
Mean Part D Premium	$8.23	$9.96	$7.60	$17.44	$18.95	$13.39
Percent Zero Premium	42.2%	54.3%	46.6%	23.1%	19.2%	19.2%
with Reduced Part B	0.0	0.0	0.0	0.0	0.0	0.0
without Reduced Part B	42.2	54.3	46.6	23.0	19.2	19.2
Mean PCP Copay	$10.25	$10.24	$11.85	$11.12	$10.96	$11.35
Mean Specialist Copay	$24.29	$23.66	$24.33	$30.77	$28.27	$28.27
Any Hospital Cost Sharing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Limit on Out-of-Pocket						
None	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$2,500 or less	0.1	0.0	0.0	3.8	0.0	0.0
$2,501-$3,999	62.7	54.2	27.8	30.8	19.2	15.4
$4,000-$4,999	37.1	3.2	33.4	65.4	7.7	61.5
$5,000 or more	0.0	42.6	38.8	0.0	73.1	23.1
Mean	$3,779.09	$5,744.11	$5,579.04	$4,396.15	$8,115.38	$5,513.46
Average Per Capita Out-of-Pocket Costs for Hospital and Physician Services[b]						
All	$786.95	$845.20	$1,010.16	$680.83	$884.44	$944.93
Healthy	$305.59	$425.00	$443.77	$167.35	$462.04	$468.65
Episodic Needs	$1,560.89	$1,649.34	$1,822.41	$1,441.69	$1,495.00	$1,632.88
Chronic Needs	$3,011.65	$2,514.78	$3,836.27	$3,836.27	$2,981.92	$3,310.96
Any Coverage in Part D Gap[c]	4.2%	19.8%	54.9%	11.5%	3.9%	65.4%
PFFS						
Mean Combined Premium (C and D)	$7.50	$20.29	$23.36	$26.83	$40.01	$29.78
Mean Part D Premium	$7.20	$8.56	$10.68	$16.82	$14.62	$13.94

Table VII.II *(continued)*

	Weighted[a]			Unweighted		
	2006	2007	2008	2006	2007	2008
Percent Zero Premium	64.0%	57.7%	46.1%	26.5%	35.8%	35.9%
with Reduced Part B	0.0	5.1	5.2	0.0	0.3	8.2
without Reduced Part B	64.0	52.6	40.9	26.5	35.5	27.7
Mean PCP Copay	$14.41	$14.17	$16.67	$14.61	$13.11	$15.55
Mean Specialist Copay	$27.98	$28.09	$28.58	$26.86	$31.69	$29.22
Any Hospital Cost Sharing	99.1%	100.0%	100.0%	99.0%	99.4%	99.2%
Limit on Out-of-Pocket						
None	17.6%	15.5%	16.9%	24.5%	11.0%	9.3%
$2,500 or less	0.0	0.0	6.4	0.0	0.3	2.3
$2,501-$3,999	2.7	19.9	36.8	12.7	59.3	62.4
$4,000-$4,999	79.7	63.2	40.0	62.7	28.8	26.0
$5,000 or more	0.0	1.3	0.0	0.0	0.6	0.0
Mean	$4,940.32	$4,636.79	$4,168.85	$4,675.32	$4,054.25	$3,855.73
Average Per Capita Out-of-Pocket Costs for Hospital and Physician Services[c]						
All	$639.60	$540.97	$546.12	$618.28	$569.40	$536.43
Healthy	$76.75	$77.47	$83.35	$91.81	$76.80	$77.88
Episodic Needs	$1,461.62	$1,196.85	$1,213.66	$1,395.00	$1,233.74	$1,185.97
Chronic Needs	$3,416.56	$2,872.46	$2,847.00	$3,199.22	$3,116.56	$2,841.57
Any Coverage in Part D Gap[c]	0.0%	0.0%	49.1%	0.0%	1.2%	23.7%

Source: MPR Analysis of publicly available data from CMS's Medicare Options Compare file. Group plans excluded.

[a]Assumes that all enrollment in that contract in a given county is in the lowest premium MA-PD plan.

[b]This analysis uses methodology from HealthMetrix Inc. to calculate out-of-pocket costs estimates for each of the three categories of enrollees (Part D costs are not included). Estimates involve use assumptions for physician services and hospitalizations within each health need category that are applied to the structure of the plan's benefits and cost sharing. Previous to 2005, HealthMetrix called the three categories "good," "fair," and "poor" health. The "all" estimate is a standardized weighted composite of the three categories of beneficiaries, with weights drawn from the Medicare Current Beneficiary Survey (community residing beneficiaries). The "all" figure assumes 71.51 percent are "healthy," 19.04 percent have "episodic needs," and 8.90 percent have "chronic needs." (CMS 2003, Table II.7). Using weights that are beneficiary rather than enrollee based is a change to reflect the extensive growth in MA that is not reflected yet in MCBS data. The change affects only the "All" row.

[c] Coverage typically is limited to generic only or certain classes or tiers of drugs.

[d]Skewing this mean are three local PPOs with out-of-pocket maximums of $100,000. Excluding these plans results in an unweighted average of $3,780.19.

[e]Skewing this mean are three local PPOs with out-of-pocket maximums of $100,000. Excluding these plans results in an unweighted average of $3,445.00.

VIII. MA QUALITY AND BENEFICIARY EXPERIENCE

CMS publicly reports a number of quality measures for selected MA products, including performance measures from the Healthcare Effectiveness Data and Information Set (HEDIS) and measures of patient experience from Medicare's Consumer Assessment of Healthcare Providers and Systems (CAHPS) data. These performance measures are available from two main sources, respectively: the HEDIS public use files and the Plan Finder downloadable files.[1,2] To understand MA contracts' performance and quality, we analyzed recent data from these two sources, both overall and by contract type. We also examined performance of selected large firms and, for the HEDIS data, we compared the two most recent years as a means of beginning to understand possible trends in quality and performance.[3]

In this chapter, we first discuss findings from our analysis of HEDIS data, followed by a similar analysis of the CAHPS data. For each, we first describe the completeness of data, to provide a sense of the number of MA contracts for which data are available, and how reflective the results may be for MA quality overall. We then summarize the descriptive statistics, highlighting the most interesting and salient findings. We next briefly discuss how these analyses compare to a recent MedPAC report that included an analysis of MA quality. (In broad terms, our analysis is less focused on trends over time than MedPAC's, and more detailed in its examination of specific measures, analyses by contract type, and the performance of specific large firms/affiliations.) We also briefly describe the five-star rating system now available on the Medicare Options Compare website and suggest how we believe our analysis aligns with that system. Finally, we present our conclusions from these analyses of quality and beneficiary experience data.

A. ANALYSIS OF HEDIS DATA

The HEDIS public use files include a large number of measures. For the purpose of this analysis, we narrowed our focus to a subset of measures commonly reported and widely regarded as appropriate measures of quality.[4] (See the methods section on quality data in Appendix A, Section C for more information.) Specifically, our analysis targets 32 selected HEDIS measures

[1] While the Plan Finder files include both HEDIS and CAHPS measures, the HEDIS data from these files are largely incomplete, with a large number of missing values. For this reason, we use the HEDIS public use files for our analysis of these data.

[2] In addition to these data sources, the Medicare Health Outcomes Survey (HOS) and the CAHPS research files also provide information on MA quality. Public use files from the Medicare HOS are available at www.hosonline.org, and the CAHPS research files are available from AHRQ upon special request.

[3] We do not compare CAHPS measures over time, but instead focus only on the most recent year of available data (2007), given that, between the 2006 and 2007 reporting years, the CAHPS unit of analysis changed from contract-market combinations to contracts.

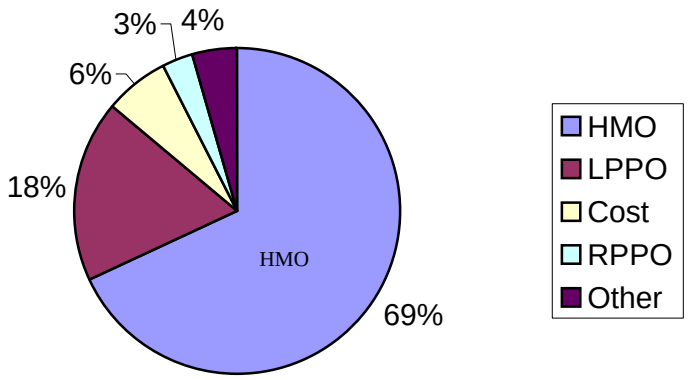
[4] The general categories of measures excluded here involve member services, provider credentials, business characteristics of the contract (e.g., years in business), utilization measures, and resource use.

related to access and preventive care; management of existing and/or chronic conditions; and medication use and management (Table VIII.1). While some of these measures apply to all Medicare members—such as colorectal cancer screening, or breast cancer screening for women—others apply only to patients with specific chronic conditions, such as diabetes and cardiovascular disease.

1. Data Completeness

A total of 275 contracts report at least some of the 32 selected measures in the 2007 HEDIS public use file (reflecting 2006 data).[5] These represent just over half of all contracts with any MA enrollment in 2006, and 90 percent of total enrollment in MA. As shown in Figure VIII.1, more than two-thirds of the 275 contracts reporting HEDIS data are HMOs,[6] although a considerable number are local PPOs (despite not being required to report these data).[7] The HMO contracts that report data represent more than 75 percent of all HMO contracts with enrollment in late 2006, and about 78 percent of all MA enrollees. In contrast, PPOs that report HEDIS data represent only about 40 percent of all PPOs with enrollment in MA in 2006; for this reason, PPOs that report HEDIS data may not be representative of this contract type overall.

Figure VIII.1 Contracts Reporting Selected HEDIS Data, by Contract Type (2006)



Source: MPR analysis of 2007 HEDIS public use file (2006 reporting year).

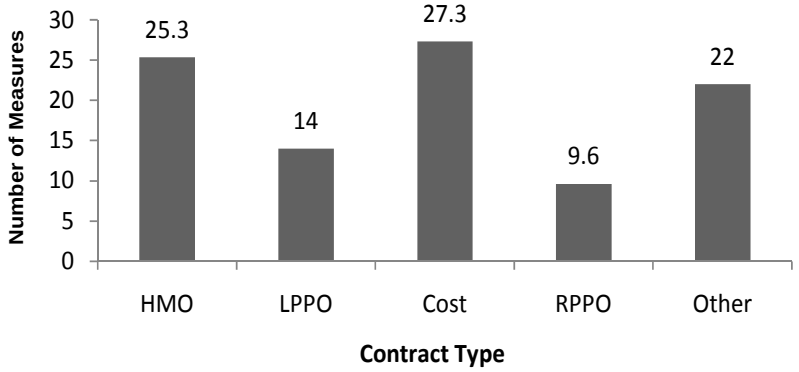
[5] The reporting of HEDIS data by 275 contracts in 2006 represents a considerable increase over the number reporting in 2005 (187 contracts). According to MedPAC (2008a), the 275 contracts reporting in 2006 represent more than 90 percent of contracts *that were eligible* for HEDIS reporting in that year.

[6] This includes HMOs that offer point-of-service (POS) plans.

[7] While HMOs with 1,000 or more members are required to report HEDIS data, PPOs need report only on the services of network providers (although some report more measures). PFFS and MSA contracts are not required to report HEDIS data.

Data Completeness in the Aggregate. Contracts reporting HEDIS data may not report specific measures for various reasons, as discussed below. Among those contracts reporting any HEDIS data, of the 32 selected HEDIS measures, the average number of measures reported was 23 (see Table VIII.2). HMOs and 1876 cost contracts (HMO-like organizations that are reimbursed on a cost basis) reported the largest number of measures on average, whereas local and regional PPOs reported substantially fewer (see Figure VIII.2). The variation in the average number of measures reported by contract type is likely related to date of program entry. HMOs and cost plans have existed as Medicare managed care products for some time, whereas local PPOs are a more recent addition to MA, and MA's regional PPOs came into existence only in 2006. Those contracts with earlier program entry reported more measures on average in 2006 (24 to 30, depending on program entry date), and relatively newer contracts—such as those that began in 2004 or later—reported substantially fewer measures (14). This is not surprising, given that more recent contracts may not have adequate time or large enough patient samples to report at least some of the selected measures.[8]

Figure VIII.2. Average Number of HEDIS Measures Reported, by Contract Type (2006)



Source: MPR analysis of 2007 HEDIS public use file (2006 reporting year).

Data Completeness of Specific Measures. There is wide variability in data completeness for specific measures (Table VIII.3). While most of the commonly reported HEDIS measures—such as those related to access and preventive care measures—have relatively complete reporting, other measures have missing data for more than half of all reporting contracts (e.g., antidepressant management).

There appear to be several reasons for missing values on specific HEDIS measures. As shown in the final two columns of Table VIII.3, data may be missing if the contract covers too small a population to calculate a representative rate (particularly on measures related to chronic conditions that affect a relatively small proportion of membership), if its members are not eligible for a particular measure, or if the contract did not offer the benefit required by the

[8] Moreover, outside of the MA program, PPOs historically have faced more issues with data capture and collection than HMOs, given their administrative systems and organizational structures. (See for example, American Accreditation HealthCare Commission, 1999.)

measure.[9] Data also are missing if a contract chooses not to calculate and report a rate, or if the contract's HEDIS compliance auditor determines that a rate is materially biased.[10] Nonetheless, the number of contracts that do not report on some measures—such as ambulatory beta blocker treatment after a heart attack—is surprising. The beta-blocker measure is a highly visible measure and has been emphasized in quality reporting. It involves a fairly common condition that likely affects a relatively large number of MA patients. It is not clear why so many contracts fail to report this measure. (While the beta-blocker measure on treatment after a heart attack was retired by NCQA in 2008—which *might* help account for low reporting in 2006—reporting was also low on persistence of beta-blocker treatment, which remains a required measure.)

2. Descriptive Results

Overall Quality Performance. MA contract performance on selected HEDIS measures varies widely, depending on the measure (see Tables VIII.4 and VIII.5, first column). While average performance was high on measures such as access to ambulatory/preventive services (92 percent in the unweighted statistics) and hemoglobin A1c testing among diabetic patients (86 percent), performance was relatively lower on other measures, such as fall risk management among patients age 75 and older (28 percent) and osteoporosis management in women who had a fracture (22 percent). Also, average performance was not consistent within categories of measures. For example, while average performance on access to ambulatory and preventive services generally was good, it was low for fall risk management, although both come under the general category of access and preventive care. Similarly, average performance related to medication use and management varied considerably by specific measure, with MA contracts providing annual monitoring for 83 percent of patients on persistent medications, on average, but only 11 percent of patients on average receiving optimal practitioner contacts for antidepressant medication management.

Consistent with the existing literature on health care quality (National Committee for Quality Assurance [NCQA] 2006), MA contracts' performance on intermediate outcome measures was lower than related process measures. For example, whereas MA contracts reported that 86 percent of their diabetic members received hemoglobin A1c testing, only 44 percent of these members on average had good control of hemoglobin A1c (unweighted analysis).[11]

Quality Performance by Contract Type. To understand whether any patterns exist in quality performance across types of contracts, we examined average performance on selected

[9] These reasons are classified in the HEDIS Public Use File as not applicable ("NA") or no benefit ("NB").

[10] MedPAC's March 2008 Report to Congress expresses concern over the number of contracts that do not report performance on certain measures. In particular, MedPAC cites the fact that contracts may choose not to report a measure even though the report may be valid. In such cases, "NR" is shown in the HEDIS public use file. NR also is shown if CMS, NCQA, or the plan determine that a reported measure is materially biased. According to MedPAC, CMS is working with NCQA to have plans specify the nature of nonreporting.

[11] Note that our results differ slightly from those of NCQA (2006). This is likely the result of our analysis including all contracts that report data in the Public Use File, whereas NCQA's analysis focuses on 211 MA contracts (MedPAC, 2008a).

HEDIS measures by contract type (see Tables VII.4 and VIII.5). For this purpose, we examined performance for HMOs, local PPOs, regional PPOs, 1876 cost contracts, and all other contracts (which include PFFS, SHMO, demonstration, and PSO contracts, for a total of 12 contracts).[12]

While these results must be interpreted with caution (as described further below), this analysis revealed some interesting differences. In particular, 1876 cost contracts appear to perform better than the overall average on most measures, which may be related to the fact that most of these contracts are group or staff model HMOs and have the infrastructure to achieve high quality. Conversely, while regional and local PPOs tend to perform the same as or better than the average contract on several access and preventive screening measures, they appear to perform worse than average on measures related to chronic conditions, such as diabetes. This finding should be interpreted cautiously for several reasons. First, and most notably, the measures on which PPOs perform worse than average tend to be "hybrid" HEDIS measures, which may draw on both administrative claims data and medical chart review. While HMOs rely on both sources of data for those measures, PPOs generally have only used claims data. Existing literature (e.g., Pawlson, Scholle, and Powers, 2007) has shown that hybrid measures that rely only on administrative claims result in lower performance than those that employ both claims and chart review. Second, it is also the case that regional PPOs entered the market in 2006, and local PPOs are relatively new entrants to the Medicare market as well; these results thus reflect the quality of care provided to a relatively new membership. As PPOs have more opportunity for interaction with their MA patient populations over time, it is possible that quality will improve. Finally, the small proportion of PPOs reporting HEDIS data may or may not be representative of all PPOs offering MA plans.

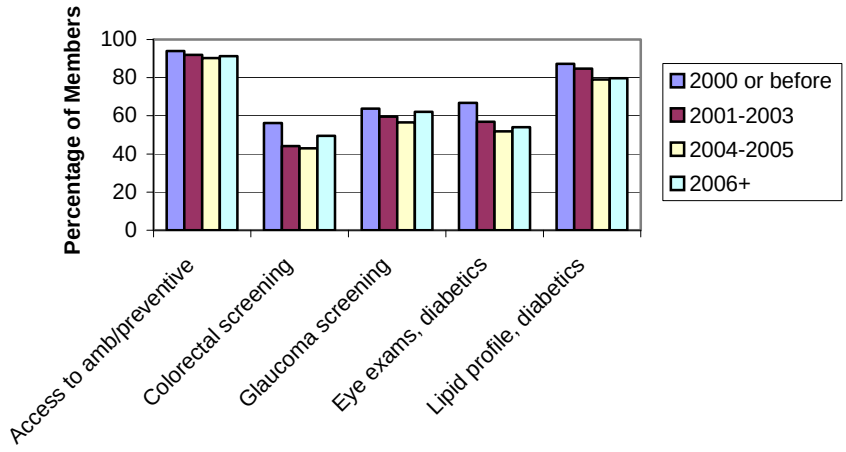
While the unweighted analysis provides a sense of the performance of the average MA contract (Table VIII.4), the weighted analysis (Table VIII.5) provides information on the quality received by the average MA enrollee by weighting each contract's measures by its enrollment. The weighted analysis results in higher scores on most quality measures, indicating that higher performance is likely in contracts with larger enrollments; this means that the average MA enrollee is receiving higher quality care than suggested by the unweighted analysis.

Quality Performance by Date of Program Entry. We also investigated performance by date of entry into the MA program. (As discussed above, date of program entry is related to contract type. PPOs in general, and regional PPOs in particular, are newer entrants to MA, whereas the large majority of HMOs and 1876 cost contracts originated in 2000 or earlier.) Figure VIII.3 presents MA contracts' performance on five different HEDIS measures by their date of program entry. As the figure shows, performance tends to be higher for older contracts than newer ones. Note, however, contracts originating in 2006 appear to be performing slightly better on several measures than their counterparts from 2004-2005.[13]

[12] Among the 275 contracts that report any HEDIS data, 21 are SNP-only contracts. Of these, 15 are HMOs, 4 are demos, and 2 are PPOs.

[13] One suggestion for further analysis is to examine performance of newer contracts (originating in 2004 or later) by those that are completely new to MA versus those that were demonstrations first.

Figure VIII.3. HEDIS Performance, by Date of Program Entry (2006)



Source: MPR analysis of 2007 HEDIS public use file (2006 reporting year).

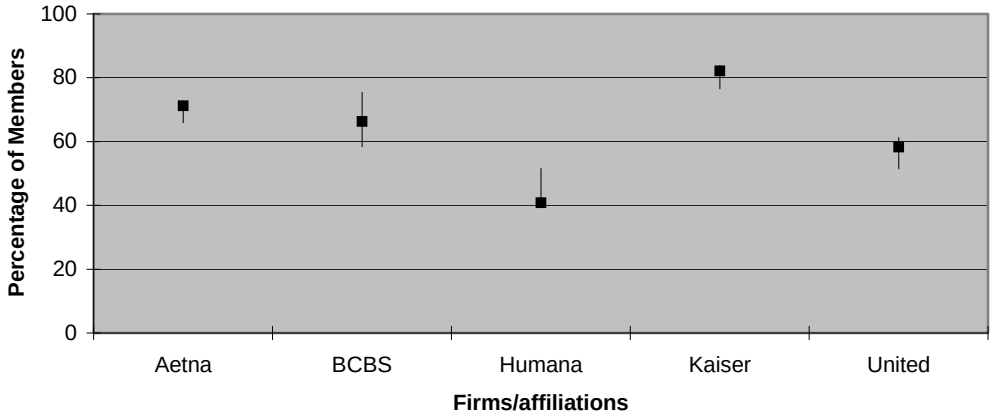
Quality Performance of Large Firms in the MA Market. We examined average contract performance for the largest firms and affiliations in the MA market. Specifically, we looked at the performance of United Healthcare, Blue Cross Blue Shield affiliates, Humana, and Kaiser Permanente, which represent the top four firms/affiliations in terms of 2007 MA enrollment.[14] We also examined the performance of Aetna, which historically has been a dominant firm. Table VIII.6a presents the simple (unweighted) average score for each firm across all of its contracts, as well as the average weighted score (weighted by enrollment in each contract). The table also presents the raw highest and lowest scores reported by any of the contracts within a firm or affiliation, to provide a sense of the range of performance. While we included all contract types when calculating a firm's performance, most contracts are HMOs or local PPOs.

The average performance scores by firm or affiliation often were within 5 to 10 percentage points of one another, depending on the measure. However, one firm (Kaiser Permanente) had substantially higher average scores than others on some measures, such as breast cancer screening, eye exams for diabetic patients, and persistent beta blocker treatment after heart attack.

Firms' highest and lowest performance scores generally showed substantially more variability than average performance. This variability highlights the fact that quality is still mixed among MA contracts offered by a given firm, and perhaps suggests that firms can continue to work on improving the uniformity of performance across the products they offer. For example, Figure VIII.4 shows the (unweighted) median score and the 25th and 75th percentiles of scores for eye exams for diabetics by firm/affiliation. The low and high scores for eye exams for diabetics were 15 and 89 percent for BCBS affiliates (Table VIII.6a), suggesting that targeting quality improvement efforts to low-performing BCBS contracts have the potential to raise the overall quality of BCBS affiliates as a group.

[14] While Blue Cross Blue Shield represents a loosely affiliated set of contracts (relative to the other firms we report on), we include it here given its substantial presence in the MA market and policy makers' and others' long-held interest in Blues plans.

Figure VIII.4. Eye Exams for Members with Diabetes, by Firm/Affiliation (2006)

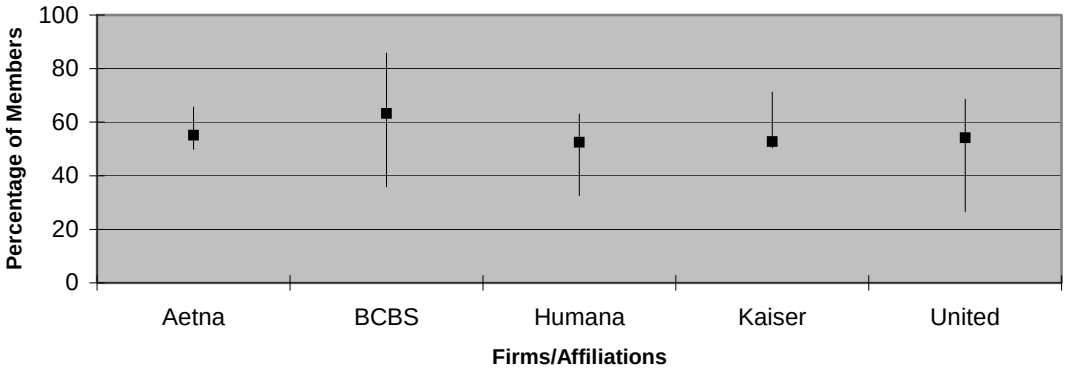


Source: MPR analysis of 2007 HEDIS public use file (2006 reporting year).

Given that firm and affiliation performance could vary for HMO versus non-HMO contracts for a variety of reasons (including data capture and collection issues), we present performance results for HMOs only by firm/affiliation in Table VIII.6b. Focusing on HMOs only sometimes results in slightly better performance, especially for outcome measures such as good control of hemoglobin A1c, and LDL-C under 100 mg/dL for diabetic patients. However, the pattern is not consistent and, in fact, performance appears lower for some measures when only HMOs are included (e.g., glaucoma screening, osteoporosis testing in older women). This analysis does not reveal consistent patterns across firms/affiliations for their HMO products only versus all their MA products that report HEDIS data.

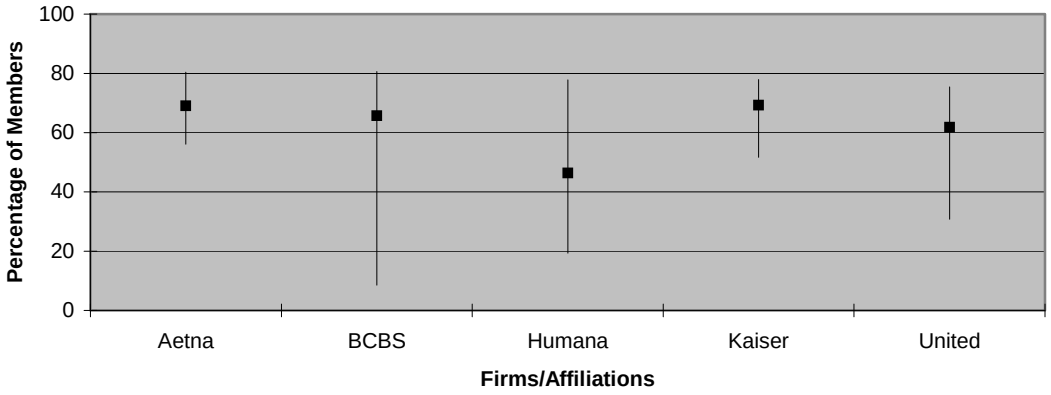
For illustrative purposes, in Figure VIII.5 we provide the results by firm/affiliation for colorectal cancer screening rates, and show glaucoma screening rates in Figure VIII.6. The average (weighted) score is provided by the point above each firm/affiliation name, and the line around the point shows the range of scores across all MA contracts within the firm or affiliation. While the average performance is similar across all firms for colorectal cancer screening, the range of high to low scores across all contracts within a firm varies considerably. Specifically, Aetna shows little variation in scores across contracts, whereas BCBS and United Healthcare vary 40 to 50 percentage points between their contracts with the lowest and highest scores on this measure. (Through other research, we know that Aetna tends to apply a standardized nationwide approach to its care management, and that BCBS consists of a set of affiliated, independently operating plans. This centralization/decentralization factor may affect variation in quality performance.) Similarly, for glaucoma screening, the average performance is quite comparable across firms (with the exception of Humana, which has a considerably lower average); however, the range of scores is notably small for Aetna and Kaiser Permanente, and large for BCBS. Although results vary somewhat from measure to measure, it is generally the case that the range between the lowest and highest score is large for BCBS affiliates (and often United Healthcare) and narrow for Aetna.

Figure VIII.5. Colorectal Cancer Screening, by Firm/Affiliation (2006)



Source: MPR analysis of 2007 HEDIS public use file (2006 reporting year).

Figure VIII.6. Glaucoma Screening, by Firm/Affiliation (2006)



Source: MPR analysis of 2007 HEDIS public use file (2006 reporting year).

Quality Performance over Time. To provide a sense of whether average performance has changed, as reflected in the past two years of available data, we compared average scores in 2005 and 2006 across all contracts (Table VIII.7a). While average performance scores increased for a number of measures (although not necessarily to a statistically significant degree), average performance remained about the same or fell slightly for most measures. Note that a number of measures could not be compared over time because of changes in how the measure was specified between 2005 and 2006. (See NCQA 2007 for more information.)

Since changes in performance over time may be attributable partially to contracts new to MA, we also examined performance among the subset of contracts that reported measures in both 2005 and 2006 (Table VIII.7b). This analysis reveals that any declines in performance were not as large when contracts that reported only in 2006 (i.e., newer contracts) are excluded. By the same token, several improvements in performance are greater in magnitude when newer contracts are excluded.

B. ANALYSIS OF CAHPS DATA

Available CAHPS data on MA products consist of six question domains:

- Overall rating of health care patients received
- Overall rating of health plan
- Getting care that is needed
- Getting care without long waits
- Doctors who communicate well
- Seeing a specialist

Results for these domains are provided in categorical responses (e.g., percent of MA beneficiaries who report that their doctors always, usually, or never communicate well). The first two measures listed above—overall rating of health care received and rating of health plan—reflect the average of beneficiaries' ratings on a 10-point scale (where 10 is the best possible rating). The remaining four measures are composite measures developed by CAHPS based on ratings of several questions covering a particular topic (see, for example, the National CAHPS Benchmarking Database 2007). Table VIII.8 provides a list of the CAHPS measures.

1. Data Completeness

Like the HEDIS data, CAHPS data are collected at the contract rather than the plan level. The 2007 CAHPS data—the most recent available through the 2008 Medicare Options Compare—generally reflect performance at the contract level, although performance still is reported for separate markets within a contract in approximately one-quarter of the contracts

reporting CAHPS data.[15] For the purposes of this analysis, we treat contract-market combinations as separate entities, and in our weighted analyses, use contract enrollment in the particular market (i.e., set of counties) reflected in the performance data, as the weight.

A total of 236 contract-market combinations reported CAHPS data for 2007 (see Table VIII.9). The 236 contract-market combinations represent only about 40 percent of the 623 MA contract-market combinations appearing in the database. The 236 contract-market combinations reflect a total of 153 unique MA contracts, which is about one-quarter of all MA contracts with enrollment in 2007. Many contracts did not report data for several reasons, including: the plans were too new to be measured (305 contract-market combinations) and CMS did not require the plans to report data, or the number of Medicare members in the plans was too small to report on the information (46 contract-market combinations).[16]

MA contracts participate in Medicare CAHPS if they have at least one year of Medicare experience. In addition to HMOs, cost contracts, and PPOs, PFFS and MSA plans also participate in CAHPS. Among the 236 contracts that reported CAHPS in the data we examined, however, 96 percent were either HMO contracts (82 percent) or 1876 cost contracts (14 percent).[17] The remaining 11 contracts (6 demonstrations, 3 local PPOs and 2 PSO contracts) were combined into the category of "all other."[18] Given the small number of contracts in the cost and "all other" categories, comparing CAHPS results across contract type must be done cautiously, with the caveat that the results may be only suggestive of possible differences between types and not necessarily representative of average performance by these contract types.

The 236 contract-market combinations reporting CAHPS data fully report all 6 CAHPS measures; that is, there is no missing data for specific measures. This is not surprising, since the CAHPS measures all come from the same survey. The only reason for data to be missing is if item nonresponse varied considerably, an unlikely result, since these measures are focused on satisfaction rather than patient knowledge.

2. Descriptive Results

Overall Performance. MA beneficiary ratings of the health care received were high, with an average of 86 percent of MA enrollees in a given contract rating their health care as 8 or higher on a 10-point scale (see Table VIII.10). Similarly, enrollee ratings of their health plans

[15] While CAHPS data now generally reflects performance at the contract level, prior to 2007, the data reflected markets within contracts.

[16] "Plan" is the terminology used by CMS in each database when providing explanations for contract-market combinations that are missing data; "plan" does not refer to individual plan offerings, but rather contract-market combinations.

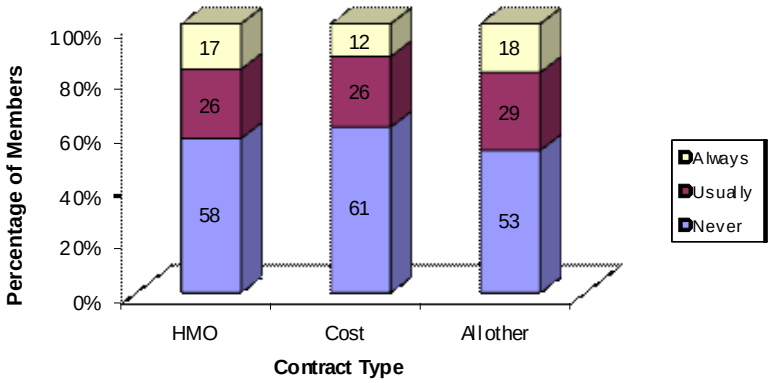
[17] The category of HMO contracts includes HMOs that offer point-of-service plans.

[18] While the CAHPS analysis in MedPAC (2008) suggests that 2007 CAHPS data include PFFS and regional PPO contracts, the number of contracts is not specified. The database we are using does not include any PFFS or PPO contracts. The discrepancy may be the difference between the Plan Finder downloadable files and the CAHPS data file that MedPAC received directly from CMS.

also were high, with almost 79 percent rating their plan as 8 or higher, on average. The remaining measures—each of which is a composite of several related variables—also suggest relatively high levels of satisfaction. For example, on average, more than 80 percent of beneficiaries reported that they always get needed care and that they have no problem in seeing a specialist. More than two-thirds reported that their doctors always communicate well. The measure associated with the most dissatisfaction involves long waits for care, with only 58 percent of beneficiaries on average reporting that they always get care without long waits, and 16 percent reporting that they *never* get care without long waits.

Performance by Contract Type. Comparing performance on CAHPS indicators by contract type (also presented in Table VIII.10), 1876 cost contracts have consistently higher performance than HMO contracts across all CAHPS measures.[19] While the numbers must be interpreted cautiously because of the small sample size, enrollees in "all other" contracts—which include demos, PPOs, and PSOs in the CAHPS data—appear less satisfied than those in HMOs or cost contracts. As one example of this pattern of performance, Figure VIII.7 presents the results for the CAHPS indicator on getting care without long waits (which is based on getting care as soon as needed when sick or injured, and getting an appointment as soon as needed when not sick or injured).

Figure VIII.7. Getting Care Without Long Waits (Unweighted)



Source: MPR analysis of 2008 CAHPS data (2007 reporting year).

We also weighted the CAHPS data by contract enrollment to provide a sense of the quality received by the average beneficiary enrolled in MA (see Table VIII.11). Such weighting does not affect the results qualitatively, except for the health plan rating. Average overall ratings across all contracts remain very similar to the unweighted results. Moreover, relevant rankings by contract type remain the same, with 1876 cost contracts having the highest average performance, followed by HMO contracts, and then "all other."

[19] Among the 236 contract-market combinations that report CAHPS data, 3 are SNP-only contracts (2 are HMOs, 1 is a demo).

Performance of Large Firms in the MA Market. We also analyzed the CAHPS data for several major firms and affiliations.[20] Table VIII.12 presents the average score for each firm, as well as the raw highest and lowest scores reported for any contract within the firm/affiliation.[21] (The weighted average response reflects performance of all of the firm's contracts, weighted by the number of beneficiaries in each contract.) The average scores across firms were generally within 4 to 5 percentage points of one another for most measures, although the variation in average score across firms is notably larger for two measures: health plan rating and long waits for care. While some variability exists in the highest and lowest scores across firms, the CAHPS data do not show the considerable variability in high and low scores present in the HEDIS data.

C. RELATIONSHIP BETWEEN OUR ANALYSES AND OTHER INFORMATION ON MA QUALITY

MedPAC Report. The MedPAC (2008a) analysis on quality performance presents data on MA contracts from HOS, HEDIS, and CAHPS. The analysis of HEDIS measures generally focuses on categories of measures (although it does present about 17 specific measures in one table) and presents information on how HEDIS scores have changed over time. There is also some analysis of HEDIS performance for older versus newer contracts (with newer contracts defined as those beginning in 2004 or later), and newer HMOs versus newer PPOs. (Other contract types are not analyzed.) The MedPAC report also presents CAHPS data by contract type, and compares Medicare performance to that of commercial and Medicaid plans (based on an analysis from AHRQ, 2007). In addition, it compares CAHPS performance for older versus newer contracts.

Our analysis differs from that of the MedPAC report in several ways. First, ours includes more descriptive statistics on specific measures and more analysis by contract type. It also reports quality performance by selected firms/affiliations. Moreover, whereas the MedPAC report provides unweighted statistics (that is, simple averages) on quality measures, we also provide descriptive statistics weighted by contract enrollment to provide a sense of the quality received by the average MA enrollee.

To the extent that our analyses overlap, our findings on the HEDIS data generally are quite similar to those of MedPAC. Our analysis of HEDIS data pertaining to newer versus old contracts includes several categorical time periods, rather than just pre-2004 versus 2004 and later. Interestingly, on the small number of measures examined, contracts from 2006 tended to perform slightly better than those that originated in 2004-2005, suggesting a need for further analysis to better understand trends by date of program entry.

[20] We did not examine CAHPS performance by date of program entry, given the relatively small amount of variability in the CAHPS data relative to the HEDIS data.

[21] Note that 86 percent of contracts comprising the firms/affiliates are HMOs, and another 10 percent are 1876 cost contracts. The remaining contracts are demos, PPOs, or other. Therefore, we report firm performance for all contract types only, and do not provide a separate table on firm performance for HMO contracts only, as we do for the HEDIS data.

We found similar results to MedPAC on CAHPS data, suggesting relatively high levels of satisfaction. A few differences between MedPAC's and our analyses of CAHPS are worth mentioning, however. First, MedPAC presents CAHPS results for both PFFS and regional PPO contracts. In contrast, our data, taken from the Plan Finder files, does not appear to include any PFFS and regional PPO contracts. The only feasible explanation seems to be the different data sources used (MedPAC's data came directly from a file that CMS provided them, rather than the Plan Finder data) and/or different classifications for contract type (with some contracts classified in the Plan Finder data as demonstrations). Second, our study includes 1876 cost contracts in the CAHPS analysis overall and as a separate category in our analysis by contract type, since these contracts comprise about 14 percent of the contract markets that supply CAHPS data. In contrast, MedPAC appears to exclude cost contracts from at least some of its CAHPS analysis.

Five-Star Rating Now Available on Medicare Options Compare Website. The five-star performance ratings were added to the Medicare Options Compare website in November 2007. We briefly describe the five-star ratings below, and then discuss how those measures may differ from the analysis presented here.

Table VIII.13 presents the measures for which ratings are available on Medicare Options Compare. The composite measures or domains are listed in bold in this table. The data source for the majority of measures is HEDIS or CAHPS data. However, the five-star rating system also draws from other sources, such as Medicare's complaint tracking module and the prescription drug plan finder (for medication-related measures). Although information is not available on exactly how the composite measure ratings are calculated, we assume they are a simple average of the measures included in the particular composite. However, it is unclear to us as to exactly how the scores are translated into star ratings.

Users of the five-star rating website can view the ratings as stars or scores (e.g., percentage of plan members who had appropriate screening for colon cancer). Users may select a state and/or county to view available health plans and then select a link that allows users to view plan ratings. Users may select up to three plans on which to compare ratings (or scores) simultaneously. They also are able to view the ratings or scores for the specific measures that comprise each composite, should they want more detail. A link is available that allows users to view a definition of each composite and related measures, although information on how star ratings are attributed to each measure and composite is not provided.

We have not run a confirmatory analysis to examine how well the results of our quality analysis align with the measures presented in the five-star rating system. However, we would expect that results on measures that use HEDIS or CAHPS would be comparable. Note that our analysis presents information on a number of measures not included in the five-star rating system. Conversely, the star rating system includes several measures (primarily from sources other than HEDIS or CAHPS) that we did not analyze, such as the measures on the rights to appeal and those related to drug benefit, pricing, and service.

D. CONCLUSIONS

Our analysis of MA performance highlights the considerable variation in quality performance—across measures, contract types, over time, and for various firms/affiliations. While most CAHPS measures show relatively high levels of satisfaction among MA enrollees,

the results are substantially more mixed for HEDIS. Whereas some HEDIS measures suggest strong performance, others—including several related to intermediate outcomes—allow substantial room for improvement.

Our analysis of both HEDIS and CAHPS data by contract type points to relatively high performance by cost contracts, which may be related to their organizational infrastructure as discussed earlier. (This result is particularly interesting in light of cost contracts being targeted for elimination, assuming sufficient competition otherwise exists.) Conversely, PPOs exhibit lower HEDIS scores than other contract types on several hybrid measures, likely reflecting their reliance on administrative claims only, which has been shown to be associated with lower HEDIS scores. Our analysis also suggests that newer contracts (originating in 2004 or later) tend to perform less well than older contracts. Further analysis, however, could help disentangle performance by contract type from performance by newer versus older contracts.

The results by large firms/affiliations highlight the variation in performance among contracts within a given firm. The range between the highest and lowest performing contracts is often considerable, although one large firm (Aetna) tends to have a much smaller spread than the others studied. Even when the analysis is limited to HMO contracts only—for which firms/affiliations may have more ability to manage their patients—the results do not change much, and the range between contracts' lowest and highest scores is still quite large for some measures. The variation in quality performance within a given firm or affiliation suggests opportunities to target quality improvement efforts to low-performing contracts to raise the firm's overall quality.

This analysis has several important limitations. With the exception of HMOs (a large proportion of which report quality data), contract types represented in the HEDIS and CAHPS analysis may not be representative of contract types that do not report data. Moreover, our analysis of performance by date of program entry and contract type is relatively basic. Further delineation of contracts into types by contract start date and enrollment levels could help to understand better what underlies recent trends that appear to show worse quality among newer MA contracts.

Table VIII.1. Selected HEDIS Measures and Definitions[a]

Indicator Name	Definition
ACCESS AND PREVENTIVE CARE	
Adults' access to preventive/ambulatory health services	Percentage of enrollees 65 years of age and older who had an ambulatory or preventive care visit
Breast cancer screening	Percentage of women 50-69 years of age who had a mammogram during the measurement year or the year prior to the measurement year
Colorectal cancer screening	Percentage of members 50-80 years of age who had appropriate screening for colorectal cancer.
Glaucoma screening in older adults	Percentage of Medicare members 65 years and older without a prior diagnosis of glaucoma or glaucoma suspect who received a glaucoma eye exam
Osteoporosis testing in older women[b]	Percentage of Medicare women 65 years and older who report ever having received a bone density test to check for osteoporosis
Fall risk management[b]	Percentage of Medicare members 75 years of age and older with balance or walking problems or a fall in the past 12 months who were seen by an MCO practitioner in the past 12 months, and who received fall risk intervention from their current practitioner
Fall risk management[b]	Percentage of Medicare members 65-74 years of age with balance or walking problems or a fall in the past 12 months who were seen by an MCO practitioner in the past 12 months, and who received fall risk intervention from their current practitioner
MANAGEMENT OF EXISTING CONDITIONS	
Comprehensive diabetes care	
HbA1c testing	Percentage of members 18-75 years of age with diabetes (type 1 and 2) who had HbA1c tested
Eye exams	Percentage of diabetic members 18-75 years of age who had an eye exam performed
Lipid profile	Percentage of diabetic members 18-75 years of age who had LDL-C screening performed
Poor control of HbA1c	Percentage of diabetic members 18-75 years of age with poorly controlled HbA1c (> 9.0%)
Good control of HbA1c[b]	Percentage of diabetic members 18-75 years of age with good control of HbA1c (< 7.0%)
LDL < 100 mg/dL	Percentage of diabetic members 18-75 years of age with LDL-C controlled (<100 mg/dL)
Blood pressure < 130/80 mm Hg[b]	Percentage of diabetic members 18-75 years of age with good control of blood pressure (< 130/80 mm Hg)
Cholesterol management for patients with cardiovascular conditions	
LDL screening	Percentage of members 18-75 years of age who, from January 1 through November 1 of the year prior to the measurement year were discharged with a cardiovascular condition and had LDL-C screened
LDL < 100 mg/dL	Percentage of members 18-75 years of age who, from January 1 through November 1 of the year prior to the measurement year were discharged with a cardiovascular condition and had LDL-C level <100 mg/dL

Table VIII.1 *(continued)*

Indicator Name	Definition
Blood pressure < 140/90 mm Hg in hypertensive patients	Percentage of members 46-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than or equal to 140/90 mm Hg)
Beta blocker treatment after heart attack	
Ambulatory treatment	Percentage of members 35 years of age and older during the measurement year who were hospitalized and discharged alive from January 1 – December 24 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and received an ambulatory prescription for beta blockers upon discharge
Persistent treatment	Percentage of members 35 years of age and older hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with AMI, and who received persistent beta-blocker treatment for six months after discharge.
Management of urinary incontinence in older adults	
Discussing urinary incontinence	Percentage of Medicare members 65 years of age and older who reported having a problem with urine leakage in the past six months, and who discussed their leakage problem with their current practitioner
Receiving urinary incontinence treatment	Percentage of Medicare members 65 years of age and older who reported having a urine leakage problem in the past six months, and who received treatment for their current problem
Osteoporosis management in women who had a fracture	Percentage of women 67 years of age and older who suffered a fracture and who had either a bone mineral density test or prescription to treat or prevent osteoporosis in the six months after the date of the fracture.
Followup after hospitalization for mental illness	
Followup for mental illness within 7 days of discharge	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders, and who had an outpatient or intermediate mental health visit on the date of the discharge, up to seven days after hospital discharge
Followup for mental illness within 30 days of discharge	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders, and who had an outpatient or intermediate mental health visit on the date of the discharge, up to 30 days after hospital discharge
MEDICATION USE AND MANAGEMENT	
Antidepressant medication management	
Optimal practitioner contacts for medication management	Percentage of members 18 years of age and older diagnosed with a new episode of depression and treated with antidepressant medication, and who had at least three follow-up contacts with a practitioner during the 84-day Acute Treatment Phase; at least one of the three follow-ups must be with a prescribing practitioner
Effective acute phase treatment	Percentage of members 18 years of age and older diagnosed with a new episode of depression who were treated with antidepressant medication and remained on an antidepressant drug during the Acute Treatment Phase
Effective continuation phase treatment	Percentage of members 18 years of age and older diagnosed with a new episode of depression and treated with antidepressant medication, and who remained on an antidepressant drug for at least 180 days

Table VIII.1 *(continued)*

Indicator Name	Definition
Anti-rheumatic drug therapy in rheumatoid arthritis	Percentage of patients diagnosed with rheumatoid arthritis who have had at least one ambulatory prescription dispensed for a disease modifying anti-rheumatic drug
Drugs to be avoided in the elderly	
Members given at least one drug to be avoided	Percentage of Medicare members 65 years of age and older who received at least one drug to be avoided in the elderly
Members given at least two different drugs to be avoided	Percentage of Medicare members 65 years of age and older who received at least two different drug to be avoided in the elderly
Annual monitoring for patients on persistent medications	Percentage of patients 18 years of age and older who received at least a 180-days supply of ambulatory medication therapy for ACE inhibitors, digoxin, diuretics, anticonvulsants, OR statins
Potentially harmful drug-disease interactions in the elderly[b]	Percentage of Medicare members 65 years of age and older who have a history of falls and a prescription for tricyclic antidepressants, antipsychotics, or sleep agents; dementia and a prescription for tricyclic antidepressants or anticholinergic events; OR chronic renal failure and prescription for non-aspirin NSAIDs or Cox-2 Selective NSAIDs, and were dispensed a contraindicated medication

Source: CMS HEDIS Public Use Files. Available at:
http://www.cms.hhs.gov/MCRAdvPartDEnrolData/HEDIS/list.asp - TopOfPage

[a]Definitions for selected HEDIS measures are based on documentation available in the Public Use Files. While some definitions indicate measures that reflect populations under the age of 65, data are reflective of members of Medicare Advantage health plans.

[b]Indicator is not available in 2006 HEDIS PUF (2005 reporting year).

Table VIII.2. Average Number of Measures for Which Selected 2006 HEDIS Performance Data are Available, Overall and by Contract Type

		By Contract Type				
	Overall (n = 275)	HMO (n=187)	Local PPO (n=50)	Regional PPO (n=9)	1876 Cost (n=17)	Other[a] (n= 12)
Average number of measures available among contracts reporting data on one or more HEDIS measures	22.7	25.3	14.0	9.6	27.3	22.0
Average number of measures available, by contract date of program entry						
Pre-1995	30.1	30.4	--	--	28.4	31.3
1995-2000	28.0	29.4	--	--	26.8	28.0
2001-2003	24.2	28.0	20.3	--	--	--
2004-2005	14.0	16.2	11.3	--	--	14.3
2006+	14.0	14.3	18.0	9.6	--	--
Unknown	27.1	28.7	--	--	25.5	--

Source: MPR analysis of data on the HEDIS 2007 Public Use File (2006 data), merged with information on contracts' date of program entry.

Note: This table reports average number of measures among 32 HEDIS measures selected by MPR for analysis.

[a]Other includes PFFS, SHMO, and demonstrations.

Table VIII.3. Number of Contracts with 2006 Data Available for Selected HEDIS Measures

		Contracts with Missing Data for Given Measure	
	Number of Contracts for Which Measure is Available	Number of Contracts with Missing Value Because Benefit Not Offered or Not Applicable[b]	Number of Contracts with Missing Value Because Health Plan Chose Not to Report or Rate Materially Biased[c]
ACCESS AND PREVENTIVE CARE			
Access to ambulatory/ preventive services	272	0	3
Breast cancer screening	199	76	0
Colorectal screening	190	41	44
Glaucoma screening in older adults	209	65	1
Osteoporosis testing in older women	178	--	--
Fall risk management, 75 years of age and older	177	--	--
Fall risk management, 65-74 years of age	174	--	--
MANAGEMENT OF EXISTING CONDITIONS			
Comprehensive diabetes care			
HbA1c testing	269	2	4
Eye exams	265	2	8
Lipid profile	268	2	5
Poor control of HbA1c	223	5	47
Good control of HbA1c	222	5	48
LDL-C <100 mg/dL	223	5	47
Blood pressure <130/80 mm Hg	209	5	61
Cholesterol management for patients with cardiovascular conditions			
LDL-C screening	187	83	5
LDL-C <100 mg/dL	178	66	31
Blood pressure <140/90 mm Hg in hypertensive patients	202	2	71
Beta blocker treatment after heart attack			
Ambulatory treatment	149	80	46
Persistent treatment	132	143	0
Management of urinary incontinence in older adults			
Discussing urinary incontinence	167	--	--

Table VIII.3 *(continued)*

	Number of Contracts for Which Measure is Available	Contracts with Missing Data for Given Measure	
		Number of Contracts with Missing Value Because Benefit Not Offered or Not Applicable[b]	Number of Contracts with Missing Value Because Health Plan Chose Not to Report or Rate Materially Biased[c]
Receiving urinary incontinence treatment	167	--	--
Osteoporosis management in women who had a fracture	156	117	2
Followup after hospitalization for mental illness			
Followup for mental illness within 7 days of discharge	130	142	3
Followup for mental illness within 30 days of discharge	130	142	3
MEDICATION USE AND MANAGEMENT			
Antidepressant medication management			
Optimal practitioner contacts for medication management	129	144	2
Effective acute phase treatment	131	144	0
Effective continuation phase treatment	131	144	0
Anti-rheumatic drug therapy in rheumatoid arthritis	191	83	1
Drugs to be avoided in the elderly			
Members given at least one drug to be avoided	268	7	0
Members given at least two different drugs to be avoided	268	7	0
Annual monitoring for patients on persistent medications	265	8	2
Potentially harmful drug-disease interactions the elderly	176	96	3

Source: 2007 HEDIS Public Use Files (2006 reporting year).

[a]This column represents the proportion of contracts with a given measure available among all contracts with any enrollment in November 2006.

[b]Health plans sometimes do not have a large enough population to calculate a representative rate (e.g., many measures require that rates be based on at least 30 members), or the health plan does not offer the benefit. In such cases, 'NA' or 'NB,' respectively, is reported in the public use files.

[c]Health plans sometimes choose not to calculate and report a rate, or the health plan's HEDIS Compliance Auditor, NCQA, or CMS determine that a rate is materially biased (applicable only to audited measures). In such cases, 'NR' is reported in the public use files.

Table VIII.4. Average Contract Performance on Selected HEDIS Measures, by Contract Type and Overall, 2006 (Unweighted)

Percent of Medicare enrollees with reported:	Overall Average Across All Contract Types	Average Percentage of MA Enrollees, by Contract Type				
		HMO	Local PPO	Regional PPO	1876 Cost	All Other[a]
ACCESS AND PREVENTIVE CARE						
Access to ambulatory/ preventive services	92.4	91.6	94.5	91.2	96.3	91.0
Breast cancer screening	69.9	70.1	69.2	70.9	76.9	58.6
Colorectal screening	52.8	53.2	44.5	52.7	58.6	44.7
Glaucoma screening in older adults	61.8	60.6	64.6	46.7	70.6	60.5
Osteoporosis testing in older women	65.5	64.7	71.4	--	66.1	57.7
Fall risk management, 75 years of age and older	27.5	27.3	26.8	--	29.2	30.7
Fall risk management, 65-74 years of age	55.8	55.7	53.5	--	58.1	60.5
MANAGEMENT OF EXISTING CONDITIONS						
Comprehensive diabetes care						
Hemoglobin A1c ("HbA1c") testing	86.3	86.8	84.2	77.4	89.7	89.0
Eye exams	60.2	60.5	55.5	43.7	74.8	66.7
Lipid profile	83.7	85.1	80.3	72.5	85.8	80.7
Poor control of HbA1c	31.3	28.2	71.4	98.7	20.0	28.1
Good control of HbA1c	43.7	45.4	19.5	0.9	51.6	45.9
LDL-C <100 mg/dL	44.7	46.3	20.2	4.7	53.0	46.1
Blood pressure <130/80 mm Hg	29.7	29.1	23.0	0.0	34.6	38.6
Cholesterol management for patients with cardiovascular conditions						
LDL-C screening	87.6	88.6	84.4	85.1	85.1	84.1
LDL-C <100 mg/dL	53.8	55.5	25.6	14.5	61.0	52.0
Blood pressure <140/90 mm Hg in hypertensive patients	56.8	56.1	55.0	--	60.9	61.6
Beta blocker treatment after heart attack						
Ambulatory treatment	93.3	93.6	84.7	83.1	93.9	93.4
Persistent treatment	69.6	68.5	74.3	59.4	70.4	83.1
Management of urinary incontinence in older adults						
Discussing urinary incontinence	56.9	56.5	57.4	--	59.0	59.9

Table VIII.4 *(continued)*

Percent of Medicare enrollees with reported:	Overall Average Across All Contract Types	Average Percentage of MA Enrollees, by Contract Type				
		HMO	Local PPO	Regional PPO	1876 Cost	All Other[a]
Receiving urinary incontinence treatment	35.4	35.1	36.7	--	35.8	38.2
Osteoporosis management in women who had a fracture	21.7	21.7	22.8	19.4	23.5	17.7
Followup after hospitalization for mental illness						
Followup for mental illness within 7 days of discharge	36.4	37.1	38.3	30.7	37.7	18.4
Followup for mental illness within 30 days of discharge	55.7	55.9	58.0	53.7	60.7	40.1
MEDICATION USE AND MANAGEMENT						
Antidepressant medication management						
Optimal practitioner contacts for medication management	11.4	11.0	13.0	15.4	13.5	12.4
Effective acute phase treatment	57.8	57.4	57.0	59.6	57.1	66.1
Effective continuation phase treatment	44.6	44.2	41.0	38.5	43.7	55.6
Anti-rheumatic drug therapy in rheumatoid arthritis	68.4	68.0	70.2	65.9	72.4	63.8
Drugs to be avoided in the elderly						
Members given at least one drug to be avoided	23.1	23.0	23.7	19.7	22.6	23.9
Members given at least two different drugs to be avoided	6.0	6.0	6.8	4.9	6.2	4.9
Annual monitoring for patients on persistent medications	82.7	83.2	84.5	78.7	72.4	83.4
Potentially harmful drug-disease interactions in the elderly	19.5	19.0	20.1	29.1	19.6	24.6

Source: MPR analysis of data in the HEDIS 2007 Public Use File (2006 data), merged with information on contracts' date of program entry.

[a]Other includes PFFS, SHMO, and demonstrations.

Table VIII.5. Average Contract Performance on Selected HEDIS Measures, by Contract Type and Overall, 2006 (Weighted)

Percent of Medicare Enrollees with Reported:	Average Across All Contract Types	Percentage of MA Enrollees, by Contract Type				
		HMO	Local PPO	Regional PPO	1876 Cost	All Other[a]
ACCESS AND PREVENTIVE CARE						
Access to ambulatory/ preventive services	93.8	93.7	94.6	93.9	95.8	91.8
Breast cancer screening	73.3	73.4	71.8	70.9	78.9	65.0
Colorectal screening	55.4	55.5	45.1	45.5	60.2	49.4
Glaucoma screening in older adults	62.8	62.2	66.1	52.2	72.1	62.9
Osteoporosis testing in older women	65.2	64.9	71.6	--	68.7	59.8
Fall risk management, 75 years of age and older	28.3	28.2	25.9	--	29.2	30.2
Fall risk management, 65-74 years of age	57.0	56.9	55.1	--	57.8	59.3
MANAGEMENT OF EXISTING CONDITIONS						
Comprehensive diabetes care						
Hemoglobin A1c ("HbA1c") testing	89.0	89.4	84.8	78.2	89.9	84.6
Eye exams	65.1	65.4	57.3	45.7	74.3	60.8
Lipid profile	87.9	88.6	82.1	76.2	86.6	84.2
Poor control of HbA1c	24.6	23.6	67.8	97.4	19.8	32.3
Good control of HbA1c	47.7	48.3	23.0	1.7	51.0	42.5
LDL-C <100 mg/dL	50.0	50.6	24.1	9.2	53.5	43.0
Blood pressure <130/80 mm Hg	31.0	31.0	24.9	0.0	34.8	28.0
Cholesterol management for patients with cardiovascular conditions						
LDL-C screening	90.0	90.4	87.0	85.1	86.8	87.0
LDL-C <100 mg/dL	57.6	58.8	21.0	14.5	62.4	48.5
Blood pressure <140/90 mm Hg in hypertensive patients	60.4	60.5	55.0	--	61.2	58.5
Beta blocker treatment after heart attack						
Ambulatory treatment	94.7	95.0	85.3	83.1	92.2	92.5
Persistent treatment	71.8	71.6	77.2	59.9	69.7	80.7

Table VIII.5 *(continued)*

Percent of Medicare Enrollees with Reported:	Average Across All Contract Types	Percentage of MA Enrollees, by Contract Type				
		HMO	Local PPO	Regional PPO	1876 Cost	All Other[a]
Management of urinary incontinence in older adults						
Discussing urinary incontinence	56.9	56.6	58.4	--	59.2	58.9
Receiving urinary incontinence treatment	35.2	35.0	37.4	--	35.9	36.9
Osteoporosis management in women who had a fracture	22.9	22.8	31.3	19.4	25.4	18.1
Followup after hospitalization for mental illness						
Followup for mental illness within 7 days of discharge	40.1	41.1	40.9	31.1	38.9	16.6
Followup for mental illness within 30 days of discharge	59.6	60.3	61.1	53.9	61.1	37.8
MEDICATION USE AND MANAGEMENT						
Antidepressant medication management						
Optimal practitioner contacts for medication management	11.3	11.1	13.3	15.4	12.7	13.1
Effective acute phase treatment	60.2	60.6	59.8	59.6	57.3	55.7
Effective continuation phase treatment	45.6	45.8	43.1	38.5	44.3	44.1
Anti-rheumatic drug therapy in rheumatoid arthritis	68.4	68.0	68.7	65.9	76.7	68.2
Drugs to be avoided in the elderly						
Members given at least one drug to be avoided	23.0	22.9	23.5	21.6	23.0	24.4
Members given at least two different drugs to be avoided	5.9	5.8	7.2	5.3	6.7	5.3
Annual monitoring for patients on persistent medications	84.4	85.0	84.5	86.4	72.2	85.5
Potentially harmful drug-disease interactions in the elderly	20.3	20.0	23.0	29.1	21.4	24.4

Source: MPR analysis of data in the HEDIS 2007 Public Use File (2006 data), merged with information on contracts' date of program entry.

Note: Weighted average results are based on November 2006 enrollment at the contract level.

[a]Other includes PFFS, SHMO, and demonstrations.

Table VIII.6a. Average Contract Performance on Selected HEDIS Measures, by Firms or Affiliations, 2006

Measure	Selected Firms and Affiliations				
	Aetna	BCBS Affiliates	Humana	Kaiser Permanente	United Healthcare
ACCESS AND PREVENTIVE CARE					
Access to ambulatory/preventive services					
Average (unweighted)	93.5	95.0	93.6	93.0	91.5
Average (weighted)	93.7	94.8	94.3	94.2	93.0
High score	96.4	98.4	97.1	96.7	99.7
Low score	88.6	84.6	87.7	85.8	65.4
Breast cancer screening					
Average (unweighted)	67.3	71.9	68.5	86.2	64.2
Average (weighted)	67.9	72.0	71.6	87.1	67.7
High score	71.5	84.1	80.0	88.2	82.7
Low score	59.7	51.4	53.0	81.6	21.4
Colorectal screening					
Average (unweighted)	58.3	58.5	46.5	58.6	48.1
Average (weighted)	55.2	63.3	52.5	52.7	54.2
High score	65.7	85.9	63.0	71.3	68.6
Low score	49.9	35.9	32.7	50.3	26.7
Glaucoma screening in older adults					
Average (unweighted)	70.4	64.4	51.4	67.4	58.2
Average (weighted)	69.1	65.7	46.4	69.3	61.8
High score	80.4	80.7	77.8	78.0	75.5
Low score	56.1	8.5	19.3	51.7	30.8
Osteoporosis testing in older women					
Average (unweighted)	65.9	68.2	65.8	61.3	64.6
Average (weighted)	64.3	67.0	59.4	62.2	64.4
High score	74.5	78.6	78.4	72.1	80.2
Low score	55.7	55.5	42.5	51.2	38.8
Fall risk management, 75 years of age and older					
Average (unweighted)	24.9	26.7	27.8	27.1	27.5
Average (weighted)	25.3	25.4	29.2	25.9	27.9
High score	29.4	39.4	33.1	35.9	36.2
Low score	23.4	20.1	24.2	23.4	19.7
Fall risk management, 65-74 years of age					
Average (unweighted)	55.2	57.2	53.9	56.1	53.9
Average (weighted)	55.3	57.6	57.6	55.0	55.6
High score	58.1	68.2	60.5	62.4	62.9
Low score	52.9	48.0	46.5	49.2	45.7
MANAGEMENT OF EXISTING CONDITIONS					
Comprehensive diabetes care					
HbA1c testing					
Average (unweighted)	88.5	86.4	84.3	93.1	85.5
Average (weighted)	89.0	89.9	86.5	94.7	88.4
High score	93.0	96.6	97.6	97.6	93.1
Low score	84.6	57.7	69.6	85.5	58.9

Table VIII.6a *(continued)*

Measure	Selected Firms and Affiliations				
	Aetna	BCBS Affiliates	Humana	Kaiser Permanente	United Healthcare
Eye exams					
Average (unweighted)	67.4	64.9	44.1	78.9	56.4
Average (weighted)	71.6	68.3	41.4	79.9	62.8
High score	74.9	88.8	67.9	88.1	77.4
Low score	46.8	15.1	24.6	57.7	29.9
Lipid profile					
Average (unweighted)	89.4	82.9	82.7	91.6	82.1
Average (weighted)	89.4	87.9	87.6	94.0	85.6
High score	92.7	94.4	98.3	94.9	94.2
Low score	85.3	50.4	70.3	87.8	59.2
Poor control of HbA1c					
Average (unweighted)	25.7	26.3	64.9	14.3	35.2
Average (weighted)	22.4	19.0	41.2	11.9	26.5
High score	40.4	100.0	97.4	22.1	56.9
Low score	16.4	10.7	13.1	7.3	14.3
Good control of HbA1c					
Average (unweighted)	47.5	48.8	23.3	44.5	43.0
Average (weighted)	50.1	53.0	40.3	49.7	48.9
High score	54.8	62.8	62.3	52.0	66.2
Low score	37.1	0.0	1.7	30.2	24.2
LDL-C <100 mg/dL					
Average (unweighted)	50.4	48.0	24.2	58.5	42.8
Average (weighted)	50.7	52.4	40.1	65.7	47.2
High score	56.0	66.9	67.9	68.1	60.2
Low score	40.2	0.0	4.3	47.4	26.4
Blood pressure <130/80 mm Hg					
Average (unweighted)	26.9	28.3	27.0	38.1	26.4
Average (weighted)	25.8	29.4	25.2	45.0	27.6
High score	32.5	39.7	32.6	47.3	36.5
Low score	17.3	0.0	13.4	29.5	18.3
Cholesterol management for patients with cardiovascular conditions					
LDL-C screening					
Average (unweighted)	90.6	89.7	88.6	92.9	86.1
Average (weighted)	90.8	90.8	92.0	94.2	87.7
High score	95.2	94.7	99.0	99.0	93.3
Low score	86.5	74.1	84.5	82.5	71.1
LDL-C <100 mg/dL					
Average (unweighted)	56.5	54.3	44.6	67.5	48.6
Average (weighted)	58.6	59.5	51.7	70.3	54.2
High score	66.2	72.0	74.9	77.1	65.1
Low score	51.7	0.0	14.5	53.3	28.9

Table VIII.6a *(continued)*

Measure	Selected Firms and Affiliations				
	Aetna	BCBS Affiliates	Humana	Kaiser Permanente	United Healthcare
Blood pressure <140/90 mm Hg in hypertensive patients					
Average (unweighted)	57.8	58.1	57.2	66.7	50.8
Average (weighted)	57.8	60.4	61.2	77.6	53.7
High score	61.7	67.1	64.3	81.3	61.7
Low score	51.6	25.0	39.7	58.2	35.4
Beta blocker treatment after heart attack					
Ambulatory treatment					
Average (unweighted)	97.7	93.7	89.0	98.1	94.5
Average (weighted)	98.0	96.3	91.4	98.4	95.7
High score	99.0	100.0	98.3	100.0	99.1
Low score	95.8	55.3	75.0	89.7	89.0
Persistent treatment					
Average (unweighted)	69.6	66.8	69.9	84.9	66.3
Average (weighted)	70.7	69.4	70.8	85.2	69.6
High score	76.9	89.3	81.8	95.1	84.1
Low score	60.9	14.9	62.6	75.5	46.4
Management of urinary incontinence in older adults					
Discussing urinary incontinence					
Average (unweighted)	59.5	59.6	53.1	56.0	56.0
Average (weighted)	60.5	58.1	53.5	55.1	54.7
High score	66.3	70.1	59.7	63.9	68.3
Low score	49.7	45.5	48.2	50.3	49.5
Receiving urinary incontinence treatment					
Average (unweighted)	36.1	38.0	33.1	37.7	35.3
Average (weighted)	35.1	37.9	33.1	37.7	32.8
High score	41.0	44.1	39.1	42.7	41.6
Low score	29.3	29.4	27.7	31.0	28.1
Osteoporosis management in women who had a fracture					
Average (unweighted)	16.6	23.9	20.7	38.7	20.9
Average (weighted)	16.5	28.3	17.7	32.5	20.7
High score	21.6	49.5	26.3	48.4	30.5
Low score	13.4	10.6	15.0	30.4	10.3
Followup after hospitalization for mental illness					
Followup for mental illness within 7 days of discharge					
Average (unweighted)	34.0	39.0	33.9	60.5	32.5
Average (weighted)	34.7	45.3	27.1	60.5	31.5
High score	48.3	75.0	53.9	73.3	61.6
Low score	9.3	2.4	7.2	37.3	18.2

Table VIII.6a *(continued)*

Measure	Selected Firms and Affiliations				
	Aetna	BCBS Affiliates	Humana	Kaiser Permanente	United Healthcare
Followup for mental illness within 30 days of discharge					
Average (unweighted)	49.2	59.7	51.3	76.7	53.5
Average (weighted)	50.3	66.3	44.5	77.3	50.2
High score	69.0	86.0	82.1	84.3	81.3
Low score	11.6	7.4	12.1	66.1	32.7
MEDICATION USE AND MANAGEMENT					
Antidepressant medication management					
Optimal practitioner contacts for medication management					
Average (unweighted)	10.7	11.7	9.9	14.7	9.7
Average (weighted)	10.8	11.4	10.1	12.3	9.4
High score	11.8	20.0	15.4	25.6	21.1
Low score	9.2	6.2	6.9	9.4	3.5
Effective acute phase treatment					
Average (unweighted)	54.2	54.1	52.7	71.0	56.0
Average (weighted)	54.6	55.6	49.5	81.7	56.5
High score	61.2	76.1	59.6	85.9	68.8
Low score	45.0	23.1	46.4	59.5	42.8
Effective continuation phase treatment					
Average (unweighted)	47.9	39.2	37.1	57.1	43.8
Average (weighted)	48.2	38.7	36.0	62.2	43.6
High score	55.3	71.7	41.2	77.6	54.3
Low score	36.7	10.5	34.6	43.4	29.1
Anti-rheumatic drug therapy in rheumatoid arthritis					
Average (unweighted)	78.9	69.0	61.5	81.0	69.2
Average (weighted)	78.3	68.1	53.3	81.3	70.7
High score	88.7	87.7	79.5	87.2	88.2
Low score	60.8	23.5	37.0	71.4	42.1
Drugs to be avoided in the elderly					
Members given at least one drug to be avoided					
Average (unweighted)	18.2	24.9	26.2	19.7	21.5
Average (weighted)	18.1	20.5	28.7	21.1	23.4
High score	26.6	61.1	40.5	25.2	39.2
Low score	10.9	2.0	14.9	15.9	10.4
Members given at least two different drugs to be avoided					
Average (unweighted)	3.6	8.6	7.1	3.9	5.1
Average (weighted)	3.5	6.1	8.0	4.4	5.7
High score	6.2	37.9	15.3	5.9	11.4
Low score	1.3	0.2	2.6	2.7	1.1

Table VIII.6a *(continued)*

Measure	Selected Firms and Affiliations				
	Aetna	BCBS Affiliates	Humana	Kaiser Permanente	United Healthcare
Annual monitoring for patients on persistent medications					
Average (unweighted)	87.4	80.5	84.2	86.2	86.3
Average (weighted)	87.1	82.0	86.9	83.2	85.6
High score	92.5	91.3	92.5	94.9	98.6
Low score	76.1	42.1	44.5	80.7	72.8
Potentially harmful drug-disease interactions in the elderly					
Average (unweighted)	12.1	21.9	22.3	19.4	18.1
Average (weighted)	12.2	21.8	22.0	18.9	19.5
High score	13.8	62.4	29.1	30.7	26.3
Low score	9.4	0.0	14.4	14.6	9.1

Source: 2007 HEDIS Public Use File (2006 data).

Note: Weighted average results are based on November 2006 enrollment at the contract level.

Table VIII.6b. Average Contract Performance on Selected HEDIS Measures, by Firms or Affiliations, For HMO Contracts Only, 2006

Measure	Selected Firms and Affiliations				
	Aetna	BCBS Affiliates	Humana	Kaiser Permanente	United Healthcare
ACCESS AND PREVENTIVE CARE					
Access to ambulatory/preventive services					
Average (unweighted)	92.7	94.7	92.7	92.7	90.8
Average (weighted)	93.4	94.5	94.4	94.3	92.9
High score	95.4	98.4	95.6	96.0	97.4
Low score	88.6	84.6	87.7	85.8	65.4
Breast cancer screening					
Average (unweighted)	68.7	72.9	66.2	86.0	64.2
Average (weighted)	68.5	72.0	71.8	87.1	67.6
High score	71.5	84.1	74.5	88.2	79.3
Low score	65.3	60.3	53.0	81.6	39.7
Colorectal screening					
Average (unweighted)	58.3	60.9	50.4	55.9	48.1
Average (weighted)	55.2	64.7	53.8	51.8	54.3
High score	65.7	85.9	63.0	60.3	68.6
Low score	49.9	37.4	43.1	50.3	26.7
Glaucoma screening in older adults					
Average (unweighted)	70.4	62.3	46.1	66.5	56.6
Average (weighted)	68.7	64.8	45.2	69.6	61.7
High score	80.4	80.7	66.0	75.3	75.5
Low score	56.1	8.5	19.3	51.7	30.8
Osteoporosis testing in older women					
Average (unweighted)	63.7	66.9	60.6	62.8	62.6
Average (weighted)	63.2	66.1	58.6	61.8	64.1
High score	69.1	78.6	71.3	72.1	74.4
Low score	55.7	55.5	42.5	55.5	38.8
Fall risk management, 75 years of age and older					
Average (unweighted)	25.6	26.0	27.8	25.3	27.6
Average (weighted)	25.5	25.2	29.3	25.2	27.9
High score	29.4	31.5	33.1	27.5	36.2
Low score	23.4	22.0	24.2	23.4	19.7
Fall risk management, 65-74 years of age					
Average (unweighted)	55.8	56.5	56.1	53.4	54.2
Average (weighted)	55.4	57.3	57.9	53.4	55.7
High score	58.1	65.6	60.5	59.3	62.9
Low score	54.4	51.2	50.9	49.2	45.7
MANAGEMENT OF EXISTING CONDITIONS					
Comprehensive diabetes care					
HbA1c testing					
Average (unweighted)	88.9	90.0	85.7	94.2	86.3
Average (weighted)	89.3	91.3	87.1	95.1	88.6
High score	93.0	96.6	97.6	95.7	93.1
Low score	84.6	65.9	69.6	92.0	71.3

Table VIII.6b *(continued)*

Measure	Selected Firms and Affiliations				
	Aetna	BCBS Affiliates	Humana	Kaiser Permanente	United Healthcare
Eye exams					
Average (unweighted)	66.1	67.5	46.9	78.1	57.6
Average (weighted)	71.9	69.7	41.5	80.0	63.2
High score	74.9	88.8	67.9	88.1	73.3
Low score	46.8	15.1	24.6	57.7	29.9
Lipid profile					
Average (unweighted)	89.6	88.4	87.0	92.3	84.2
Average (weighted)	89.5	89.7	88.8	94.3	85.8
High score	92.7	94.4	98.3	94.9	94.2
Low score	85.3	73.7	82.0	90.3	73.0
Poor control of HbA1c					
Average (unweighted)	21.8	21.9	31.8	13.0	35.7
Average (weighted)	20.2	18.1	32.9	11.4	26.6
High score	26.2	79.8	69.8	17.5	56.9
Low score	16.4	10.7	13.1	7.3	14.3
Good control of HbA1c*					
Average (unweighted)	49.6	51.5	45.5	43.7	42.2
Average (weighted)	51.5	53.5	46.1	50.1	48.6
High score	54.8	62.8	62.3	51.5	61.9
Low score	43.1	7.5	13.6	30.2	24.2
LDL-C <100 mg/dL					
Average (unweighted)	52.4	50.7	46.5	59.0	42.4
Average (weighted)	51.7	52.8	45.3	66.4	47.1
High score	56.0	66.9	67.9	68.1	60.2
Low score	45.9	11.7	20.2	49.2	26.4
Blood pressure <130/80 mm Hg*					
Average (unweighted)	26.4	29.2	27.0	39.2	26.0
Average (weighted)	25.5	29.4	25.2	45.8	27.5
High score	32.5	34.8	32.6	47.3	33.4
Low score	17.3	11.9	13.4	34.1	18.3
Cholesterol management for patients with cardiovascular conditions					
LDL-C screening					
Average (unweighted)	91.0	91.3	90.1	95.5	86.2
Average (weighted)	90.9	91.4	92.8	94.8	87.7
High score	93.8	94.7	99.0	99.0	93.3
Low score	86.5	86.5	85.2	93.2	71.1
LDL-C <100 mg/dL					
Average (unweighted)	59.5	61.7	58.6	70.3	48.1
Average (weighted)	59.9	63.7	56.1	70.9	54.1
High score	66.2	72.0	74.9	77.1	65.1
Low score	53.9	45.3	50.4	63.7	28.9

Table VIII.6b *(continued)*

Measure	Selected Firms and Affiliations				
	Aetna	BCBS Affiliates	Humana	Kaiser Permanente	United Healthcare
Blood pressure <140/90 mm Hg in hypertensive patients					
Average (unweighted)	57.8	59.1	57.2	68.4	50.5
Average (weighted)	57.8	61.5	61.2	78.6	53.5
High score	61.7	67.1	64.3	81.3	61.7
Low score	51.6	25.0	39.7	58.2	35.4
Beta blocker treatment after heart attack					
Ambulatory treatment					
Average (unweighted)	97.7	93.5	93.0	97.6	94.3
Average (weighted)	98.0	96.8	92.5	98.4	95.6
High score	99.0	100.0	98.3	100.0	99.1
Low score	95.8	55.3	86.1	89.7	89.0
Persistent treatment					
Average (unweighted)	69.6	66.5	67.4	83.0	66.4
Average (weighted)	70.7	70.3	70.4	85.2	69.9
High score	76.9	89.3	73.1	91.9	77.9
Low score	60.9	31.6	62.6	75.5	46.4
Management of urinary incontinence in older adults					
Discussing urinary incontinence					
Average (unweighted)	61.5	58.9	54.6	53.9	55.7
Average (weighted)	60.9	57.8	53.6	53.3	54.7
High score	66.3	70.1	59.7	55.9	68.3
Low score	51.5	45.5	52.2	50.3	49.5
Receiving urinary incontinence treatment					
Average (unweighted)	35.6	38.0	33.7	38.3	34.8
Average (weighted)	34.8	37.9	33.1	38.4	32.7
High score	41.0	44.1	39.1	42.7	41.6
Low score	29.3	29.4	30.0	33.6	28.1
Osteoporosis management in women who had a fracture					
Average (unweighted)	16.5	22.8	20.9	35.3	20.9
Average (weighted)	16.3	27.8	17.5	31.7	20.7
High score	19.8	44.2	26.3	48.4	30.5
Low score	13.9	10.6	15.0	30.4	10.3
Followup after hospitalization for mental illness					
Followup for mental illness within 7 days of discharge					
Average (unweighted)	34.0	40.3	26.6	66.8	33.7
Average (weighted)	34.7	45.5	24.9	61.0	32.0
High score	48.3	75.0	40.7	73.3	61.6
Low score	9.3	5.9	7.2	60.3	18.2

Table VIII.6b *(continued)*

Measure	Selected Firms and Affiliations				
	Aetna	BCBS Affiliates	Humana	Kaiser Permanente	United Healthcare
Followup for mental illness within 30 days of discharge					
Average (unweighted)	49.2	61.7	43.0	80.5	53.9
Average (weighted)	50.3	66.8	42.4	77.7	50.2
High score	69.0	86.0	62.0	84.3	81.3
Low score	11.6	7.4	12.1	77.2	32.7
MEDICATION USE AND MANAGEMENT					
Antidepressant medication management					
Optimal practitioner contacts for medication management					
Average (unweighted)	10.7	11.4	9.0	14.9	9.3
Average (weighted)	10.8	11.0	9.7	12.1	9.3
High score	11.8	20.0	10.3	25.6	21.1
Low score	9.2	6.2	6.9	9.4	3.5
Effective acute phase treatment					
Average (unweighted)	54.2	53.5	51.6	72.1	55.3
Average (weighted)	54.6	56.3	48.7	83.1	56.3
High score	61.2	65.8	57.8	85.9	68.6
Low score	45.0	27.9	46.4	62.8	42.8
Effective continuation phase treatment					
Average (unweighted)	47.9	37.8	36.8	57.1	43.3
Average (weighted)	48.2	38.8	35.9	63.2	43.5
High score	55.3	53.3	41.2	64.4	54.3
Low score	36.7	16.4	34.6	48.4	29.1
Anti-rheumatic drug therapy in rheumatoid arthritis					
Average (unweighted)	75.4	72.0	58.3	79.5	68.2
Average (weighted)	77.4	68.4	51.5	81.3	70.6
High score	85.5	83.9	77.6	84.1	82.3
Low score	60.8	39.7	37.0	71.4	42.1
Drugs to be avoided in the elderly					
Members given at least one drug to be avoided					
Average (unweighted)	18.7	22.9	28.2	18.7	21.4
Average (weighted)	18.2	18.9	29.2	21.2	23.4
High score	26.6	61.1	40.5	22.0	37.5
Low score	10.9	2.8	14.9	15.9	10.4
Members given at least two different drugs to be avoided					
Average (unweighted)	3.6	7.1	8.3	3.6	5.1
Average (weighted)	3.5	5.0	8.2	4.4	5.7
High score	6.2	37.9	15.3	4.7	11.4
Low score	1.3	0.2	2.6	2.7	1.1

Table VIII.6b *(continued)*

Measure	Selected Firms and Affiliations				
	Aetna	BCBS Affiliates	Humana	Kaiser Permanente	United Healthcare
Annual monitoring for patients on persistent medications					
Average (unweighted)	86.2	83.6	82.9	84.7	87.1
Average (weighted)	86.6	82.2	87.1	82.9	85.7
High score	92.5	91.3	92.5	92.6	93.1
Low score	76.1	60.5	44.5	80.7	76.2
Potentially harmful drug-disease interactions in the elderly					
Average (unweighted)	11.8	20.0	20.6	17.9	17.7
Average (weighted)	12.1	20.5	21.4	18.9	19.5
High score	13.2	62.4	24.7	23.6	26.3
Low score	9.4	5.7	14.4	15.4	9.1

Source: 2007 HEDIS Public Use File (2006 data).

Note: Weighted average results are based on November 2006 enrollment at the contract level.

Table VIII.7a. Trends in Percentage of MA Beneficiaries Receiving Selected HEDIS Measures over Time, Among All Contracts Reporting (Unweighted)

Measure	N 2005	Average, 2005	N 2006	Average, 2006	Overall Percentage Point Change From 2005 to 2006[a]
ACCESS AND PREVENTIVE CARE					
Access to ambulatory/ preventive services	181	93.2	272	92.4	-0.7
Breast cancer screening	176	70.9	199	69.9	untrendable[b]
Colorectal screening	163	53.6	190	52.8	-0.8
Glaucoma screening in older adults	166	61.2	209	61.8	0.7
MANAGEMENT OF EXISTING CONDITIONS					
Comprehensive diabetes care					
Hemoglobin A1c ("HbA1c") testing	184	87.6	269	86.3	-1.3
Eye exams	183	64.4	265	60.2	-4.2
Lipid profile	184	92.4	268	83.7	untrendable[b]
Poor control of HbA1c	171	24.8	223	31.3	6.5
LDL-C <100 mg/dL	171	49.3	223	44.7	-4.6
Cholesterol management for patients with cardiovascular conditions					
LDL-C screening	170	82.1	187	87.6	untrendable[b]
LDL-C <100 mg/dL	163	50.6	178	53.8	untrendable[b]
Blood pressure <140/90 mm Hg in hypertensive patients	159	66.3	202	56.8	untrendable[b]
Beta blocker treatment after heart attack					
Ambulatory treatment	127	92.9	149	93.3	0.4
Persistent treatment	109	64.6	132	69.6	5.0
Management of urinary incontinence in older adults					
Discussing urinary incontinence	152	55.9	167	56.9	1.1
Receiving urinary incontinence treatment	152	33.2	167	35.4	2.2
Osteoporosis management in women who had a fracture	131	20.1	156	21.7	1.5
Followup after hospitalization for mental illness					
Followup for mental illness within 7 days of discharge	109	38.5	130	36.4	-2.1
Followup for mental illness within 30 days of discharge	109	58.3	130	55.7	-2.6
MEDICATION USE AND MANAGEMENT					
Antidepressant medication management					
Optimal practitioner contacts for medication management	104	11.5	129	11.4	-0.1

Table VIII.7a *(continued)*

Measure	N 2005	Average, 2005	N 2006	Average, 2006	Overall Percentage Point Change From 2005 to 2006[a]
Effective acute phase treatment	104	53.9	131	57.8	3.9
Effective continuation phase treatment	104	40.0	131	44.6	4.6
Anti-rheumatic drug therapy in rheumatoid arthritis	118	63.5	191	68.4	4.9
Drugs to be avoided in the elderly					
Members given at least one drug to be avoided	145	23.7	268	23.1	-0.7
Members given at least two different drugs to be avoided	145	6.5	268	6.0	-0.5
Annual monitoring for patients on persistent medications	144	76.8	265	82.7	untrendable[b]

Source: 2006-2007 HEDIS Public Use Files (reflecting 2005-2006 data).

[a]Slight differences between the percentage point change reported in this column and the result when subtracting the reported 2006 average from the reported 2005 average are due to rounding error.

[b]A change in measure specification in 2006 means that the measure cannot be compared between 2005 and 2006.

Table VIII.7b. Trends in Percentage of MA Beneficiaries Receiving Selected HEDIS Measures over Time, Among Contracts that Report Measures in Both 2005 and 2006 (Unweighted)

Measure	N	Average, 2005	Average, 2006	Overall percentage point change from 2005 to 2006[a]
ACCESS AND PREVENTIVE CARE				
Access to ambulatory/ preventive services	166	93.2	93.4	0.2
Breast cancer screening	163	70.9	71.0	untrendable[b]
Colorectal screening	154	53.1	54.0	1.0
Glaucoma screening in older adults	154	61.4	62.2	0.8
MANAGEMENT OF EXISTING CONDITIONS				
Comprehensive Diabetes Care				
Hemoglobin A1c ("HbA1c") testing	170	87.9	88.5	0.5
Eye exams	168	64.7	64.9	0.2
Lipid profile	170	92.7	86.5	untrendable[b]
Poor control of HbA1c	159	24.0	24.7	0.8
LDL-C <100 mg/dL	160	49.7	48.8	-0.8
Cholesterol management for patients with cardiovascular conditions				
LDL-C screening	157	82.4	88.3	untrendable[b]
LDL-C <100 mg/dL	153	51.0	55.5	untrendable[b]
Blood pressure <140/90 mm Hg in hypertensive patients	151	66.2	57.4	untrendable[b]
Beta blocker treatment after heart attack				
Ambulatory treatment	118	93.0	94.0	1.0
Persistent treatment	101	64.9	69.1	4.2
Management of urinary incontinence in older adults				
Discussing urinary incontinence	141	55.9	57.0	1.1
Receiving urinary incontinence treatment	141	33.3	35.5	2.2
Osteoporosis management in women who had a fracture	123	20.1	22.1	2.0
Followup after hospitalization for mental illness				
Followup for mental illness within 7 days of discharge	91	38.7	38.6	-0.1
Followup for mental illness within 30 days of discharge	91	58.9	58.9	0.0
MEDICATION USE AND MANAGEMENT				
Antidepressant medication management				
Optimal practitioner contacts for medication management	98	11.5	11.1	-0.4
Effective acute phase treatment	98	53.8	57.5	3.7

Table VIII.7b *(continued)*

Measure	N	Average, 2005	Average, 2006	Overall percentage point change from 2005 to 2006[a]
Effective continuation phase treatment	98	39.8	44.2	4.3
Anti-rheumatic drug therapy in rheumatoid arthritis	112	63.4	69.1	5.6
Drugs to be avoided in the elderly				
Members given at least one drug to be avoided	135	23.7	21.8	-1.9
Members given at least two different drugs to be avoided	135	6.5	5.4	-1.1
Annual monitoring for patients on persistent medications	133	77.4	83.6	untrendable[b]

Source: 2006-2007 HEDIS Public Use Files (reflecting 2005-2006 data).

[a]Slight differences between the percentage point change reported in this column and the result when subtracting the reported 2006 average from the reported 2005 average are due to rounding error.

[b]A change in measure specification in 2006 means that the measure cannot be compared between 2005 and 2006.

Table VIII.8. CAHPS Indicators Available for 2008

CAHPS Indicator (type of result generated)	Information Provided on Beneficiary Responses
Overall rating of health care patients received	Percent rating 7 or less; 8 or 9; or 10, where 10 is the highest possible rating
Overall rating of health plan	Percent rating 7 or less; 8 or 9; or 10, where 10 is the highest possible rating
Getting care that is needed	Percent responding never; usually; or always
Getting care without long waits	Percent responding never; usually; or always
Doctors who communicate well	Percent responding never; usually; or always
Seeing a specialist	Percent responding no problem; small problem; or big problem

Source: Medicare Health Plan Compare database, 2008. Available at the Medicare Options Compare website: http://qa.medicare.gov/MPPF/Include/DataSection/Questions/Welcome.asp.

Table VIII.9. Number of Contract-Market Combinations with 2007 CAHPS Data Available[a]

		Contract-Market Combinations with Missing Data for Given Measure	
	Number of contract-market combinations for which measure is available (percent of total contract-market combinations)	Number of contract-market combinations with missing data because plan is too new	Number of contract-market combinations not required to report, or with too few members to report
All Quality Indicators	236 (40.2%)	305	46

Source: 2008 Medicare Health Plan Compare file on quality at contract-market level.

[a]Contract-market combinations in U.S. territories are excluded, as are contract-market combinations for which market areas were unavailable.

Table VIII.10. Average Contract-Market Performance on CAHPS Measures, 2007, by Contract Type and Overall (Unweighted)

Percent of Medicare Enrollees Who Reported:	HMO/POS (n=193)	1876 Cost (n=32)	All Other[a] (n=11)	Average Across All Contract Types (n=236)
Health care rating of 10 on a 10-point scale (where 10 is the highest)	46.0%	48.5%	45.1%	46.3%
Health care rating of 8 or 9 on 10-point scale	39.7%	39.8%	38.8%	39.7%
Health care rating of 7 or less on 10-point scale	14.2%	11.8%	16.2%	14.0%
Health plan rating of 10 or more on a 10-point scale	39.0%	43.7%	43.1%	39.8%
Health plan rating of 8 or 9 on 10-point scale	38.8%	38.4%	38.2%	38.7%
Health plan rating of 7 or less on 10-point scale	22.1%	18.1%	18.9%	21.4%
Always getting needed care	86.1%	89.4%	85.1%	86.5%
Usually getting needed care	9.2%	7.6%	10.5%	9.0%
Never getting needed care	4.7%	3.0%	4.6%	4.5%
Always getting care without long waits	57.6%	61.3%	52.8%	57.9%
Usually getting care without long waits	25.8%	26.4%	28.8%	26.0%
Never getting care without long waits	16.6%	12.4%	18.2%	16.1%
Doctors who always communicate well	68.8%	70.5%	67.5%	68.9%
Doctors who usually communicate well	24.5%	24.8%	25.3%	24.6%
Doctors who never communicate well	6.7%	4.7%	7.1%	6.4%
No problem seeing a specialist	82.2%	85.8%	78.8%	82.5%
Small problem seeing a specialist	11.2%	9.6%	13.6%	11.1%
Big problem seeing a specialist	6.6%	4.7%	7.3%	6.4%

Source: 2008 Medicare Health Plan Compare files at contract-market level.

[a]This category includes 6 demonstration, 3 local PPO, and 2 PSO contract-market combinations.

Table VIII.11. Average Contract-Market Performance on CAHPS Measures, 2007, by Contract Type and Overall (Weighted)

Percent of Medicare Enrollees Who Reported:	HMO/POS[a]	1876 Cost[b]	All Other[c]	Average Across All Contract Types
Health care rating of 10 on 10-point scale (where 10 is the highest)	45.5%	48.5%	43.2%	45.5%
Health care rating of 8 or 9 on 10-point scale	40.2%	40.5%	38.6%	40.1%
Health care rating of 7 or less on 10-point scale	14.3%	11.0%	18.3%	14.3%
Health plan rating of 10 on 10-point scale	39.5%	43.6%	43.9%	40.0%
Health plan rating of 8 or 9 on 10-point scale	39.2%	39.2%	37.4%	39.1%
Health plan rating of 7 or less on 10-point scale	21.3%	17.5%	18.9%	21.0%
Always getting needed care	86.1%	89.9%	82.3%	86.1%
Usually getting needed care	9.3%	7.3%	12.2%	9.3%
Never getting needed care	4.5%	2.9%	5.9%	4.5%
Always getting care without long waits	57.0%	61.4%	50.6%	57.0%
Usually getting care without long waits	26.1%	26.2%	28.5%	26.3%
Never getting care without long waits	16.9%	12.2%	20.8%	16.8%
Doctors who always communicate well	68.3%	70.8%	65.7%	68.3%
Doctors who usually communicate well	24.8%	24.3%	26.1%	24.8%
Doctors who never communicate well	6.8%	4.9%	8.2%	6.7%
No problem seeing a specialist	81.8%	85.9%	76.3%	81.8%
Small problem seeing a specialist	11.6%	9.3%	14.6%	11.6%
Big problem seeing a specialist	6.6%	4.9%	9.0%	6.6%

Source: 2008 Medicare Health Plan Compare files at contract-market level.

[a]Contract-market combinations in this category represent 4,791,683 beneficiaries.

[b]Contract-market combinations included in this category represent 324,207 beneficiaries.

[c]Contract-market combinations in this category represent 218,474 beneficiaries.

Table VIII.12. Average Contract-Market Performance on CAHPS Measures, 2007, by Firms or Affiliations

Measure	Selected Firms and Affiliations				
	Aetna	BCBS Affiliates[a]	Humana	Kaiser Permanente	United Healthcare
Percent rating health care 10 on a 10-point scale (where 10 is the highest)					
Average (unweighted)	41.5%	48.1%	44.0%	42.9%	45.6%
Average (weighted)	42.0%	48.8%	43.1%	42.5%	43.9%
High score	47.0%	58.0%	55.0%	49.0%	59.0%
Low score	37.0%	33.0%	32.0%	37.0%	34.0%
Percent rating health care 8 or 9 on a 10-point scale					
Average (unweighted)	41.8%	39.8%	38.1%	43.2%	39.7%
Average (weighted)	41.8%	39.0%	38.1%	43.8%	41.0%
High score	43.0%	46.0%	46.0%	49.0%	48.0%
Low score	39.0%	30.0%	30.0%	36.0%	31.0%
Percent rating health care 7 or less on 10-point scale					
Average (unweighted)	16.5%	12.0%	17.8%	13.9%	14.7%
Average (weighted)	15.9%	12.2%	18.7%	13.6%	15.1%
High score	20.0%	21.0%	25.0%	19.0%	30.0%
Low score	10.0%	7.0%	11.0%	10.0%	7.0%
Percent rating health plan 10 on a 10-point scale					
Average (unweighted)	33.0%	35.0%	42.5%	42.8%	37.2%
Average (weighted)	33.9%	35.7%	43.5%	42.1%	36.9%
High score	41.0%	48.0%	55.0%	50.0%	64.0%
Low score	26.0%	24.0%	31.0%	34.0%	27.0%
Percent rating health plan 8 or 9 on a 10-point scale					
Average (unweighted)	39.5%	40.3%	34.2%	40.0%	38.7%
Average (weighted)	39.0%	39.9%	33.1%	40.9%	40.3%
High score	43.0%	46.0%	42.0%	46.0%	49.0%
Low score	38.0%	33.0%	27.0%	33.0%	26.0%
Percent rating health plan 7 or less on 10-point scale					
Average (unweighted)	27.5%	24.7%	23.3%	17.2%	24.1%
Average (weighted)	27.3%	24.4%	23.3%	17.1%	22.9%
High score	31.0%	37.0%	30.0%	24.0%	40.0%
Low score	22.0%	16.0%	16.0%	13.0%	5.0%
Percent always getting needed care					
Average (unweighted)	86.0%	88.6%	83.5%	87.1%	85.2%
Average (weighted)	86.5%	88.6%	82.4%	86.9%	84.6%
High score	91.0%	93.0%	90.0%	90.0%	94.0%
Low score	83.0%	76.0%	78.0%	85.0%	75.0%
Percent usually getting needed care					
Average (unweighted)	9.8%	7.8%	10.4%	9.4%	9.8%
Average (weighted)	9.4%	7.7%	11.1%	9.6%	10.3%
High score	12.0%	14.0%	14.0%	11.0%	16.0%
Low score	6.0%	4.0%	6.0%	7.0%	3.0%

Table VIII.12 *(continued)*

Measure	Selected Firms and Affiliations				
	Aetna	BCBS Affiliates[a]	Humana	Kaiser Permanente	United Healthcare
Percent never getting needed care					
Average (unweighted)	4.0%	3.7%	6.4%	3.4%	4.9%
Average (weighted)	3.9%	3.8%	6.8%	3.5%	5.0%
High score	6.0%	11.0%	9.0%	6.0%	12.0%
Low score	3.0%	2.0%	3.0%	2.0%	2.0%
Percent always getting care without long waits					
Average (unweighted)	55.5%	60.4%	54.3%	55.6%	57.2%
Average (weighted)	55.7%	60.4%	52.6%	54.9%	56.3%
High score	58.0%	67.0%	64.0%	63.0%	68.0%
Low score	51.0%	43.0%	46.0%	44.0%	44.0%
Percent usually getting care without long waits					
Average (unweighted)	26.8%	24.8%	25.7%	29.9%	25.5%
Average (weighted)	27.1%	24.1%	25.4%	30.2%	26.0%
High score	28.0%	31.0%	31.0%	39.0%	32.0%
Low score	25.0%	19.0%	22.0%	24.0%	21.0%
Percent never getting care without long waits					
Average (unweighted)	17.8%	14.8%	20.0%	14.5%	17.3%
Average (weighted)	17.4%	15.5%	22.1%	14.9%	17.8%
High score	21.0%	27.0%	27.0%	20.0%	31.0%
Low score	15.0%	9.0%	11.0%	9.0%	7.0%
Percent whose doctors always communicate well					
Average (unweighted)	66.5%	70.0%	65.4%	68.4%	68.7%
Average (weighted)	66.7%	70.3%	64.2%	67.7%	67.9%
High score	71.0%	75.0%	72.0%	74.0%	75.0%
Low score	61.0%	62.0%	59.0%	60.0%	59.0%
Percent whose doctors usually communicate well					
Average (unweighted)	26.5%	24.3%	25.5%	25.7%	24.3%
Average (weighted)	26.4%	23.6%	25.8%	26.5%	24.7%
High score	31.0%	29.0%	30.0%	31.0%	30.0%
Low score	23.0%	18.0%	21.0%	19.0%	20.0%
Percent whose doctors never communicate well					
Average (unweighted)	6.8%	5.7%	9.0%	5.7%	7.1%
Average (weighted)	6.6%	6.0%	9.9%	5.5%	7.4%
High score	8.0%	11.0%	14.0%	8.0%	14.0%
Low score	5.0%	2.0%	5.0%	3.0%	0.0%
Percent reporting no problem seeing a specialist					
Average (unweighted)	83.3%	84.1%	78.2%	82.1%	81.7%
Average (weighted)	83.6%	83.7%	76.7%	81.6%	80.8%
High score	86.0%	90.0%	89.0%	88.0%	94.0%
Low score	78.0%	69.0%	70.0%	76.0%	63.0%

Table VIII.12 *(continued)*

Measure	Selected Firms and Affiliations				
	Aetna	BCBS Affiliates[a]	Humana	Kaiser Permanente	United Healthcare
Percent reporting small problem seeing a specialist					
Average (unweighted)	12.0%	10.3%	12.6%	12.6%	11.3%
Average (weighted)	11.8%	10.1%	13.3%	13.1%	12.0%
High score	14.0%	18.0%	20.0%	18.0%	20.0%
Low score	9.0%	6.0%	7.0%	7.0%	2.0%
Percent reporting big problem seeing a specialist					
Average (unweighted)	14.8%	5.6%	9.4%	5.3%	7.0%
Average (weighted)	4.6%	6.2%	10.2%	5.3%	7.1%
High score	8.0%	15.0%	12.0%	9.0%	20.0%
Low score	1.0%	2.0%	4.0%	3.0%	2.0%

Source: 2008 Medicare Health Plan Compare files at contract-market level.

[a]This category includes WellPoint, Inc. contract-market combinations, which are BCBS affiliates.

Table VIII.13. Quality and Patient Experience Measures Available as Five-Star Rating on CMS Options Compare

Measure	Data Source
HELPING YOU STAY HEALTHY	
Breast cancer screening	HEDIS
Colorectal cancer screening	HEDIS
Cardiovascular care – cholesterol screening	HEDIS
Diabetes care – cholesterol screening	HEDIS
Glaucoma testing	HEDIS
Appropriate monitoring of patients taking long-term medications	HEDIS
Annual flu vaccine	CAHPS
Pneumonia vaccine	CAHPS
GETTING CARE FROM YOUR DOCTORS AND SPECIALISTS	
Access to primary care doctor visits	HEDIS
Getting needed care without delays	CAHPS
Doctor followup for depression	HEDIS
Followup visit after hospital stay for mental illness (within 30 days of discharge)	HEDIS
MANAGING CHRONIC CONDITIONS	
Osteoporosis management	HEDIS
Diabetes care – eye exam	HEDIS
Diabetes care – kidney disease monitoring	HEDIS
Diabetes care – blood sugar controlled	HEDIS
Diabetes care – cholesterol controlled	HEDIS
Antidepressant medication management (6 months)	HEDIS
Controlling blood pressure	HEDIS
Rheumatoid arthritis management	HEDIS
Testing to confirm chronic obstructive pulmonary disease	HEDIS
Continuous beta blocker treatment	HEDIS
GETTING TIMELY INFORMATION AND CARE FROM YOUR HEALTH PLAN	
Doctors who communicate well	CAHPS
Getting appointments and care quickly	CAHPS
Overall rating of health care quality	CAHPS
Overall rating of health plan	CAHPS
Call answer timeliness	HEDIS

Table VIII.13 *(continued)*

Measure	Data Source
YOUR RIGHTS TO APPEAL	
Plan makes timely decisions about appeals	Third-party Independent Review Entity
Reviewing appeals decisions	Third-party Independent Review Entity
Measures relevant to PDPs or Plans with drug benefit only	
DRUG PLAN CUSTOMER SERVICE	
Time on hold when customer calls drug plan	Call center surveillance data collected by CMS
Calls disconnected when customer calls drug plan	Call center surveillance data collected by CMS
Time on hold when pharmacist calls drug plan	Call center surveillance data collected by CMS
Calls disconnected when pharmacist calls drug plan	Call center surveillance data collected by CMS
Complaints about the drug plan	Medicare's Complaint Tracking Module
How helpful is your plan when you need information	CAHPS
Rating of drug plan	CAHPS
Using Your Plan to Get Your Prescriptions Filled	
Getting prescriptions easily	CAHPS
Pharmacists having up-to-date plan enrollment information	Medicare's Management Information Integrated Repository
Pharmacists have up-to-date information on plan members who need extra help	Medicare enrollment records
Complaints about the plan's benefits and access to prescription drugs	Medicare's Complaints Tracking Module
Complaints about joining and leaving the plan	Medicare's Complaints Tracking Module
Delays in appeals decisions	Third party Independent Review Entity
Reviewing appeals decisions	Third party Independent Review Entity
Drug Pricing Information	
Availability of drug coverage and cost information	Medicare Prescription Drug Plan Finder
How often the plan's drug prices change	Medicare Prescription Drug Plan Finder
Complains about the plan's pricing and out-of-pocket costs	Medicare Complaints Tracking Module

Source: The Medicare Options Compare website. Available at: http://qa.medicare.gov/MPPF/Include/DataSection/Questions/Welcome.asp.

IX. INSIGHTS FROM FIRM DISCUSSIONS

A. INTRODUCTION

Our discussions with insurance firms and other organizations that contract with CMS to sponsor MA plans have provided insight into the dynamics behind some of the trends and processes discussed in the previous chapters. They also provided valuable insight into some topics addressed poorly by current public data—such as the emergence of the group market, and what this means. ASPE included the discussions as part of this project because they viewed such insights on the market valuable in providing them with institutional insight on the way MA firms view that market that could be useful to them in addressing the policy issues under consideration in MA.

The discussions took place between mid-February and early May 2008, and generally lasted between 45 minutes and one hour. At each firm, we spoke with the senior executives responsible for the MA product and product decisions. Typically, these were administrative executives, not clinical personnel responsible for oversight of the content and quality of care purchased under MA. The firms were assured that their comments would not be attributed to them and would remain confidential. The discussions with firms fell into three types, each of which provided a somewhat different perspective on the market.[1]

First, we talked to *seven MA sponsors that have large or growing enrollments nationwide, or in multiple markets.* Because these firms enroll a disproportionate share of MA enrollment (the firms we talked with had over 3 million MA enrollees as of March 2008, or about a third of the total), they can provide the most representative information on the overall dynamics of MA and prevalent industry concerns. We supplemented what we learned from these discussions with reviews of presentations that Citi and Lehman gave to Wall Street analysts. Through this we were able to learn a little more both about large publicly traded MA sponsors we talked with and those we did not.

Second, we talked with *six large but locally based MA sponsors*-- four from the traditional prepaid group practice sector (although they may be more diversified at this point), and two that were locally based affiliates of the Blue Cross and Blue Shield Association. These six have a combined enrollment of over half a million. These discussions allowed more probing of the dynamics of and concerns about sectors of the market, and provided insight into issues arising in particular markets that may shed light on or complement more general concerns.

Third, we talked with *six more specialized organizations with diverse perspectives on MA.* Two are employers that directly contract with Medicare to sponsor Medicare related plans versus doing so indirectly through firms already contracting with Medicare to offer such products in the marketplace[2]; one offers a PDP and the other a PFFS plan. The other four include: two MA

[1] For additional detail on the methods used for this part of the project and the way firms were chosen, see Appendix A.

[2] CMS's Summary Monthly Report refers to such plans as "employer direct".

sponsors that specialize in dual eligibles and public sector plans, a new MA sponsor a market with extensive rural areas and limited prior MA history, and an organization that co-brands coordinated care plans offered by a national MA firm. These organizations typically have small and specialized enrollments or play unique roles, so they provided fewer insights on overall market dynamics but they allowed us to take a focused look at particular areas of interest.

In this chapter, we summarize what we have learned from the discussions, organizing the contents to best convey the major insights gained. Our discussion reviews the following topics:

- Firms' overall approaches to the MA market—its importance to them, and what we learned that adds to previous insights about the commonalities and diversities in their reasons for interest in MA, as well as the way they structure their products.
- Emergence of the Group Market—the reasons for this, how group contracts are manifested, the pervasiveness of the growing interest in this market, and its implications.
- Potential Future Viability of Regional PPOs—why they have not been more attractive to firms and what, if anything, might make them more viable in the future.
- Rationale for Growth of PFFS and Potential Alternatives—their continued popularity among firms and their growing share of the market, how firms react to legislative uncertainty, and their view of coordinated care plans as an alternative to PFFS, particularly in rural areas.
- Status of the Local Coordinated Care Sector—how firms view these products, what they see as the market dynamics, and the implications of this for future growth within the sector.
- Special Needs Plans—where they fit within firms' strategies and the coordinated care sector.
- CMS Oversight—what we have learned about firms' perceptions in this area and what they view as the issues with MA administration.
- The Broader Policy Environment—the effect of legislative uncertainty on the market, the issues firms view as most significant at this time, and the firms' long-term commitments to Medicare.

Below, we describe in general terms what firms told us on each of these topics. There are two reasons for this. First, firms in the industry are relatively distinct, as are markets. Because we guaranteed confidentiality, we sought to summarize firms' perspectives in ways that made the identity of our informants less obvious. Second, we perceive that the value in what we learned goes beyond specific comments. In many cases, insight came both from what firms' executives said and did not say or conveyed only implicitly. We used our knowledge of the industry to assist us in drawing inferences from the discussions. We show the information base upon which they are drawn by using quotations or examples as frequently as possible.

B. FIRMS' OVERALL APPROACHES TO THE MARKET

1. Review of Insights from 2006 Discussions

The discussions we earlier conducted in 2006 soon after the MMA became effective revealed that three strong national forces encouraged firms to seriously consider pursuing MA aggressively: (1) the entire Medicare program was in transition, particularly because of the introduction of Part D; (2) MMA introduced more favorable payment rates; and (3) the aging of the U.S. population has made senior products demographically attractive to firms (Gold et al. 2006).

Because of the extensive changes taking place in 2006, firms' actions were constrained by resources, particularly since most firms also were establishing PDPs, which had very large start-up costs. In deciding how to position themselves in MA, firms handled 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 business niche
- Targeted "low-hanging fruit"
- Favored strategies consistent with their perceived market strength
- Sought expansions that reflected their base business in and out of Medicare
- Tailored the level of business risk they wished to assume
- Responded to market preferences
- Began their positioning by 2005, at the latest

Some firms were responding to new opportunities, whereas others were motivated more by the threats to their existing book of business. Traditional HMO-model firms were particularly likely to fall into the latter category. These findings are described in more detail in Gold et al 2006.

While our 2008 discussions did not revisit this set of issues, they reinforced the continuing relevance of taking a broad perspective on the way firms have responded to the MMA, and the types of considerations they are applying to their decision making. Since 2006, firms seem to have intensified their focus on MA and have taken advantage of the additional time to expand offerings. Their decision making, however, continues to reflect a response to the general influences of the marketplace, using strategies that capitalize on a firm's unique strengths and positions in the market.

2. Insights into the Overall MA Market in 2008

Institutionalization of MA. By 2008, firms appeared to have institutionalized their responses to the MMA into the ongoing planning and execution of their organization. In our discussions, firms' executives talked less about making fundamental decisions regarding strategy

than about strategy execution and refinement in response both to changes in the marketplace and the political environment. Such decisions frequently involved a multi-year time horizon. For example, one firm said that it made the most extensive changes (new types of products, offerings) on a biannual basis, using the second year to consolidate such changes and provide stability.

While few if any of the firms found the annual calendar cycle of MA attractive, many showed by their comments an appreciation for its reality. As one said, "There are only so many days in the year." Another representative explained, "Contracting is a year-round event. We settle on the geographical areas that we want to target in December for the March application….The next three months, we focus on getting everything priced for June, and then we work on the marketing plan, so come June 15th we can submit everything to CMS for review." We print out materials by mid- to late August, so independent agents are ready [to market] on October 1st." The firm noted that in planning, such as for investments in network development, they are always operating at least 18-24 months out, but in reality, they use a three-year horizon. By fall 2008, for example, they will be discussing 2011. Because MA has been institutionalized in this way, firms likely will respond to legislative changes in MA with a lag consistent with the way they plan and roll out MA products, as also occurred with the lagged reaction to the changes in MA (then termed Medicare+Choice) under the Balanced Budget Act of 1997.

Intensity of Competition and Breadth of Products. Firms saw the MA market as highly competitive in 2008, both from a price perspective and because of the large number of plans and products being offered in most markets. One large firm explained that there were many new players and new (geographic) markets; this made the issue of how to make enrollees aware of their own products more challenging. Firms sought ways to differentiate both themselves and their products. One noted the "explosion in products and price points," with fairly aggressive marketing and sales by competitors in almost every market. A local plan observed that their market historically had been very stable, with only two major HMO players. In 2005, three organizations in that market were involved in MA, with only five plan offerings. By 2007, there were 17 organizations with 100 plans and, by 2008, this grew to 23 organizations and 100 plans. From this firm's point of view, the MA market had become much less concentrated. Our quantitative analysis reinforces these observations.

To a large extent, the competition described in many discussions was predominantly among HMOs and PFFS plans, although firms also said the sheer growth in the total number of plans made differentiating products more challenging. Some said that the growth of PFFS in particular was making price competition more salient, and this seemed especially true for "zero premium" offerings. Firms with a long history in the market saw adding new plans as a way to better position themselves to attract each of the different segments of consumers, whether or not they seek more "skinny" or "comprehensive" products. Whether firms characterized their plan in either category was in some ways relative—a company with a history of relatively comprehensive benefits might describe an MA plan without a drug benefit as "skinny" regardless of the cost sharing limits elsewhere in the benefit package. These considerations explain the probably unanticipated explosion in MA plans since the MMA was enacted.

Influence of Competition. Our discussions provided insights on how competition in the marketplace, at least under current MA rules, may influence the choices made available to

beneficiaries. In the short term, some firms said that competitive pressures were restraining them from raising premiums or adding cost sharing to their benefits. Pressure to maintain a zero premium appeared particularly strong; firms viewed this as critical to attracting and retaining large segments of their enrollment in many markets. Firms that had been conservative in budgeting their design of benefit plans in 2006 noted they maintained or expanded their benefits in subsequent years, a fact we interpret to mean that an originally conservative position limited financial risk but also enrollment gains. Firms noted both efforts to maintain benefits both for stability and to stay competitive, but also said that over time there was more cost sharing, often in ways less visible to those considering enrollment. These reports appear consistent with our quantitative analyses.

Firm decisions currently are taking place in a context in which MA payments are relatively high (MedPAC 2008a). Since 2006, the main issue for firms has been how to accommodate the fact that annual updates to the MA benchmarks used to establish payment are lower than in the recent past. Higher payments provide firms with more flexibility to address competitive concerns. If policymakers want to understand what firms are likely to do in the future, they also need to understand the way financial considerations influence firm decision making. For business reasons, firms typically aim to make a profit, or at least break even. If revenue (capitation, supplementary beneficiary premiums, point-of-service cost sharing) falls short of cost trends, firms need to respond, and such responses typically are market-by-market, although they may be influenced by an overall firm strategy. As was observed in 2006 and reinforced through this year's discussions, each year firms review rates on a county-by-county basis against projected costs. They identify whether the coming year's rates support the plans currently offered, what shortfalls may exist, and what opportunities to enhance benefits may be provided. Simultaneously, they review the marketplace and try to anticipate what the competition will do. While MA rates may exceed the traditional program's costs, firms still view the MA market as one in which increases in capitation, on a year-to-year basis, fall short, compared to trends in medical costs. If a firm decides it needs to achieve a certain percentage in savings[3], it may do so directly by reducing the value of the MA benefit in ways perceived to harm it least in the marketplace. To enhance its competitiveness, it may negotiate internally across departments to achieve operational savings (e.g., marketing costs) that will lessen the need for such reductions. Such negotiations probably are the sources of efficiency intended by competition. However their role in firm decision-making on how they structure plans appears subordinate to the basic financial calculations and response.

Some local firms believe that national firms have advantages in responding to cost pressure in the marketplace, because they can cross-subsidize across markets or product lines, despite the CMS regulations designed to limit such behavior via the bidding process. Many firms told us that "others" were taking advantage of MA rate-setting processes to "arbitrage" among counties based on the difference between rates and costs both for general enrollment MA plans and for SNPs, particularly those dealing with duals. However, each firm ascribed such behavior to

[3] Such "savings" needs come about if a firm estimates that its costs for the Medicare benefit will exceed the MA benchmark (which would mean an additional premium for beneficiaries) or, if lower, be higher than the firm feels it can absorb to offer the current premium and benefit structure of a plan.

"others" rather than themselves, and we have no way of validating or disputing such concerns from the information available publicly from CMS.[4]

Because "branding" is important, some firms see other characteristics as providing them with advantages in the marketplace. Long-established local plans that have remained in the market through the contractions under Medicare+Choice say that beneficiaries remember their long-term presence, and will take that into account in their decision making. Plans with a strong local provider base say that this base helps them in both provider contracting and enrollee recruitment/retention. According to one new entrant, this was one of the factors that helped it to introduce an HMO into a market with limited prior MA penetration overall. The "Blues" brand is viewed as powerful in the marketplace, both locally and nationally.

Market Segmentation is Central to the Competitive Process. Regardless of their type, all of the firms described market segmentation as critical to their business planning and operations. Firms see beneficiaries (and employer groups) as reflecting subgroups whose interests in MA differ. For example, one local firm defined five major segments for its market: (1) groups, including national groups with an interest in one-stop shopping, and unions who want flexibility on the timing for their decision making; (2) municipalities concerned about new accounting rules (i.e., Governmental Accounting Standards Board [GASB]), and how that affects their liability; (3) counties; (4) core MSA, versus outlying rural areas where it has established networks; and (5) a unique demonstration.

While firms may express their own preferences among products, for the most part they appear to view their business interests as furthered by defining and meeting the needs and interests of customers from a customer perspective, rather than changing customers' preferences. Segmenting the market allows the firms to define differences in their customer base and the products these customers seek, set priorities across segments, identify which segments and products they are best positioned to provide, and develop specific marketing plans for each segment that reflect the characteristics of that group.

Firms differ in the priorities they set across segments of the MA market. For example, we heard about big differences, even among national firms, in their focus on the group market. While a number of local firms said their group focus was not on large national employers, some were considering how to leverage their products to attract this business segment. Some firms were more focused than others on primarily reaching lower-income beneficiaries, as opposed to different segments of beneficiaries with diverse product interests. To a large extent, the variation reflects differences in the role groups play in their commercial products, with group MA more relevant to those already in the group market in their commercial business.

Firms varied in how comprehensive they sought to be in developing products that spanned the full spectrum of MA segments, and how far their interests ranged beyond MA to other senior products. In their decision making, firms seemed to go beyond MA to include PDPs, and some were focused on a much broader spectrum of senior products. Firms' breadth of interest reflected

[4] CMS has some relevant information on these issues from the plan bids and risk data submitted, although data quality and interpretation remains a lingering issue. For proprietary and perhaps other reasons, the latter are not made public. MedPAC, however, has done some analysis of these (MedPAC 2008a).

both differences in available resources, as well as differences in how they were positioning themselves in the insurance market overall. For example, a large firm with its origins in large employer accounts put more emphasis on PPOs and less on SNPs that involved collaboration with Medicaid. Another, whose marketing focus was based around "portfolios" of products and different "platforms," prided itself on having products that responded to each segment of the market. Broader business considerations also factored into decision making. For example, one firm said it did not offer SNPs or HMOs because a subsidiary with which it had a long-time relationship offered such products.

In general, most firms seemed to convey implicitly the sense that their success would be enhanced by their ability to serve more market segments rather than fewer. For this reason, an aggressive, relatively new MA competitor whose business model emphasized the HMO model and attracting lower income beneficiaries still decided to offer at least a few PFFS plans with limited enrollment, even though it perceived that the economics of this model would make it difficult to achieve a favorable medical loss ratio. Similarly, a firm might offer an MSA now, not expecting major enrollment immediately, but with an eye toward the potential of the baby boom market, and an advantage in being a "first entrant." In some cases, firms viewed it as an advantage to be the first to enter a market with a given product; but we also heard from firms of cases where later entry might be regarded as more desirable because such later entry allowed them to draw on the knowledge building work of others.

In 2006 and the early years of MA, firms also were unsure about how the market would evolve, so they were motivated to offer a more extensive set of products early on. Some firms said their decision to offer a PDP reflected such uncertainty and experimentation. A number (generally with smaller PDP enrollment) now said they were offering but not actively marketing the PDP currently, and were using it mainly to serve auto-assigned enrollees. We did not have time to explore the reasons for this but speculate that such offerings provide a way to add revenue with little additional administrative expense, particularly if the firm has to develop a Part D offering for its MA products.[5]

We did not hear from many firms that they explicitly were focusing on trying to "migrate" enrollees from one product to another, a strategy Humana described in 2006 as its rationale for broad-based enrollment in PFFS. In general, most firms told us that, from the point of view of care management, they preferred MA over PDP, and more managed MA products to PFFS. However, despite this preference, they tried not to encourage movement across products, both because they were concerned with the ethical issues (bait-and-switch, marketing abuse), and also because they did not view migration as a very effective marketing technique, given the variety of beneficiaries with different (and set) preferences for products. When firms introduced new kinds

[5] At least one firm, however, specifically targeted dual eligibles for their PDPs, most of whom voluntarily enrolled. The firm said it perceived difficulty in develop products with a price point and formulary attractive to both markets given the low income subsidy benchmarks. We are uncertain whether the firm is saying that prior Medicaid formularies were less comprehensive (a point some would dispute) or that higher income beneficiaries can afford higher premiums and so plans could be attractive to them if they offered a comprehensive formulary even if that plan was not very efficient (e.g., in its negotiations with pharmacy) and was priced higher than the low income threshold.

of products, they generally were seeking to gain new enrollees or, in some cases, keep enrollees who otherwise might leave for competitors. At least in terms of short-term enrollment, firms varied in their success with such new introductions.

Additional details are provided later in this chapter to the way such considerations translate into firms' interest in specific types of MA products.

The Delayed Effect of the Removal of the "50/50 Rule." Until 1997, private plans in Medicare were required to have a base of half of their enrollment in the commercial sector.[6] The concept was that such diversity would serve as an additional protection for quality, because commercial enrollees and the groups to which they belonged were less vulnerable and better organized to protest against poor care. In practice, it meant that firms needed to have a commercial base of enrollment in order to participate in Medicare. Relatively little attention has focused on the effects of removing this rule, probably because its immediate effect was negligible, given that MA was shrinking rather than expanding over the period in which it took effect. In 2008, however, we talked with a few firms—some national in focus—for which Medicare was a central focus for their business development and revenue. They entered the Medicare market with new contracts, by acquiring companies with existing products, or expanding on a pre-existing but very small base. With the 50/50 rule still in place, some of these firms would not have been able to enter the market. Whether such entry is a net opportunity or risk for the Medicare program and its beneficiaries cannot be assessed from the public data now available.[7]

C. GROWING INTEREST IN THE GROUP MARKET

1. What Appears to be Occurring

We heard from many firms that MA enrollment from groups was of growing interest, although the level of interest appears to differ across the country. Historically, group enrollment always has had a role in MA as a means to minimize disruption for new retirees who historically have been enrolled in HMOs. Many of these plans are built around delivery systems or providers that are strongly integrated into their coverage; MA (and its predecessors) provided a way both to avoid disrupting these relationships and also offer Medicare beneficiaries the kinds of choices prevalent in the market. The difference now is that (1) the arrangements newly being considered tend to involve "total replacement products," or offerings with strong financial incentives for retirees to select an MA plan, versus the traditional employer that supplemented ("wrapped around") Medicare benefits for this subgroup; and (2) they tend to be built around a PFFS model.

Box IX-1 provides examples of what we learned about from our discussions. In each case, the purchaser (employer or union), not the MA firm, decides how premiums and benefits will change, if at all. MA firms submit to CMS for approval a "generic" MA plan that covers

[6] The Balanced Budget Act of 1997 included a provision eliminating this requirement effective 1999. The Act also granted CMS authority to waive the requirement earlier (i.e. in 1998).

[7] In future years, CAHPS, HEDIS, and other indicators will be able to shed light on this question, but not all such indicators are all required for each plan type. PFFS in particular is not required to report HEDIS indicators.

Box IX.1. Examples of Recent Group Conversions among Public Employers

Group A. Previously offered a commercial coordination of benefit product that wrapped around Medicare A/B. Shifted to an MA PFFS product from the same commercial firm; retirees opting out lost the group subsidy. Part D was provided separately by the firm in year one so that they could continue to receive the subsidy authorized by the MMA. Such coverage was integrated the next year. This was and remains a comprehensive plan with no premiums and comprehensive benefits. MA sponsor offers case/disease management with potential to generate savings. The change-over resulted in a one-time shift of more than 100,000 members.

Group B. Shifted retirees from the existing traditional wraparound plan they contracted for to a PFFS plan with a different company. Actuarial value of benefits said to be maintained, but there was a shift in structure, with copayments increasing and premiums decreasing.

Group C. Shift from traditional wraparound plan to a series of MA options. The default is a PFFS plan with benefits and premiums identical to the previous plan. Beneficiaries choosing other MA plans can do so, but receive less comprehensive benefits, and must make an affirmative choice.

Medicare Part A and B benefits, and possibly other benefits, if they can be covered for the basic Medicare contribution. The MA firm then negotiates with each firm about what additional benefits to offer, and at what price, if any, to the retiree. Retirees who want to use the group's supplement select from among the plans offered. Firms say that subsidies range from nothing (group offering, but no subsidy on premium except through what Medicare provides) to complete (zero premium for the entire plan).

Firms say that some group purchasers (former employers or unions) may be dropping the retiree benefit entirely, although they may facilitate access to individual MA plans. In this case, certain MA plans might be promoted to retirees, but these would be identical to those that could be bought on the open market for the same premium, and the retiree would pay the full premium. CMS statistics would "count" these retirees as individual, rather than group enrollees. Such accounting complicates the analysis of the group and individual markets for MA. CMS is testing the feasibility of collecting data from groups about their MA offerings; if successful, such information might help fill in these knowledge gaps.

Group purchasers typically have open enrollment periods and limit opportunities to switch plans outside these periods. However, the time periods for such elections vary. While January is the most popular month for open enrollment (and coincides with the individual MA period), others permit a switch in June or other times, and some have contracts that extend for longer than a year. CMS historically has applied only limited distinctions between group and individual enrollments in its monthly reporting. If we are in a period of transition for group accounts, the MA data on enrollment trends in aggregate could be difficult to interpret, as we show in Appendix B-2 in analyzing monthly enrollment changes.

2. Factors Promoting and Inhibiting Growth of the Group Market

Firms described several main reasons for the growing interest in the MA product by group purchasers.

- ***Cost and Accounting Pressures.*** The first, and most extensively discussed reason, involves cost considerations and the pressure that firms perceive resulting from rising health care costs in an environment where Financial Accounting Standards Board (FASB)/GASB standards are requiring firms to account for such costs on a prospective basis (Dakdduk 1991; McNichol 2008). Pressure on public employers appear particularly acute, because GASB only went into effect in Fiscal Years 2007-2008 whereas FASB requirements have been in place since Fiscal Year 1992. In this environment, the capitated form of MA accomplishes two objectives. First, according to MA discussants, it allows accounting with more financial predictability. For example, a firm might specify obligations at the current spending level (e.g., $1,500 per year) with or without an allowance for inflation, as a way of defining obligations into the future.

  Second, MA has the potential to allow employers to reduce their current outlays for Medicare-eligible retirees by increasing the Medicare revenue applied to the benefit (although firms did not volunteer this point and noted instead the way savings were used to maintain coverage). The potential savings come because MA payments are higher than Medicare pays under the traditional program, assuming equal risk. Groups thus benefit from the ability to apply savings from Medicare A and B to offset the costs of supplemental coverage. MA firms say that groups typically do not see it this way; they view MA more as an alternative that lets them avoid dropping retiree coverage entirely. In the examples provided to us, some firms replaced their entire retiree benefit for Medicare beneficiaries, and others used an MA-only product to cover Medicare Part A and B and the supplemental benefits and reduced cost sharing the employer provided. The latter kept their existing prescription drug coverage (and thus the Part D subsidy they are authorized to get under the MMA). In both cases, employers' future obligations could be capped by the assumptions, with retirees' premiums increased (or benefits reduced) if inflation exceeds whatever estimate is used. In 2008, most employers can make the switch while maintaining current benefit levels, and choose whether they or their retirees garner any savings if Medicare capitation is higher than what traditional Medicare previously paid to offset employer obligations.

- ***The Ease of Administration and the Attraction of Integration.*** Before the advent of Part D, those employers offering retiree health benefits typically did so by wrapping supplemental benefits around the basic Medicare product. In pursuit of an MA product, MA firms we talked with said that employers could achieve greater integration for their enrollees, and so reduce beneficiary confusion over claims payment across primary and secondary payers. MA firms said that groups also got the benefit of the MA firm's care management. The MA firms said that employers viewed a separate Part D benefit in Medicare as providing a third source of complexity for them in funding retiree health benefits. Those using a total replacement product via MA (Part C) gained the ability to integrate Medicare Part A, B and D. Historically, the use of MA typically was unattractive to employers, because the network-based offerings in the program did not span the country and all locations where retirees reside. The growth of PFFS, however, has removed this barrier.

- ***The Role of Consultants.*** MA firms told us that selected consultants had been promoting the movement to MA by some group purchasers. In particular, a number of

> firms with business in Michigan described the role of ExtendHealth (based in Salt Lake City), in encouraging one of the "big three" auto companies to use them as "super agents" when they dropped retiree health coverage for non-unionized workers.[8] Under the arrangement, non-union retirees no longer receive health coverage, although the employer contributes to a fund such retirees can use to subsidize their coverage. The employer contracted with ExtendHealth to serve as intermediary for these retirees, and ExtendHealth in turn contracted with four or five MA plans across the country. While free to choose other plans, this arrangement encouraged the use of ExtendHealth to retain the employer subsidy. Note that, under this arrangement, such enrollees would count as *individuals not groups*, because they were joining the plan on an individual basis. Because we heard about these arrangements indirectly through the MA sponsors we talked with, we were unable to pursue further how they are structured and whether they should be of any concern to policymakers.

While a number of factors have encouraged growth in the group market, there also are forces, we were told, that offset an interest in MA by group purchasers.

Because most arrangements involve PFFS, uncertainty over whether Congress will maintain the authority for PFFS reportedly has slowed conversion among those who perceive they had an alternative way to maintain retiree benefits. Previous research shows that the stability of MA offerings has been a barrier to group purchasers using private plans in years before MA, although the environment may differ now.

Another drawback involves potential problems with provider access, because PFFS is not network-based and uses "deeming." However, in presentations before the National Health Policy Forum[9], and in our discussions, we also heard that groups have an advantage over individuals in this regard, since the group purchaser can find out what providers retirees see, encourage them to participate in the plan, and use their leverage to promote success in assuring important providers participate in the replacement plan.

Unions have been a significant barrier to the conversion of retiree health benefits because of the negotiations and agreements such changes require. Some firms speculated that the Supreme

[8] The firms web site indicates it is it is one of the leading providers of defined contribution benefit programs to employees and retirees of corporate America, with a unique platform that enables corporations to control costs, comply with FASB 106, and reduce administrative burden. It says that in the Medicare market, it has transitioned "tens of thousands" of retirees from traditional group based Medicare supplement policies to individualized Medicare Advantage and Medigap plans through a defined contribution HRA vehicle. Clients such as Ford, Chrysler, and Kellogg, they say, have "reduced their future retiree benefit obligation by more than $80 million. Employers set up an HRA allowance determined annually whose use the employer determines (within IRS guidelines). Funds can be used to pay Medicare Part B premiums, individual Medicare plans and other qualifying expenses, with unused funds carried over from year to year. The Medicare plans include Medicare Advantage, Medigap and Medicare Part D. (See www.extendhealth.com.com, accessed on June 19, 2008).

[9] See http://www.nhpf.org/index.cfm?fuseaction=Details&key=688 for information on an April 11, 2008 session on Employer Use of Medicare Private Fee for Service Plans as a Retiree Health Benefit.

Court decision allowing employers to differentiate between those retirees under 65 versus 65 and older (and thus Medicare-eligible) could provide a vehicle for compromise and conversion.

Finally, differences among employers and markets appear to contribute to variation. For example, it is likely to be very disruptive to introduce a total replacement product based on PFFS in a market with a significant presence of an HMO, especially if the HMO is based around an integrated delivery system with a long history of serving a significant segment of an employer's market. With unions in the east and integrated systems in the west as obstacles, the movement toward PFFS currently appears to be most active in the Midwest.

3. The "Employer Direct" Model

When CMS reports data on employer direct MA enrollment, it is referring only to instances in which the employer contracts directly with Medicare to provide an MA plan, not when the employer does so via an existing MA plan offered by a sponsor that provides coverage to the general population. Employer direct models are rare and their enrollment is limited. We talked to two firms with such arrangements, one of which uses it to offer an MA PFFS plan, and the other a PDP. Both appear to have unique profiles, in that they are organizations created to be dedicated vehicles for delivery of health and other benefits, with widely dispersed organizations that share some features. This means that they have administrative infrastructure not present in most groups' human resources departments. Such sponsors also appear to place a great deal of emphasis on retiree service, and view direct management of the PDP or MA product as a way to retain control over customer service. Like other employers, the ability to achieve integration was viewed as an asset. They often incorporate external contracts to help them administer the benefits (e.g., prescription drugs, claims processing). These firms viewed control and savings on additional overhead/profit via contracting as valued offsets to going to an MA firm. Both of these firms noted, however, that the administrative burden of coordinating with Medicare is heavy.

D. FIRMS' INTEREST IN PARTICULAR MA PRODUCTS

1. Potential Future Viability of Regional PPOs

We asked all firms, with a few exceptions where there was less relevance and likely knowledge, about the viability of regional PPOs in the MA marketplace. They all said that such plans are not viable now, because regional plans cannot compete effectively with local plans able to modify benefits by county, when the former must offer a uniform benefit throughout the region (a set of one or more states). As one firm observed, the product "has no legs." For example, one firm, with experience in the market, noted that even in single-state regions, the cost structure could vary substantially within the state; yet, the rating methodology for regional PPOs requires them to offer a uniform product throughout the state (and region). In high-cost areas, the premium would be much higher than the local plan, making it less competitive. In low-cost areas, premiums would be lower, and the regional plan would be more competitive. However, the regional firm would not be compensated adequately for costs, and could be adversely selected against.

Firms did not necessarily disagree with the conceptual value of moving from counties to larger aggregates for purposes of pricing and uniformity, a concept MedPAC has advanced.

However, most firms did not comment on this point, and we suspect that their actual reactions would depend on the impact of the change in their revenues.

As long as local plans exists, firms could not identify any policy changes that could make regional PPOs more viable in the marketplace. Some also noted that, even if regional PPOs themselves were viable, the particular regions that exist now might not be meaningful to their firm if the definition of a region differed from the way they typically perceived their market for business purposes.

Some firms with experience in regional PPOs noted that the network requirements were more flexible for that product than for local products. For example, CMS might approve a regional plan even though its network in a particular set of counties did not meet requirements for a particular provider type (e.g. orthopedists), if the network otherwise was adequate; the firm would have a few years to address the shortfall. This discussant suggested that applying such flexibility to local coordinated care plans might make it viable for firms to develop them across additional areas of the country, where provider contracting was an issue. In this circumstance, beneficiaries obviously would need to be protected through alternative means.

2. The Growth of PFFS Plans

PFFS continues to be attractive to industry in 2008, with interest broadening from an initial focus on individual enrollment products in 2006 to current interest in using such products to build a group market for MA. The growth of this product is reflected in statistics previously presented, which show sizeable increases in the number of sponsors offering PFFS and the growing share such plans reflect in the market. In mid 2007, we did not yet see the substantial expansion of enrollment in the group market, but our firm discussions confirm CMS's reports that group enrollment constitutes an increasing share of the growth of PFFS enrollment and explains some of its recent growth.[10] Group decisions have a disproportionate effect on the marketplace because with one decision, an employer may be moving 100,000 or more members into MA. Firms that benefit from such growth may find their enrollment growing substantially, and state penetration rates also may be affected, as we saw in Michigan with the shift in plans of public school teachers between 2007 and 2008. Given current MA payment rules, a shift of retirees in groups to MA would add to the total costs of the Medicare program (MedPAC 2008a).

Firms initially were attracted to PFFS at the beginning of the MMA because it allowed them to enter markets where they might face limited competition from existing MA coordinated care sponsors. High "floor" payments rewarded such entry, although firms tended not to talk about this aspect of payment. In 2006, the many competing demands and opportunities of MA were incentives to focus on products, such as PFFS, that could be established with less administrative burden (Gold et al. 2006). For the most part, PFFS plans do not involve contracts between the MA firm and provider; such plans "deem" providers to participate on a case by case basis when they see a payment and they also use Medicare payment rates to provide the infrastructure for

[10] CMS recently started releasing monthly enrollment data that distinguish group from individual MA enrollees. The June 2008 data show 600,543 group enrollees in PFFS (of a total enrollment of 2,263, 271 in such plans).

the transaction (Gold 2007b). Such features lower the expense and administrative costs of establishing PFFS plans, particularly for firms with national networks of agents providing distribution channels for such products. It appears that these considerations are still relevant in 2008, since firms continue to enter the market, expand their service areas, and offer individual products. Enrollment in PFFS continues to grow. Some firms said that it was an advantage for them to be late entrants, as prior firms already would have established awareness of the product among providers. Another noted that early efforts by PFFS that antagonized providers or beneficiaries could complicate marketing.

In the individual market, most firms appear to be positioning PFFS plans to attract price-sensitive beneficiaries who desire broad choice. While PFFS offerings initially were focused on the individual market, the impetus for their expansion today may be aimed as much or more at groups. For example, one large national firm observed that PFFS is a "great alternative for the employer market. Most…have retirees residing all over the country, so simplified administration is important. They need one product that gives them broad access." The firm also noted the value such plans have in the rural market.

Firms had different perspectives on the adequacy of provider access within PFFS. Most acknowledged some scattered issues with providers available and willing to serve their enrollees in various markets or specialties, but also said that overall provider participation in PFFS was good. A few noted, however, their concern that poor communication with providers by their firms' competitors hurt the reputation of the PFFS product, and adversely affected them. For example, one firm may have to address resistance generated by the communication failures of its predecessor. One, focused on the group market, said that 98 percent of available doctors participate in its products, and that the group base makes it easier to identify and follow up with the providers used by those enrolling in their plans. However, another firm, with less name recognition in the marketplace, described more difficulties in assuring access, particularly if some hospital systems actively decided to "deem them out." Firms with multiple lines of business and long- standing relationships with providers seemed less likely to report, or at least acknowledge, problems.

We are not certain how to interpret what firms told us about their perspectives on PFFS's role in the future MA market, especially as it applies to the individual market. Many acknowledged that PFFS constituted a large share of their enrollment and that they were not actively seeking to convert that enrollment to other products. They also said they were seeking to expand the diversity of MA products over time. Some explained that PFFS could provide them with an initial beachhead in a given market, from which they could expand with more coordinated care products. One large company, in fact, said that it was surprised and concerned by the explosive growth of the product in 2006, and sought to limit growth through selective service area reductions, a change consistent with its enrollment trends. When asked however, firms also acknowledged, the challenges in expanding network-based products across the country, and thought that such products likely would be more feasible in some markets than others. Firms said their strategies for expanded coordinated care were driven by more than concern for the long-term availability of the PFFS option. Our quantitative analysis, however, provides little indication that enrollment patterns are shifting along with growing availability, as discussed below.

3. Status of the Local Coordinated Care Sector

The quantitative analysis shows relatively limited growth in the PPO sector, despite the expanded availability of products and a relatively stagnant enrollment in HMOs (once the enrollment growth generated by SNPs, particularly serving new dual eligibles, is removed).

In our discussions, while firms active in the HMO market did not necessarily admit to a declining or stagnant enrollment, they did say that marketing and growing enrollment in these plans was a challenge. Large established HMO firms said they were able to retain their existing members, but found it more difficult to grow their enrollment with new individuals other than those aging into their products. They said that this was due to the increasing competition in the marketplace and, in particular, to competition from low-cost PFFS plans. Others attributed limited growth to the added burden of offsetting natural attrition due to mortality among this population or said that slow growth in new HMOs or PPOs reflected entry into new markets, where beneficiaries had less experience with managed care. They noted that a slow pace of growth was to be expected, but that growth would nevertheless occur.

Some HMOs are concerned that the current focus on PFFS is putting them at a competitive disadvantage, because PFFS faces fewer requirements. Those with delivery-based models expressed concern that current policy does not adequately value continuity of care and the needs of delivery systems. Some firms said that they are taking a look at the new "network adequacy requirements for group plans," hoping that these would allow them more flexibility to compete in the group market against the advantages of PFFS. (CMS's guidance allows coordinated care plans to relax network adequacy requirements for groups outside their core service area, as long as at least 50 percent of the membership under the contract continues to reside within that area).

From our discussions, we anticipate that the number of HMO—and especially PPO—contracts will expand in 2009 and the next few years. A few firms, particularly those growing rapidly and dominated by PFFS enrollment, said they were aggressively growing PPO products. One firm, for example, explained that care management was a critical feature of its philosophy, and one that was applied even to their PFFS products. While the bulk of their expansion would, at least in the beginning, involve "PPO lite" type products, the firm also hoped to develop more aggressively managed PPOs in some markets, where they could recruit and work closely with MDs. Another described its historical acquisitions strategy as a vehicle to enhance its capacity to offer HMOs in more areas of the country, as well as its use of PPOs in markets less hospitable to managed care. A third strategy described involved active pursuit of partnerships with provider groups to develop networks that would allow it to expand products within markets in which the firm already had a presence

We are uncertain, however, what the expansions will mean for MA enrollment. For the most part, firms said that networks probably were feasible in some areas of the country, where current coordinated care penetration is low, but not in others. The latter included lightly populated areas where the economies of scale were not present, which was an obstacle, as well as areas where providers were reluctant to contract, especially for other than substantially higher payments than under traditional Medicare. Most firms said that provider contracting was no more difficult than in the past, but some reported active pushback, especially from hospital systems.

4. Insights on SNPs[11]

Firms varied in their interest in SNPs, although most expressed at least some interest in these products. In considering SNPs, it is relevant to keep in mind that three kinds of SNPs exist—dual eligibles, institutionalized, and severe chronic and disabling conditions (Verdier et al. 2008). As we have described elsewhere, plans that target dual eligibles are dominant in the market, although the other forms (many also serving the dual eligibles among their members) are growing. While there are common concerns across all SNPs, unique issues also apply to each. We were not able to talk with firms in depth about their SNP offerings, but were able to gain insight into general aspects of the SNP role in the market.

Reasons for Interest in SNPs. The most commonly mentioned reason for the interest in SNPs is that they *allow firms to tailor their benefit packages to subgroups of individuals.* Benefits that might not be financially feasible to offer all enrollees are more affordable in a plan that limits enrollment to a subgroup of beneficiaries more homogenous in their needs. Firms say that SNPs make it feasible to offer specialized formularies with reduced cost sharing for certain drugs that are most likely to benefit that subgroup. Targeted expansion in coverage becomes feasible because SNPs serve a targeted subgroup more likely to benefit from treatment (and potentially even offset other care savings). Because MA now uses risk adjustment based on conditions, payments may be higher for subgroups of individuals, thus increasing the revenue available for expanded benefits. Tailored packages presumably are valuable in that they enhance the firm's ability to market to different segments of the population, better serving them and expanding overall enrollment.

Dual eligibles are a special case of targeted benefit design. When Medicare beneficiaries are dually eligible, Medicaid may cover all or most of the cost sharing in Medicare, depending upon the individual state, and also may provide additional benefits. A general MA plan's cost-sharing structure does not take dual eligibility into account, and so may duplicate coverage already offered by Medicaid. With SNPs, firms told us, they can develop tailored plans that have benefits consistent with both dual eligibility and special state benefits. Instead of covering services for which Medicaid may pay, the SNP MA plan might use savings, for example, to cover hearing aids, transportation, vision, medical equipment, or other needs of this population. Some plans also may cover home safety assessments, for example.

Second, firms can use SNPs *as a way of providing more intensive care management*. Firms perceive this as an important attribute of SNPs, both clinically and administratively. Lower-income beneficiaries, one observed, required "high touch" in communication. Another firm, which is cautious about SNPs, said this was due to SNPs requiring strong engagement with providers and an underlying infrastructure; in the segments it serves, it overlays care management on the delivery system, and does not perceive the development of such strong relationships to be as important.

From the discussions, it is unclear how much effort truly is being directed at care coordination in SNPs beyond what would be feasible in general MA. Firms told us that, by

[11] Given the range of topics to be covered in our discussions and our general focus on MA, we were able only to skim the surface of firms' responses to the SNP market.

targeting, they may be able to afford care that otherwise would be difficult to cover financially on the uniform basis required by Medicare (e.g., home visits for very ill patients; stationing staff within nursing homes). These are benefits, but they also enhance care delivery.

From the examples provided by firms, we can identify a few ways that those with general MA business are using SNPs to modify the care process.

- ***Information.*** Because conditions or subgroup status must be defined prior to enrollment, SNPs provide firms with an easy and early way of identifying patients to target for certain care. In general MA, the plan must rely on post-enrollment assessment.
- ***A Learning Laboratory.*** One firm now actively pursuing SNPs noted that the SNP activity currently is handled in a separate unit on a specialized basis. With experience, however, certain elements of care could be transitioned into the general MA program.
- ***A Source of New Enrollment.*** SNPs provide a way for firms in a crowded marketplace to draw attention to unique competencies. A firm with a history of chronic disease management can use SNPs to attract individuals with conditions likely to benefit from its systems—a practice now more feasible through risk adjustment than it was previously, when firms feared adverse selection. SNPs for duals and institutionalized individuals seek, by definition, to attract subgroups treated outside of MA. Some firms that previously had not moved aggressively into MA in the past because of competing demands on operational resources were concerned that they would be disadvantaged in the MA marketplace by the moratorium on new SNPs in 2009, particularly as they had begun considering or planning for such an expansion.

Third, SNPs have *some operational advantages*. Because many potential enrollees are dually eligible, firms are not limited to marketing only during the open enrollment season. In this way, SNPs provide a way to support their marketing efforts during the entire year, and enable them to continue to grow enrollment.

Coordination with States. Discussions with firms identified at least two challenges to be anticipated if Congress seeks to encourage firms with dual eligibles to coordinate with states on payment for acute services, particularly for the supplemental cost sharing that Medicaid absorbs for those dually eligible.

First, states are diverse, and see their interest in coordination from different perspectives. We talked about state differences with one firm that has dual eligible enrollment in several states. They said that, in one state, Medicaid is very interested in coordination, and is moving toward developing a capitated payment to the SNP to cover Medicare's cost sharing. Two other states with which they are working want to continue their current practices, rather than engaging directly with SNPs. In one, the state historically has paid the full amount of Medicare's cost sharing, and will continue to pay that amount directly to providers. In another, however, the Medicaid fee schedule is 80 percent of Medicare's, so Medicaid pays nothing additional for physician services. The state intends to continue that practice. Physicians, bound by law against

balance billing, will have to absorb the difference, a fact that the firm says has not, at least to date, led to a great deal of contention, although we suspect this could occur if providers decline to see patients or attempt to recover lost revenue in other possible ways. Second, some firms do not view coordination with states as a high priority. For example, one firm that is based solely around Medicare has extensive dual eligible enrollment but, by preference, only limited engagement with states. The firm did not perceive Medicaid as a priority for business development. Their dual eligible SNPs are set up to involve zero cost sharing, thus eliminating the need to coordinate with the state.[12] In this situation, MA essentially is using savings to substitute what Medicaid otherwise *could* pay should the state choose to do so. Such use of MA may not necessarily benefit dual eligible enrollees, particularly if enrollment does not enhance provider access or care quality beyond what they otherwise would receive.

In our interviews, we had the opportunity to talk with the representatives of a few SNPs that began as state demonstrations for dual eligibles in Massachusetts and Minnesota. They each emphasized the strong differences between their design (which they said was driven by states) versus the dominant dual eligible SNPs rolled out by CMS. They said their demonstrations had been framed by state procurement standards that laid out specific requirements for infrastructure and care coordination, including requirements dealing with care management, an interdisciplinary team with specific credentials, clinical access, and a centralized decision process, among others. They contrasted these features with CMS's strategy for rolling out SNPs which, at least for 2006 and 2007, did not have such requirements.

Firms with such demonstration-based products viewed themselves as having little in common with most SNP sponsors and their more generic dual eligible SNPs. While supportive of SNPs, they said that they, and firms like them (many of whom belong to the SNP Alliance), hoped that CMS would use the moratorium on new SNPs to identify how best to recruit partners willing to focus on the integration they saw as vital to improve care for dual eligibles.

Policy Perspectives. From a policy perspective, what firms described as "tailoring" also means that firms are subdividing the risk pool of Medicare beneficiaries, although that is not how firms characterize it. In general MA, any savings are shared across all beneficiaries. Because more are healthy than unhealthy, such an allocation may result in small additions to benefits for each enrollee, providing a less than proportionate benefit for an enrollee who is sick are requires a lot of care that makes that at most risk for uncovered costs. With SNPs, savings are shared among a smaller subset of beneficiaries who usually have a higher level of need. Some extra benefits also involve services that strengthen the ability to manage care, although our discussions did not provide strong evidence of that. Medicare's risk adjustment system is central to SNPs' viability. The SNP system places a heavy burden on risk adjustment because any such system includes substantial diversity in the members included in each subgroup, however rigorous the system. This introduces the potential for gaming, as does the fact that expenses among beneficiaries, both within and across subgroups, are highly skewed. On the other hand, such

[12] Previously, under general MA, some firms did such waiving informally, so that they could continue to serve members who became dually eligible. One was told, reportedly by CMS, that it needed to convert to an SNP to serve dual eligibles, while the other continues its current practice.

gaming could be difficult given the effort CMS has put into developing risk adjustment and also that fact that SNPs, like other MA plans, are dependent on providers to adequately code data to support the adjustment.

E. ADMINISTRATIVE AND POLICY CONCERNS

1. CMS Oversight

Appreciation for the Magnitude of CMS's Job. Most of the firms with which we spoke with expressed positive views about their relationship with CMS. Some volunteered, when given the opportunity to provide feedback on administrative concerns, that CMS was "very collaborative and very appropriate," that they "had a good working relationship with the agency," that "CMS is a good partner," or they were "used to the way CMS operates." Firms did not come to the discussions with a long list of administrative concerns, although they had some (discussed later), which colored their perspectives. A firm might note that its relationship with CMS was good, but that the same might not be true in other CMS regions. Discussants having a long history with the program pointed out the administrative challenges CMS currently faced. One noted that retirement had depleted CMS of some of its most experienced staff. Because MA is a "high profile situation," Congress and consumer groups are investigating all aspects of the program, a fact, they said, that influences CMS's regulatory style—making it more aggressive and formal. For example, in the past CMS might have sent a "friendly reminder," but now sends a "nasty-gram."

Growing Complexity of the Program. Firms, especially those with previous experience, say MA is much more complex as a result of the MMA, with "so many moving parts." We heard that "not a day goes by that we don't get another piece of guidance from CMS," or that "every day there's some new notice about eligibility and enrollment." One firm's executive spoke of having to turn off his Blackberry at night because he would have 100 new messages from CMS in the morning. Another noted that it took a lot of resources to sift through triple daily notices from CMS on documentation, policies, changes, etc." Part D, in particular, they said, had complicated administration substantially because of all the additional requirements, new plans, and the low-income subsidy. They said they supported efforts to protect beneficiaries, and to push for health plans achieving high levels of performance. While we heard comments such as [they are] "just strangling us in bureaucracy," firms for the most part recognized that CMS was seeking to manage very complex legislation. Generally speaking, our perception is that the most important things firms need from CMS is to align their work with the business needs of the firm. Failure to do so has led to the following kinds of concerns:

- Lack of consistency or predictability that frustrate day-to-day operations, such as when there is a disconnect between various regulations and payment changes. Policies perceived as "zigging and zagging" were said to reflect this inconsistency.
- Lack of transparency, as reflected in the use of "subregulatory guidance" (and the industry does not get an opportunity to comment on these rules), as well as "vagueness" in the guidance. They wanted clarity, although another firm noted that such clarity might conflict with what they viewed as the flexibility needed in the program to support innovation.

- "Patchwork change," in which concerns get addressed piece-by-piece, rather than on an overall basis.

- Failure to anticipate the cost of systems changes when setting requirements and providing guidance. Firms might get multiple communications, each requiring some change in their internal information systems, with its associated expense.

Support for CMS's Work on Marketing Concerns. For the most part, those with whom we talked were very supportive of CMS's actions in 2007 to address marketing concerns, and were supportive of voluntary efforts to shut down new enrollment.[13] They generally were concerned that marketing problems cast a pall over the entire MA program and had to be handled. Firms were critical of what they termed "rogue agents" who misrepresented the program in ways that MA firms found difficult to control. Commissions were another issue of concern, both as they affect marketing, and also as differential incentives for promoting enrollment in particular plans. While we talked with firms before CMS released its recent marketing proposals, which included prohibitions on commissions, some that used outside agents and commissions suggested, off the record, that some limits needed to be imposed, because high commissions were hurting the marketplace, as firms sought to compete with those initiating such high commissions.

We also heard some caveats. Several national firms expressed concern over involving states in oversight of MA marketing, something they perceived would add to their administrative burden and result in inconsistencies across their market. A firm with a long history in the market was concerned that CMS was not discriminating appropriately in its oversight, based on a firm's past performance, and so added to its administrative costs. Another firm that had a very small PFFS enrollment was concerned about the burden that CMS's oversight strategy imposed on the firm, as well as on individual enrollees, who might be called by multiple parties to validate the voluntary and informed nature of the enrollment. They also were concerned that the expectations of secret shoppers for PFFS were not consistent, with some expecting the broker to cover the full list of seven points CMS had identified, and others content to have the firm answer consumers' questions. The firm preferred the latter, but said that consistency in expectations was important, regardless of the rule. There also was concern regarding a complaint about tracking systems that resulted in reports to senior management for events later shown to be consistent with rules or outside the plan's control.

Annual Enrollment Concerns Persist. In several discussions, firms cited the challenges created by an annual open enrollment season that concentrates marketing within a short period of time. They said that this policy makes it more likely they will need to rely on outside agents, since the firm cannot staff up for such a peak load. We heard concerns about the historical absence of a realistic timeframe for the period between enrollment and eligibility for services—they said that the 2006 experience of enrolling one day and receiving care the next was unrealistic, and suggested that new enrollment cease a few weeks before January 1st. Some suggested moving the open enrollment period to avoid complications associated with marketing

[13] Our discussions generally took place before CMS's May 11, 2008 proposed rule on marketing standards for MA. (See http://www.cms.hhs.gov/apps/media/press/release.asp)

over the holidays. However, the major concern appeared to center on having any defined enrollment period.

Enrollment Reconciliation a Major Concern. The most comments and serious concerns we heard firms express involved the problems experienced in reconciling enrollment with CMS, so that the firm could be paid for services already provided to enrollees. As one observed, "we still have people from 2006 that we're paying claims for and not getting anything from CMS—about 2,500 such members." Firms were uncertain as to why problems remained, attributing them possibly to a contractor, and CMS's shift in its enrollment management system; to the volume and challenges of 2006, which still were being resolved; and to inherent inconsistencies between the CMS and SSA computer systems. Many expressed concern about lingering reconciliations from 2006. Some of them felt that things were improving and would be better in future years, once this problem was addressed, whereas others said they still were encountering similar problems.

Support for Risk Adjustment but Concerns over Coding Oversight. While the industry has not always supported the transition to risk adjustment, firms we talked with now express strong support for it, as a way of putting the right incentives into the system. One firm even indicated that the transition to this system allowed it to re-enter the program. Firms generally said that risk adjustment provides the right kind of market incentives, and lets them be paid appropriately for enrolling sicker patients, although there were concerns about how revisions in the weights within the hierarchical classification system will affect them, and whether these revisions are equitable. We were surprised that more of those to whom we spoke did not appear able to respond to our questions about precisely how risk adjustment had affected their revenues. This may be attributable to general reluctance to talk about this topic, and also may be due to the fact that we spoke with generalists rather than the specialists who oversee this work and have the ability to differentiate risk adjustment's effects from other aspects of the payment system.

However, it also may reflect lags between scoring and adjustment, as well as the challenges many still sensed about getting providers to do what they viewed as appropriate coding. Traditional group practices noted, for example, that their physicians joined the plan in part to avoid the paperwork that risk adjustment requires in terms of coding, although the burden ultimately may be reduced with electronic medical records. For all firms, the need to document diagnoses annually for risk adjustment contributed to what they saw as their challenge to get physicians to code all diagnoses at each encounter, regardless of the reason for the visit. As one said, "We have to be good coders, or we are dead."

Whereas CMS has been concerned with "upcoding," firms saw a lack of incentive to code diagnoses in the traditional program, resulting in an undercount. A particular problem they say is motivating independent physicians paid on a fee-for-service rather than risk basis to code more fully. Our interviews spanned the period in which CMS transitioned from draft to final guidance on 2009 rates. A number of firms expressed serious concerns about CMS's proposal to institute across-the-board reductions in a subset of contracts that had experienced the greatest increases in codes. They viewed this approach as a "blunt instrument" that failed to recognize that accurate coding should be the goal; they were encouraged that the policy did not relate to the final payment notice, but remained concerned about CMS's long-term approach to such oversight.

Few Specific Suggestions about the Bidding Process. In general, firms appear to have accepted the timeline and process for submitting their bids. They did not suggest broad changes to CMS policy, beyond a general concern for consistency, predictability, and transparency. We did hear a few specific suggestions. One firm commented, for example, that the way bids currently must be uploaded is antiquated. Another said that it was disappointed that CMS did not allow annual benefit "buy-ups" through riders that are not part of the general plan, noting that the nature of eyeglass coverage meant that it had to be categorized as an annual benefit, but that CMS had required them to provide such benefits on a month-to-month basis only. Audit variability was another issue mentioned. Firms also continue to express concerns over last-minute changes in rules that might, for example, hold them accountable for costs not previously built into their bids, such as a late reinterpretation of formulary requirements.

Clear Economies of Scale and Experience. The complexity of MA clearly gives important advantages for large firms with substantial in-house capabilities and enough covered lives to amortize administrative costs. We have discussed previously how, in the group market, the scale of administration is a factor driving most employers to "buy rather than create" their MA products. Within the health insurance industry, scale also matters. Small SNPs that started as state demonstrations say that care delivery is the easy part of their job—it is handling the administrative complexity that challenges them. One firm that started small and has aggressively expanded around a managed care model says that a year ago it was not clear that its scale would be sufficient to succeed, but now, with 200,000 members, they are more optimistic. A smaller firm, new to the program, said that the market was "very rewarding," but also cautioned that those considering entry should be "prepared for a lot of bureaucracy."

Expertise also matters, given the complexity of Medicare, individuals said. Firms noted the experience of their own staff. Firms new to the market often had individuals among their senior management who had come from leading large MA firms with substantial years of market experience. The few new entrants without such expertise typically were smaller and more specialized; they hired the expertise through the use of consultants. Firms with TriCare experience also sought to leverage their knowledge of working with the requirements of a large government agency.

2. Broader Policy Concerns and MA Future

Firms appeared to be committed to the MA marketplace, although they acknowledged that their continued participation will require, at a minimum, an ability to break even. While the MMA has expanded the market substantially, firms with whom we spoke had a mixed reaction to current trends and their ultimate value. Below, we review what we learned about how firms view the long-term Medicare market.

Accepting Uncertainty. Firms with whom we spoke generally accepted that working in MA meant that, by definition, they would be operating in an environment of uncertainty. As one said, "I've learned that you never reach a conclusion in the Medicare debate….If you wait for debate to be concluded, it will never happen. Anytime you're depending on government payment for a major area of your business, things can change." As another expressed it, "There's nothing new each year…Every year there is vulnerability caused by payment issues. Every year is a roller coaster ride. We look to stay in the program. We do the math, figure out what services we can

provide, and figure out what we can contribute. It has never become financially unviable." Another executive said, "We're in it for the long haul."

Moving Forward Despite Concerns but "Hedging Their Bets." Firms clearly remained concerned about federal policy. At the end of our discussions, each sought to make sure that they had drawn attention to their particular areas of special concern, such as PFFS authority, reauthorization of SNP, or continued authority for cost contracts. We encountered no firms retreating from MA because of the Congressional debates on their future. For the most part, we heard that they were pursuing multi-year strategies for MA, which allowed them to expand in the marketplace. Firms do not appear to be shifting strategy or reducing their interest in MA because of its legislative uncertainty; instead they are "hedging their bets." Firms heavily based in PFFS, for example, are adding local PPOs for many reasons, but they said that such products give them an alternative, should PFFS authority be revoked or such products become less attractive. Such hedges also occur on a smaller scale. A firm with a cost contract, for example, might be maintaining a low enrollment coordinated care contract in the same market, to build on should their cost contract authority be revoked.

The Compelling Case of the Senior Market. Our discussions with these firms reinforced earlier findings that the demographics of the baby boom, combined with the opportunities of the MMA, have made the senior market in general, and MA in particular, very attractive to firms in the health insurance industry. The firms we interviewed expressed a strong commitment to this market, with an intention to participate long-term.

Common considerations reinforce the attraction of Medicare. In Box IX.2, we summarize facts about their business made public by some of the larger public companies that participate in MA. These facts show that MA is central to the financial health of many firms, because it contributes substantially to their revenue. Most aim for a diversified financial base, because it makes them less dependent on a single payer and reduces their risk. Some firms, such as Universal Health, say that they have been "transformed" since enactment of the MMA, and are positioned so that Medicare dominates their firm's revenue. Companies that rely so heavily on revenue from MA would find it harder to walk away from the business; such actions could be easier for companies such as WellPoint, which depends much less extensively on Medicare nationwide for its revenue. It remains to be seen whether the patterns of consolidation and acquisition seen in the late 1990s will occur after this expansion, as they did during the previous one.

The Business of MA. MA firms are businesses, whether profit or nonprofit. Their continued participation in MA is likely to depend on the economics of the program as it gets interpreted in their environment. As one firm said when we pushed them about their commitment and whether there was a point at which they could no longer remain in the market: "Yes, but I am not sure where it is. It's fair to say that, not just for us, but for everyone in the industry." This individual went on to refer to the politics of cutbacks in Medicare, noting, "There would really be an uprising for those used to getting those benefits as well."

Because of the revenues associated with Medicare, firms are motivated to make it work, and view themselves as having multiple opportunities for doing so. They still are bound by economics, however. Even the most committed plans acknowledge this fact. So, for example, they told us that:

- If cost plans get cancelled (our biggest risk), we would probably bring up another in-house product to help retain as many beneficiaries as possible.

- We're always going to grow because even if you make 1 percent (margin) that's still real money when you multiply it by the number of our members. But if it goes to minus 1 percent, then you'll be talking to someone else next year.

- It (payment uncertainty) is like that leaning rock on the cliff above you: you're not sure how it's going to crush you. Our point of view is that we believe that as a large non-profit, part of our mission is to take care of the population we've served for some time. We'll have to figure it out….

- Every year it's like the Sword of Damocles. The election will tell the tale of where things are going"…We'll stay in as long as we can break even. We live here and work here. Our goal is to serve the community, and we'll continue to do that.

- We can never get out of the Medicare market (given the number of covered lives). The question is not whether we get out of Medicare, but how we get paid.

Diversity in Assessment of Change. The firms with whom we talked had different views on the changes that had taken place in MA under the MMA, based on where their firm was positioned in the market and their own history with Medicare. Many with a long history with the program, from various vantage points within the firm, expressed concern explicitly or implicitly, over the proliferation of PFFS plans, a form they perceived as moving the program away from strong management, rather than toward it. They expressed concern with a move "away from comprehensive products with an emphasis on coordination of care and prevention" and perceived that "many of the product types proliferating in the market don't fit this mold." Some would like to see the private PFFS option eliminated, although they would not necessarily say that publicly. Firms with delivery-based systems are concerned about continuity of care, and question whether policy changes will make it difficult for a patient to continue receiving care from their providers. With an election forthcoming, the issue of what form Medicare should take may become more prominent. In the next chapter we discuss more generally what the findings from our analysis indicate to be important issues for policymakers.

SELECTED INSIGHTS INTO PUBLIC FIRMS FROM BRIEFINGS GIVEN TO ANALYSTS

UnitedHealthGroup: Touches nearly every aspect of health care financing and delivery and serves more than 73 million Americans. Has 10 million Medicare members (9 million unique) with 1.4 million in MA, 4 million in MedSupp and indemnity, and 4.1 million in PDPs. Market shares range from 16 to 27 percent. Estimated 2008 revenue is around $28 billion. Has a growth opportunity, with 25 million new Medicare eligibles turning 65 in next 10 years (11 million net growth) (Citi presentation, May 2008).

Humana: On track to add an expected 200,000 to 250,000 net new MA members in 2008. Growth of 153,000 by April 1. PPO products continuing to gain popularity. With 2009 announced rates, firm expects to continue to offer competitive products and will adjust benefits for medical cost trends. PPO accounts for about 30 percent gross sales but 45 percent net change in membership. (PFFS next biggest component). In January 2008, 85 percent of MA membership growth was from individual sales (up from 61 percent in 2007); PDP claims higher than expected; will take corrective action in 2009 (adequate premiums regardless of benchmarks (Citi presentation, May 2008, Lehman presentation, March 2008).

WellPoint. Seniors are projected to be 4 percent of total customers at year end 2008. In 2008, expects to add 65,000 net medical members from senior market out of 500,000 net membership growth. Firm will continue to focus on this large and growing market. BCBS National Provider Network includes more physician and hospitals than any other network in the industry (Citi, May 2008). Firm has industry-leading transparence tools for performance measurement, and seeks to deliver innovative new products to drive membership growth (Citi presentation, May 2008, Lehman presentation, March 2008).

Aetna. Hopes to segment and diversify the market to add membership group. Large customers were 60 percent of market in 2007, versus 69 percent in 2004, with the difference made up by newer segments. Medicare comprised 207,000 of the 2.3 million members in new segments, versus 97,000 in 2004. Company's leadership strategy is that consumerism leads to growth (Citi presentation, May 2008, Lehman presentation, March 2008).

Coventry. Two of the four key growth levers are (1) government programs; and (2) expansion of the health plan footprint. Targeting MA growth of 100,000 in 2008, with 90,000 net growth shown through May on CMS report. Expanding its Medicare network-based footprint to new markets and other products (SNP, MSA). Estimated 2008 year-end membership of 1.235 million members. Long-term prospects outweigh short-term political noise. Seventeen of 22 acquisitions firmwide since 1999 were local health plans. Local health plans are essential building blocks, with firm planning to target 30+ markets and have a balanced exposure to government business; expand Medicare network footprint as well as increase Medicaid weighting. (Investor presentation, May 2008).

Universal American. The company has been transformed with the passage of the MMA. In FY 2004, Heritage was acquired, adding $94 million in revenue (12 percent of its total). MA revenue increased to $241 million in FY 2005 and to $451 million in FY 2006, with the Part D roll out (32 percent of revenue). MA revenue was $1943 million (43 percent of revenue) in FY 2007. Part D (PDPs) also added $296 million in FY 2006 and $1.907 billion in FY 2007. Total company revenue from all business segments grew from $559 million in FY 2003 to $4.472 billion in FY 2007. MA and PDP were 86 percent of revenue in FY 2007. At year end 2007, there were 46,000 members in MA HMOs, 190,000 in PFFS, 505,000 in Prescription Pathway PDP, and 1.2 million in Community CCrx PDP. Another 176,000 had Medicare supplements (down from 309,000 in 2003). The company has strategic alliances with the National Community Pharmacy Association, CVS/Caremark, and Hartford. Of the PFFS enrollment, 80 percent are in 125,000 markets (Lehman presentation, May 2008).

Health Net. Strength comes from a diverse business base in 4 western states and a northwest region of 3 states. Total enrollment is 6.6 million, of which 236,000 were in MA and 379,000 were in PDPs at year end 2007. Medicare was 19 percent of fourth quarter premium revenue. In 2008, the company expects its MA business to grow 15 to 20 percent, and its PDPs to grow 40 to 45 percent. Using PFFS and PDPs, the company is moving into 7 addition states (Lehman presentation, March 2008).

X. CONCLUSIONS AND IMPLICATIONS

A. WHAT THE FINDINGS SHOW

The findings provide evidence of an active MA market that has expanded since 2006. The higher payment rates associated with MA have encouraged firms to take advantage of existing (e.g., PFFS) and new (e.g., SNP) authority to expand rapidly the number of MA plans they offer and premiums and develop benefit structures sufficiently competitive to generate substantial enrollment growth within the MA sector. The proliferation of choice reflects an expanded set of MA contract types, the value firms see in offering a range of types to attract a range of beneficiaries with different interests, and the expanded number of organizations seeking to sponsor MA plans.

Regardless of where they live, all Medicare beneficiaries now have access to multiple types of MA, although access to coordinated care plans is more limited, especially in rural areas. Beneficiaries also have access to PFFS plans offered by many competing sponsors. MA enrollment is growing rapidly. Penetration rates also have increased substantially (even in rural areas), although most beneficiaries remain in the traditional Medicare program (where they receive standardized Part A and B benefits and can choose to be in a free-standing PDP). In related work for others (Gold 2008), we have shown that among those enrolled in Part D, a large share are in MA—one third—although MA-PDs remains less popular than the free-standing PDP choice. If groups continue to have a growing presence in MA, the MA's share of the Medicare market is likely to increase still further.

The information we provide about the structure of premiums and benefits in MA provides a basis for understanding why segments of Medicare beneficiaries have found MA increasingly attractive. Most Medicare beneficiaries have low to moderate incomes (KFF 2008). While plan structure varies depending on the market, the presence of MA means that most beneficiaries probably have an MA plan available to them that offers—for no additional premium, or a very limited one over and above what Medicare charges for Part B—an enhanced drug plan and some offsets for the cost sharing Medicare imposes. With PFFS widely available, a beneficiary can choose the plan and, at least in theory, not have to change anything about the way they get care. These advantages probably are easy to convey in marketing, whereas downside risks associated with the remaining cost sharing and actual provider availability are more difficult to assess when comparing MA plans or deciding between MA and Medigap if the latter is a financially feasible choice.

B. WHERE THE FINDINGS PROVIDE LESS INSIGHT

While the findings from this study present good documentation of the range of choices that are available to beneficiaries under the MA program, they are more limited in terms of answering questions about the value provided by the MA program to beneficiaries or to Medicare as a whole.

For example, the available public data upon which we based our study provide very limited information on the actual structure of cost sharing within plans as it would be experienced by the

typical beneficiary. Available public data also have limited utility in assessing the comprehensiveness of coverage or the value of additional benefits – such as whether a beneficiary's current providers are "in-network", whether a plan's providers are accepting MA enrollees, how coverage is defined for particular services, what drug coverage in the "gap" actually provides for a beneficiary with a particular constellation of drugs and needs, and how well a plan would be able to accommodate the uncertainty of a beneficiary's future health needs within a given year.

Additionally, at the time that the study was completed, CMS did not provide public information on the actual plans in which individuals were enrolled within geographically distinct parts of the country, which limited our ability to accurately calculate the average premium paid by a beneficiary enrolled in MA. (CMS recently began releasing plan-level enrollment data at the State and county levels in May 2008).

Moreover, publicly available quality data, are often several years old, tend to be incomplete (with more indicators available for contracts with substantial experience in the program), and certain important contract types such as PFFS plans not being required to begin reporting on certain quality measures until 2010), and are reported at the contract level rather than at the plan level (an important caveat when contracts can include a range of regular, SNP, and group-only plans).

Because of these limitations, the publicly available data provide only limited evidence of the "value" of MA in enhancing the quality of care for beneficiaries, limiting their out-of-pocket costs, or enhancing equity in the Medicare program as a whole." The MMA sought to encourage competition as a means of controlling costs, yet Medicare now pays more for each beneficiary within MA than outside it, meaning that costs grow as the program expands. Policymakers can debate the values behind current decisions on the design of the MA program; this study's data highlight the relevance of those debates and the issues at stake. Arguably the most important thing we do not know is what form the value equation takes. That is, what is Medicare gaining to offset the additional complexity and costs of MA compared to the traditional program?

C. KEY ISSUES FOR POLICYMAKERS

The MMA arguably has changed fundamentally the Medicare program by expanding choice and competition among private plans for Medicare beneficiaries. The findings of this study point out some key issues for consideration:

- ***Equity.*** While Medicare makes benefits universally available to all beneficiaries, the benefits of MA are targeted to those who enroll. MA therefore divides the Medicare risk pool by location and by the characteristics of beneficiaries and their needs. Policymakers seeking to understand the overall impact of the MA program on Medicare need to assess the underlying equity of the changes introduced by MA and understand the winners and losers from this process.

- ***Choice.*** Is the current absence of limits on the number of marketplace choices desirable? How many choices can beneficiaries consider simultaneously? Are inefficiencies introduced by a large number of firms that often compete to offer

essentially the same product? Are sufficient beneficiary protections in place to support a marketplace of expanded choice among plans?

- ***Data for Oversight.*** Medicare's databases for oversight were developed in the context of the traditional program. They emphasize information on where spending occurs across provider types and geographic areas, and the services provided. In the context of MA, such questions remain relevant, but others emerge, and may be even more critical. For example, indicators of rapid disenrollment could reveal potential confusion in the marketplace, and complaint data by plan and state could highlight where problems are more likely to occur. If care coordination is a goal, indicators of management capacity would provide an indication of the infrastructure being supported. Requiring HEDIS reports both for PFFS and the traditional Medicare program would support better assessment of their relative performance. (Under MIPPA, PFFS plans are required to begin reporting HEDIS data starting in 2010.) Publicly available data on the risk distribution within particular contracts (named or unnamed) could help to identify how equitably MA is serving diverse subgroups. One might envision, for example, CMS briefing Congress annually on the performance of the program, as judged on a series of measures and over time.

- ***Resources for Administration and Oversight.*** The findings from this study highlight the complexity of MA within the Medicare context. Administering MA creates new demands on CMS to oversee an annual process of soliciting interest in the program, updating rates, reviewing bids for large numbers of plans, and overseeing marketing of an annual choice, as well as the overall performance of firms participating in MA. As participating firms point out, the administrative demands on both CMS and the firms themselves are substantial. In future deliberations on MA, it will be important for policymakers to consider the administrative requirements of such a complex program and provide adequate operational resources to CMS to accommodate both MA and the simultaneous operation of the traditional Medicare program, which requires individual claims processing and provider oversight. Policymakers also may want to consider potential issues relating to administrative inefficiencies associated with running s such a complex system with so many participants.

- ***Future Program Direction.*** Our study documents ways in which the MA program has evolved that, arguably, were unanticipated when the MMA was enacted. That legislation intended to encourage a broader availability of choice within MA, using coordinated care models, with regional PPOs serving as an alternative vehicle in those markets where local plans could not thrive. The hope was that regional PPOs would mean that each beneficiary had at least a few MA choices in a program that encouraged better care management and quality through the traditional program. Instead, growth in PFFS plan availability and enrollment have come to drive the market—a trend that contrasts with the evolution of the private commercial insurance market, in which provider choice is more restricted and based around preferred provider organizations that may have more flexibility to work with providers and so be better able to coordinate care than traditional Medicare. SNPs were intended to support specialized care delivery for subgroups of beneficiaries with unique and challenging needs, but our firm discussions suggest that the majority of these plans appear, at least to date, to have focused more on targeting their benefit packages and

attracting increased enrollment, than in improving care coordination more than would be feasible in general MA.

In sum, through its use of public data and discussions with firms, our study has highlighted much of the evolution and complexity associated with MA, but also has drawn attention to the limitations on what is known, as well as the policy considerations inherent in both the data and the limitations. After the 2008 election, if not before, these issues likely will gain even more prominence. Our hope is that this analysis will provide insights that can help frame that debate and those issues worthy of consideration.

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APPENDIX A

DATA SOURCES AND METHODS

A. CONTRACT AVAILABILITY AND ENROLLMENT

Data Sources. The data used to analyze contract availability and enrollment builds on our practices for the previous project using public CMS data. The base core data come from the monthly CMS State/County/Contract file (the historical equivalent of the CMS quarterly Geographic Service Area Report [GSA file]). This file provides the main source of information on MA contracts by type, service area, and enrollment. The core structure is based around "contract/county" combinations. This structure allows for estimates of the geographic availability of contracts of different types in urban/rural areas, regions, states, and other geographic aggregations. We supplement our earlier work using March 2005 and December 2005 data, with similar data now available for November 2006 (the earliest reported enrollment data in 2006), March 2007, and March 2008.[1]

We link these data to other information on the counties served. Beneficiary counts for each county were drawn from the market penetration state/county file; as previously discussed, the most recent data consistent with historical definitions are for December 2005. Rate information comes from the Medicare Advantage Ratebook annual files. Counties were identified as urban/rural using the Area Resource File. Firm codes were updated using MPR's historical codes; these rely on information from InterStudy, the Blue Cross Blue Shield Association's annual paper on member MA offerings, and other sources of data.[2]

Problems with the timing of the release of the State/County/Contract file resulted in our use of alternative data sources for analysis of contract availability in 2006-2008. Because CMS did not release this file in 2006, we created a "pseudo-GSA file" based on the November 2005 release of CMS's Medicare Options Compare data file (also known as the Plan Finder) for 2006.[3] For consistency and improved timeliness, we continued this practice in 2007. In 2008, because the Plan Finder release was delayed by CMS, we used the "Landscape File" so that we could analyze data on availability as early as possible.

We also use these sources to make certain adjustments to the data. For example, in the MMA, SNPs are defined by population, rather than type of contract. As a result, many SNPs are not authorized by a separate contract number and distinct contract type, but instead as one of several plans offered under a given contract. Most SNPs, therefore, are not distinct units within the contract file. Because SNPs are not available to all beneficiaries (just a subset), we excluded

[1] We have used March in the past because contracts renew and change in January of each year; the March date provides time for beneficiaries to respond to these changes. Since the MMA was enacted, most beneficiaries can enroll only during open enrollment season. Monthly trend data for enrollment by contract type from November 2006-March 2008 suggests that a March date captures most, but not all, of the open enrollment changes. Appendix B.2 provides more analysis of the trends in monthly change in enrollment, and how we interpret them.

[2] This is necessary because, while the CMS files show the "parent" organization, they do not necessarily show common ownership of firms with differently named "parents;" i.e., the effects of consolidation in ownership over time, or the Blue Cross Blue Shield affiliations.

[3] The main differences between this file and the actual 2006 GSA file are that the CMS Plan Finder file did 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).

from the analysis of availability contracts that include *only* SNPs. We similarly exclude contracts that involve *only* employer direct plans.

Consistency Across Sources. In Appendix B.3, we examine in depth how the data source and the definition of which contracts are included in our analysis influence contract counts, and how they compare to CMS's counts in the monthly summary reports for March 2007 and March 2008. That report includes more contracts because it encompasses Puerto Rico, which we excluded from all of our other analyses. The data we use for the enrollment analysis is otherwise almost identical to that in the CMS report. The data we use for the availability analysis reflects fewer contracts for two reasons: first, because we exclude SNP-only and employer direct contracts to show only those contracts available for general enrollment, and second, because there are inconsistencies across the files. For the most part, these inconsistencies are for "other prepaid contracts" versus the MA contracts (HMOs, local PPOs, regional PPOs, PFFS, and MSA) that are the focus of analysis, and where most enrollment is located. The inconsistencies appear to have little, if any, influence on the findings.

Analysis of Availability. As in our previous work**,** we use two basic measures to capture the choices available to beneficiaries nationwide. The first is a simple count of the choices (contracts) approved, by type, for the nation as a whole, or within a region for any county. The second more accurately conveys the actual choices available to beneficiaries, given their county of residence, by expressing choice in terms of the percentage of beneficiaries with access to particular kinds of choices (for example, any MA, types of MA, number by type). For this second measure, we exclude contracts offering only SNPs and employer plans, as they are not available to the entire population. As in the past, we provide breakdowns by contract type to distinguish categories of central policy focus: local CCPs (HMOs versus PPOs and PSOs),[4] regional PPOs (2006 onward), PFFS, MSAs (2007 and onward), cost contract, and other types. We also provide a national overview of contract changes—terminations and new entrants—for each year, as well as selected characteristics of those contracts.

Analysis of Enrollment. We examine two basic measures of enrollment—absolute size of enrollment and market penetration. For the most part, the analysis involves straightforward data in tabular form on the changes over time in plan participation, concentration, characteristics, and enrollment. We also look at the distribution of enrollment by county payment rate in floor counties, with special attention to enrollment by contract type.

B. ANALYSIS OF PLAN BENEFITS AND PREMIUMS

Data Source. This part of the project replicates for 2007 and 2008 selected analyses included in the AARP work for the 2006 plan year (see Gold et al. 2006). This earlier analysis used the November 2005 release of the 2006 Medicare Personal Plan Finder, a database of the plans offered to Medicare beneficiaries by county.[5] The data also show the contract under which

[4] For consistency, PPO demonstration plans are included in the 2005 totals, since this option was folded into the regular MA program in 2006.

[5] Technically, these are referred to as plans within "contract segments." Plans are offered under a specified MA contract. Because payment rates vary by county, CMS allows firms to subdivide the service area of that contract (typically a set of counties) into "segments" that have plans with differing benefits/premiums. (This option is not available for RPPOs.) Within each segment, firms may offer one or more MA plans. These may be available for all

the plan is offered, which, along with the county identifier, allows us to link them to other selected information included in the Personal Plan Finder (e.g., contract enrollment by county). We use analogous files for 2007 and 2008.[6] This analysis includes plans in Puerto Rico and the territories. We exclude employer-sponsored plans ("800" plans), because they are not available to beneficiaries who are not members of specific groups, and also are structured uniquely to make them easy to sell to groups.[7]

The contracts included in this analysis are narrower in scope than in the availability/ enrollment analysis. In analyzing benefits and premiums, we consider only HMOs, local or regional PPOs, PFFS plans, and SNPs. (MSAs are now included as well, since the first one was offered in 2007.) Consistent with historical practice, Health Care Prepayment Plans, cost contracts, demonstration, and PACE contracts are excluded, because these types of plans have unique benefit requirements, have not always been included in the Plan Finder, and are not central to most policy concerns about MA.

The basic unit of analysis for this part of the project is the plan, which is a particular package of benefits and premiums offered consistently throughout a set of counties (i.e., by local plans) or in each region (regional PPOs). Such a geographical subdivision within a contract is called a "contract segment," and there may be one or more distinct plans offered in each. While SNPs are not a unique contract type, we separate out SNP plans offered under various types of contracts and treat them as if they were unique, since the unique populations they serve (mostly dual eligibles and some institutionalized) lead them to have distinct benefits packages.[8] Plans may serve individuals or groups only. Group plans are excluded from the analysis. Because there is considerable interest in knowing how many group plans are offered, we provide analysis in Appendix B.4 of the numbers and types of group plans in 2007, the most recent year for which data are available.

To distinguish among plans and guide the analysis, we also state whether a plan includes the Part D prescription drug benefit (MA-PDs) or not (MA only).[9,10] When there is more than one

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enrollees. If they are offered under a coordinated care contract, plans also may be offered on a restricted basis to subsets of beneficiaries (duals, institutionals, or individuals with severe or disabling chronic conditions).

[6] 2008 data were not released as a downloadable file until late January 2008.

[7] Group plans typically are streamlined to cover Medicare benefits, so that firms can negotiate with individual groups about what buy-downs of cost sharing or additional benefits they want to add or "wrap around." MedPAC's analysis indicates that bids for group plans are higher on average than for those in the individual market, raising concerns that firms have incentives to structure bids for group plans as close to the benchmark as possible for Medicare services, so that they are in a position to offer savings to group purchasers (MedPAC April 2008b).

[8] This classification creates mutually exclusive categories of plans with benefits and premiums that can be analyzed separately. It is also useful because of the constraints on enrollment data, which exist by contract only, and not by plan. The MA contract totals we will create will include only those in which at least one plan is available to all beneficiaries. This distinction prevents double-counting contracts that may include both general and SNP plans, and provides a clear summary of the characteristics of plans available to the general Medicare population.

[9] All RPPOs and SNPS must include this benefit. Local coordinated care contracts must offer one plan that is an MA-PD, but also can offer MA-only plans. PFFS plans have the option to offer MA-PDs or not. MSAs are not authorized to offer MA-PDs. Beneficiaries in the latter type of plan can choose a stand-alone PDP to complement their MA-only coverage. (Beneficiaries in local CCPs cannot enroll in a stand-alone PDP, even if they select an MA-only plan to encourage coverage that integrates the two benefits.)

type of plan serving the same geographical area (contract segment), we differentiate between the one with the lowest premium and all others to expedite analysis of what beneficiaries living in a given area have available to them. (In Chapter VII, where these findings are discussed, we provide additional information on lowest premium and other plans.) We also discuss what the findings show about the types of plans being offered, not just their benefits and premiums (i.e., MA-PD versus MA-only and lowest premium versus other plans.)

Analysis. As discussed previously in reference to our work for ASPE, working with the data from the Plan Finder is complex for a number of reasons, one of which is its incorporation of text fields. This work was only feasible within contract resources because we were able to take advantage of programs already written for use on the AARP project. There are two major challenges in generating data on MA premiums and benefits. The first is the risk of overload. There are 5 or more types of contracts, and 3 or more categories of plans, within each type (lowest premium, other, and all), as well as MA-PD and MA-only plans, and many variables. The analysis we developed aims to focus on comparisons that we believe yield the most important information. Core tables show results by contract type and incorporate data for lowest premium and other plans, as well as the totals. A few focus on benefit features that affect out-of-pocket costs in PFFS and out-of-network PPO benefits. Because MA-only plans have limited enrollment, especially outside of PFFS, most tables are presented for MA-PDs only. Since only a few MSA plans currently exist (beginning in 2007), we do not cover them in the regular tables, but instead have developed a text table that profiles their basic characteristics.

In sum, we have developed a basic set of 11 tables for each year. The tables capture the following topics related to MA benefits and premiums:

- Changes from the previous year in the number of plans offered within each contract, and by MA-PD and MA-sector
- Premium summary for that year, by MA-PD plan type
- Part D plan characteristics for that year, by MA-PD plan type
- Selected use and amount of physician and hospital cost sharing, by MA-PD plan type for that year
- A more in-depth look at specific issues involving benefit design in PPOs (cost sharing for out-of-network benefits) and PFFS plans (profiling Part A/B cost sharing in ways that incorporate PFFS plans), for that year
- Estimated out-of-pocket costs for physician and hospital cost sharing, by MA-PD plan type (using the HealthMetrix methods discussed later), for that year
- Inclusion of supplemental benefits in MA-PDs, by plan type, for that year

[10] Because MA-only plans have unique functions under most types of contracts, making this distinction provides us with the option to create more meaningful data by focusing on MA-PDs only for certain variables (e.g., total premiums, prescription drug benefits).

- Overview of key features of premiums and benefits in MA-only plans, by contract type, for that year
- Summary of benefit design in MSAs offered that year

Analysis of Estimated Out-of-Pocket Costs for Part A/B Cost Sharing. Estimated out-of-pocket costs for cost sharing on Part A/B benefits focus mainly on ways to summarize likely differences across plans in their cost sharing for hospital and physician services. The estimates are calculated using licensed assumptions on use of services developed by HealthMetrix, Inc. The methodology provided by HealthMetrix provides use assumptions for beneficiaries in three categories of health—termed "good," "fair," and "poor" through 2004, and renamed "healthy," "episodic needs," and "chronic needs" thereafter. The use assumptions relate to spending on in-patient admissions, physician office visits, urgent care, and emergency room visits, each of which vary with health status, as well as physical exams, which do not.[11] In 2005, HealthMetrix also modified the utilization assumptions used for enrollees in fair and poor health by increasing the assumed number and length of hospital stays. Essentially we use their assumptions and apply them to the benefit design of each plan. Their application factors in any existing limits on out-of-pocket costs. For PPOs, where there is an option to go out of the network, the HealthMetrix application assumes the use of in-network benefits. (We include other tabular analyses in the report to provide some insight into the cost sharing that applies when out-of-network benefits are used.) We compare average use for all enrollees across plans by assuming a standardized mix of enrollees that reflect the characteristics of community residing Medicare beneficiaries, as estimated through the Medicare Current Beneficiary Survey. Because these data lag and MA's enrollment mix is changing, the weights used are based on beneficiaries rather than the mix of those in good, fair and poor health the MCBS shows for enrollees in private plans.

Weighted versus Unweighted Data. Enrollment in MA plans is highly skewed; that is, a substantial number of enrollees are in a small number of plans. This means that, while a simple (unweighted) average across plans will represent what the average plan offers, it typically does not represent what the average enrollee in an MA plan receives. For this reason, weighting plans by their enrollment is critical to understanding the premiums and benefits that apply to MA enrollees versus what is available for selection. Unfortunately, CMS did not, prior to May 2008, publicly release enrollment data within a county at the plan level, only at the contract level. In our previous work (prior to 2006), we applied the entire contract enrollment in a county to the basic premium plan to measure what the average enrollee received. While it is likely that this method understated premiums and benefits (to the extent that multiple plans were offered), such offerings were less common at that time, and the perception was that most enrollees were in a basic plan. This assumption may no longer be true today, in which case premiums likely are understated and benefits overstated. Because of the issues associated with using available data to construct weights, we mostly use unweighted data for 2007 and 2008.

Trend Analysis. Because of the complexity of data for each year, it is not possible to capture trends in the detailed tables. Single-year tables already are at their limit in terms of

[11] HealthMetrix also supports assumptions on prescription drug use, but we have not used them since 2006, when the drug benefit began, because we were concerned that developing spending estimates for such a new and complex benefit would be too difficult.

complexity. We focus on the most current year (2008) in the report, but include 2007 tables as Appendix C. We place 2008 data in context with a summary analysis of trends for key variables. The trend analysis examines 2006-2008 for these basic benefits:

- Mean premiums, overall, and for Part D
- Zero premium offerings, including application of savings to Part D
- Selected measures of cost sharing (mean primary care and specialist premiums, whether a limit on out-of-pocket costs exists (and in what form), and average estimated A/B out-of-pocket costs)
- Coverage in the Part D gap

Our analysis includes trends for these variables from 2005-2008. In this analysis, we show trends based both on unweighted and weighted data. The weights require assuming that the contract enrollment is all in the lowest premium MA-PD plan. Results are presented for all contract types, and also separately for HMOs, local PPOs, regional PPOs, and PFFS plans. No separate analysis is provided for SNPs because dual eligibility complicates estimates of out-of-pocket costs, and because SNPs are not distinct contracts, which complicates weighting.

C. ANALYSIS OF QUALITY DATA FROM HEDIS AND CAHPS

Data Sources. CMS publicly reports a number of quality measures for selected MA products, including performance measures from the Healthcare Effectiveness Data and Information Set (HEDIS) and measures of patient experience from the Medicare Consumer Assessment of Health Plans Surveys (CAHPS). These performance measures are available from two main sources: the HEDIS public use files and, for CAHPS, the Plan Finder downloadable files.[12,13]

The HEDIS and CAHPS data available are provided as a percentage of beneficiaries (such as the percentage of female beneficiaries in a given MA contract receiving mammograms, or the percentage of all beneficiaries rating the health care they received as 8 or 9 on a 10-point scale). The numerators and denominators of these performance measures are not available. For this reason, we can report only on the performance measures as provided in the data files, and are unable to analyze the data in other ways.

Specifics on HEDIS data. A wide variety of HEDIS indicators and other variables are publicly available at the contract level through the HEDIS public use files for reporting years

[12] While the Plan Finder files include both HEDIS and CAHPS measures, the HEDIS data from these files are largely incomplete, with a large number of missing values. Therefore, we use the HEDIS Public Use Files for our analysis of HEDIS data.

[13] In addition to these data sources, the Medicare Health Outcomes Survey (HOS) and the CAHPS research files also provide information on MA quality. Public use files from the Medicare HOS are available at www.hosonline.org, and the CAHPS research files are available from AHRQ upon special request.

1997 through 2006. For example, the 2007 file (which reflects 2006 data) includes more than 20 measures related to managing existing health conditions, and 15 measures related to medication use and management. For purposes of understanding the types of information available, we sorted measures into the following broad categories:

1. ***Access and preventive care.*** Access to ambulatory or preventive care visits in prior year; colorectal cancer screening; glaucoma screening; breast cancer screening; osteoporosis testing in older women; fall risk management.

2. ***Management of existing conditions***. Comprehensive diabetes care; cholesterol management for patients with cardiovascular conditions; controlling high blood pressure; beta blocker treatment after heart attack; management of urinary incontinence; osteoporosis management in women who had a fracture; follow-up care after hospitalization for mental illness.

3. ***Medication use and management.*** Antidepressant medication management; anti-rheumatic drug therapy in rheumatoid arthritis; drugs to be avoided for the elderly; annual monitoring for patients on persistent medications; potentially harmful drug-disease interactions for the elderly.

4. ***Other measures.*** Use of spirometry testing in assessment and diagnosis of COPD; physical activity in older adults.

In addition, the 2007 HEDIS Public Use File includes several measures on MA contracts' member services, provider credentials, years in business and enrollment by product type, various utilization measures, average length of stay, resource use, and initiation of alcohol and drug dependence treatment. Given our focus on quality performance, and the resource constraints of this study, these measures were not included in our analysis.[14]

For this study, we examine those HEDIS measures related to access and prevention, management of existing conditions, and medication use management (Table VIII.1). These categories of measures reflect commonly reported HEDIS indicators widely regarded as appropriate measures of quality. Moreover, many of the available categories reflect disease states that are relatively common among the elderly. Given resource constraints, we focus on data for the reporting years 2005 and 2006, the most recent data available at the time of our analysis.

Specifics on CAHPS data. Through the Medicare Health Plan Compare database on its Medicare Options Compare website, CMS provides CAHPS data on beneficiaries' satisfaction and experiences with the health care they receive. Data are generated from CAHPS health plan surveys administered to Medicare beneficiaries in private health plans and collected by CMS. Many types of MA contracts, including PFFS, participate in CAHPS. The CAHPS data in the 2008 database largely reflect contracts, though a small proportion of entries reflect contract-

[14] We also did not analyze utilization and related measures, because of the difficulty in interpreting utilization data out of the context of other analysis and controls.

market combinations, in which markets are given by the county or counties in which contracts operate.

For this study, we analyze the six CAHPS indicators provided in the 2008 Medicare Health Plan Compare database, which represented the most recent available data at the time of our analysis (reflecting 2007 CAHPS survey data). The six CAHPS indicators are presented in Table XIII.8.

Data Limitations. There are several important limitations in the available HEDIS and CAHPS data, as follows.

Missing data. A primary limitation of both the HEDIS and CAHPS data is the number of contracts with missing data. Approximately 150 contracts report CAHPS data, and fewer than 200 contracts report HEDIS data (with the number reporting varying by the HEDIS measure). Contracts do not report quality data for two primary reasons: (1) they are too new to be measured,[15] or (2) the number of Medicare members is too small to report any quality data. In addition, some HEDIS indicators focus on specific subpopulations—such as those with rheumatoid arthritis or with a hospitalization for mental illness—and contracts may not have adequate numbers of enrollees to report data for these specific indicators. Given these issues of missing data, our analysis is relatively basic, and requires careful interpretation, since it does not reflect a majority of MA contracts.

Limitations in analysis by contract type. Most of the available HEDIS data reflect HMO contracts, with relatively few other contract types reporting HEDIS data. (For example, PFFS contracts are not required to report HEDIS data). The same is true for CAHPS data. For example, in the 2008 CAHPS data, more than 80 percent of contract-market combinations reporting data are HMOs. For this reason, for both HEDIS and CAHPS data we are limited in our ability to compare performance on selected measures by contract type.

Time lags. The time lags in the quality data are notable. For example, the most recent HEDIS public use file reflects 2006 data. This means that our ability to monitor how the MMA currently might be affecting performance and quality is relatively limited.

Analysis. Our analysis of quality data is presented in Chapter XIII. This analysis involved two primary steps. The first was to understand fully the availability and completeness of performance data. To do this, we assessed data accuracy and completeness overall, and by contract type. We then produced descriptive statistics on HEDIS and CAHPS data, analyzing these measures in several different ways. For example, we examined average performance on various HEDIS and CAHPS measures by contract type (as sample sizes allowed) and firm affiliation (for those contracts from major firms). While such analyses may be suggestive of various findings or trends, we caution against drawing conclusions from these subgroup analyses, given the small sample sizes.

[15] Many of the HEDIS measures require one year of continuous enrollment.

As with other analyses, the analysis of performance measures was limited to MA plans in the 26 MA regions, excluding U.S. territories and Puerto Rico.

We report both unweighted and weighted descriptive statistics on the quality data. Simple (unweighted) averages across contracts reflect the quality provided by an average contract. However, because a substantial number of enrollees are enrolled in a small number of contracts, unweighted measures will likely not reflect the quality received by an average enrollee in MA. For this reason, we also present performance measures weighted by contract enrollment.

At ASPE's request, our analysis and discussion of quality performance also touches on two other topics. First, we briefly summarize the results of an MA quality analysis from a recent MedPAC report (Report to Congress: Medicare Payment Policy, Chapter 3, March 2008) and highlight, in broad terms, how our analysis and findings differ from those of MedPAC. Second, we discuss briefly the five-star performance ratings recently added to the Medicare Options Compare website, summarizing the CAHPS and HEDIS measures used in those ratings and noting how those measures relate to our analysis of quality data.

D. DISCUSSIONS WITH FIRMS

We conducted telephone discussions with senior executives responsible for the Medicare Advantage product in a diverse set of firms (from 45 minutes to one hour in length). In the advance letter, we shared a list of the topics we sought to address, and reassured the recipients that their comments would be confidential and not attributed to individual firms. We asked to speak with the most senior person or persons in the organization responsible for the MA product line. Table A.1 shows the topics of interest shared with the firms (a different list was provided for the few employer-sponsored plans selected). We tried to schedule discussions for late February through mid-April, so they would be after the open enrollment season but before concentrated work was completed. All discussions were led by an experienced researcher with substantial experience with MA (our project director, Marsha Gold), accompanied by an analyst who took notes (either Chris Fleming or Stephanie Peterson). We discuss below how we selected firms for discussions, and the responses.

Selection Criteria for Discussions. Our goal was to conduct 15 to 20 telephone discussions with executives in a variety of MA plans via conference calls. For the most part, these were designed as informal, single-firm discussions to encourage openness, given that the plans were likely to regard many of the issues discussed as proprietary, and that respondents would be sensitive to the use of the information they provided. For this reason, we perceived that their responses would be constrained if competitors were part of the same call. To expand the reach of firms with which we could consult, we tried to conduct group discussions with selected non-competing local firms of similar orientation (e.g., traditional prepaid group practices, Blue Cross affiliates). However, it proved too complicated to schedule some group sessions, so all discussions included only a single firm.

Table A.1. List of MA Topics to be Discussed (Tailored for Specific Types of Firms)

Firm MA Position and History

- Review firm's 2008 offerings, and any significant shifts from prior years
- Major factors that led firms to change (or not change) their offerings from 2006 through 2008
- If relatively new entrant: What led you to enter the MA market?

Decision Making on Products

- What are the main factors that make specific MA products attractive (or not) to your firm and to the marketplace overall?
- How do firms position individual products relative to one another in the marketplace?
- What is the motivation for offering an SNP, and who does it seek to serve?
- Are employers becoming more of a market, why, and for which products?

Enrollment Strategy

- How aggressively are firms seeking to grow the MA product line, and in which segments?
- How do firms position their MA products vis-a-vis their Part D or other products?

Geography, Networks, and Payment Rates

- Has experience led firms to change how they think about forming provider networks in different parts of the country, and how does this influence the market?
- How are firms marketing beneficiary access to physicians in relation to competing MA plans and traditional Medicare?
- If for some reason the Medicare program eliminated the PFFS option, or made it less attractive, how would firms respond?
- How has risk adjustment influenced the relative attractiveness of MA for firms, or the profitability of the MA product? What is the influence of MA payment rates?

Policy Feedback

- Has the slower increase of MA payments in 2008 led to changes in MA products?
- How have congressional deliberations on MA influenced how firms think about the way they position themselves in the MA market?
- Is the RPPO option ever likely to be a viable product, and what policy changes might make it so?
- How do firms view CMS's oversight and support for operational concerns relevant to the program, such as marketing, bidding, and enrollment?
- What modifications in bidding, marketing, or other policies do firms view as important to making the program work better in the future?

Long-Term Commitments and Concerns

- Have firms made decisions about 2009, and what are their long-term interests in the MA program?
- What assumptions have firms made about the time horizon? How likely are they to stay in the market if the experience proves unfavorable?
- What are firms' most pressing concerns now with respect to MA policy?

In general, we sought to identify firms for discussion based on the following four criteria:

1. each of the largest national firms in the market
2. a good mix of firms that represent particular segments of the market (e.g., traditional HMO firms, BC/BS affiliates)
3. geographic variation
4. unique insights (e.g., as to particular types of new entrants)

Operationally, we developed six types of groupings, and candidate firms associated with them, on which to focus, so we could meet the criteria. The six include:

- ***National firms*** dominant in MA, with the three largest—United Healthcare, Humana, and Kaiser Permanente—each slotted for a discussion.
- ***Historically dominant firms*** that now have smaller market shares—like Aetna, Cigna, and Health Net—with a discussion to be scheduled with at least one of these.
- ***Aggressive new national entrants***, including WellPoint, Coventry, and Universal American, each of which we would try to schedule for discussions.
- ***Blue Cross and Blue Shield affiliates*** (other than WellPoint)—two to three that are dominant in the market (such as Highpoint and Regence), or known to have extensive experience with group MA for retirees (like Michigan BCBS).
- ***Traditional prepaid group practices*** such as Group Health Cooperative, Health Alliance Plan, Harvard Community Health Plan, HIP, and Group Health, all of which we would try to call in two group sessions.
- ***Other plans with unique and diverse attributes,*** including firms offering:
  - Employer-direct plans, or a direct PDP but not an MA plan (Deseret, National Rural Electrical Cooperative)
  - A focus on dual eligibles or Medicaid (two from HealthSpring, WellCare, Molina, and Bravo)[16] as well as public plans such as CalOptima and Commonwealth Care Alliance
  - New entrants, including firms in markets with little previous MA (e.g., Martin's Point in Maine), and private investor-led groups outside of the insurance sector (e.g., Healthcare Assured)

Arranging Discussions. For each firm, we identified a known contact or, if not known, used CMS files and websites to identify either the President of the company or (particularly with large

[16] In our discussions, we learned that some of these firms had a market focus different than what we had thought originally.

firms) another senior officer likely to have at least some oversight of the MA product. We have learned that MA plan sponsors have very different organizational structures, making it important to identify by function rather than title the appropriate person to interview. The letter we sent indicated that we sought to talk with the most senior executive responsible for decisions on MA plan offerings and/or enrollment and marketing. In our previous work for ASPE and others, we have found that, while the degree to which decisions are centralized varies by firm, the national office can provide valuable insight into the major criteria and processes used in decision making. For national firms, we focused on the national office lead staff responsible for decisions on the MA line of business.

Through FedEx, fax, or e-mail (depending on available contact information), we sent a letter that explained the request and its rationale, and provided assurance on confidentiality issues; a one-page project description was attached, and the letter noted that an MPR staffer would follow up in a few days to identify appropriate people with whom to talk, and schedule a convenient time for a conversation. As we did in the previous study, the letter was sent by MPR, but officially copied the ASPE staff (in this case, the Division Director, Steven Sheingold). For each firm, we tailored our follow-up based on what we learned from the initial contact. Each firm was contacted a number of times, ceasing only after we received no response despite persistent efforts. No firm explicitly refused our request, although a few were nonresponsive.

Completed Discussions. We succeeded in completing discussions with 19 firms, including firms from each of the categories. The 19 firms include more than 3.5 million enrollees in March 2008. We are not listing the firms so as to provide an additional layer of protection for the confidentiality we promised the participating firms.

The main shortfall was our inability, despite numerous attempts, to arrange a discussion with two of the major MA firms, one among the top three in enrollment, and the other a major new entrant. We also interviewed only two of the three BCBS firms with whom we sought a discussion, and were unsuccessful in reaching one of new small entrants. The two major firms each are publicly traded, and we have accessed the presentations on MA they made recently for analysis. One of the two was included in our discussions during the previous contract with ASPE.

APPENDIX B

SELECTED METHODS ANALYSES

APPENDIX B.1

INFLUENCE OF BENEFICIARY COUNTS ON MA PENETRATION

Counts of Medicare eligibles are necessary to calculate MA penetration rates. To provide flexibility to develop such rates across diverse areas of the country, we and other analysts use data on eligibles that is arrayed by county and aggregate it. In our work, we use the December 2005 eligible counts historically made available for this purpose by CMS. That file shows 42,986, 024 beneficiaries in the 50 states and District of Columbia[17], the total, including Puerto Rico and the territories, is 44, 074,640. Because of changes in the way it produced monthly MA information files, CMS no long released the number of MA eligibles quarterly after December 2005. The file includes all those eligible for Part A OR Part B.

Since then, CMS has released files that include information on eligibles. For the most part, the definitions used in these are consistent with the past or not provided and the data may not necessarily be at the county level. These include:

- CMS released a denominator file through the fourth quarter of 2006 with eligibles by zip code. http://www.cms.hhs.gov/IdentifiableDataFiles/06_DenominatorFile.asp We could not access the link but decided in any case not to use these data for 2006 or later years because they were based on those with Part A AND Part B, a lower count that results in higher penetration rates. We wanted to be consistent with MedPAC and we learned that they had decided not to use these data because it would make it look like penetration was changing more rapidly over time than in fact is the case.

- Two files were released with eligible counts for 2007 for firms to use in operations. An LIS Toolkit file shows 42,961,772 beneficiaries as of July 2007.[18] The second file includes Medicare beneficiaries extracted from the Medicare Beneficiary Database on September 24, 2007. Excluding Puerto Rico and the territories this file shows 43,082,584 beneficiaries. These numbers are not sufficiently different from what we used, at least at the national level, to make a big difference in the finding.[19]

After we completed our analysis, CMS released a modified set of public data that will be available in the future on a monthly basis. These data would appear to support more accurate trending of the number eligible for Medicare on an ongoing basis. The June 2008 data show 44,532,865 eligibles as compared with December 2005 data of 44,074,640 for the entire period. The difference shows about a one percentage point growth in the number of Medicare eligibles. However, there is county variation in growth rates and some counties decline in enrollment. That means that while the update would have a minor influence on what we calculate to be the overall MA penetration rate for the nation, the effects may be greater in states that are experiencing more rapid growth or loss of population that carries over to Medicare beneficiaries.

[17] There are 42,983,823 beneficiaries used in the payment rate analysis because a small number of beneficiaries are not able to be geographically linked to a county with a given payment rate.

[18] Source File: Targeting Estimates by County (July 2007) [Zip, 141KB] <http://www.cms.hhs.gov/partnerships/downloads/Counties.zip>

[19] http://www.cms.hhs.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.asp

APPENDIX B.2

MONTH-TO-MONTH FLUCTUATION IN CHANGES IN MA ENROLLMENT

Table B-1 includes the absolute enrollment counts for each month overall, and for select contract types. Table B-2 includes the percentage changes that correspond to those counts, and Figure B-1 graphs the data. All of these tables use all contracts, without the exclusions we made for this report (i.e., they include Puerto Rico and the Territories). We looked at these numbers to help identify the strengths and weaknesses of our use of March data. From these data we drew the following conclusions:

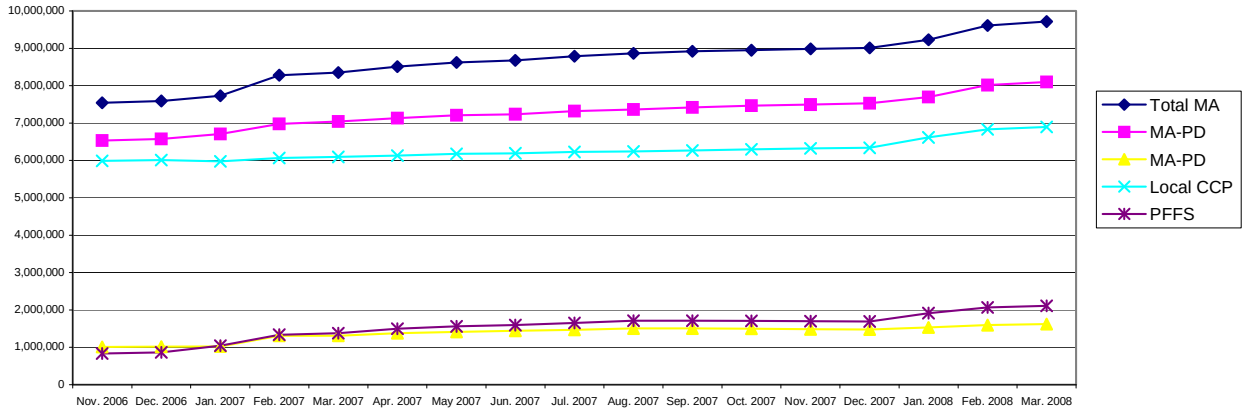
1. There is not one "perfect" month to examine, in part because (1) timeframes differ for general MA (reflecting the open enrollment period); (2) group plans differ in their annual review date (month of renewal with January and July common, but others are used as well—e.g., a larger public employer in Pennsylvania is bringing its retirees into MA this spring); and (3) dual eligibility status (no constraints on switching from one month to the next). Historically CMS's public files have not allowed analysts to take into consideration these different patterns for group and individual enrollees; changes in data for May 2008 may allow such analysis in the future. Even with change, it could be difficult to sort out trends due to dual eligibles (having to use SNP as a not very comparable proxy). MA-only and PFFS plans are most influenced by groups, although others are as well.

2. The March date we used captures most, but not all, of the open enrollment (there are some additional enrollments in April). Waiting until June would capture more complete open enrollment, and still come before the July group jump, but that would delay knowledge of major patterns.

3. The analysis confirms that January is not a good month, since it takes until February for most change to be reflected.

4. The quietest time is from August through November. CMS precludes certain activities and enrollments at that time in anticipation of the new year.

Figure B.1. MA Enrollment, November 2006-2008



Source: Data is from the Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations-Monthly Contract and Enrollment Summary Report released each month by CMS on its website at: <http://www.cms.hhs.gov/MCRAdvPartDEnrolData/

Table B. 1. MA Enrollment, November 2006–March 2008

	2006		2007											2008		
	Nov 2006	Dec 2006	Jan 2007	Feb 2007	Mar 2007	Apr 2007	May 2007	June 2007	July 2007	Aug 2007	Sep 2007	Oct 2007	Nov 2007	Dec 2007	Jan 2008	Feb 2008	Mar 2008
Total MA	7,542,757	7,591,051	7,728,782	8,282,806	8,350,765	8,508,544	8,622,976	8,678,224	8,790,422	8,865,325	8,919,710	8,949,143	8,982,041	9,007,800	9,224,895	9,609,452	9,715,707
MA-PD	6,532,036	6,572,159	6,704,489	6,975,934	7,040,909	7,132,071	7,207,871	7,234,420	7,318,237	7,360,314	7,416,865	7,454,358	7,495,364	7,529,773	7,696,081	8,012,310	8,096,355
MA	1,010,721	1,018,892	1,024,293	1,306,872	1,309,856	1,376,473	1,415,105	1,443,804	1,472,185	1,505,011	1,502,845	1,494,377	1,486,269	1,478,027	1,528,814	1,597,142	1,619,352
MA by Type																	
Local CCP	5,991,058	6,007,625	5,988,184	6,064,666	6,090,735	6,125,284	6,176,316	6,191,304	6,223,265	6,238,646	6,267,459	6,296,444	6,321,499	6,339,642	6,616,948	6,829,803	6,890,674
PFFS	835,074	864,100	1,047,383	1,338,026	1,379,277	1,494,955	1,558,371	1,591,967	1,650,439	1,709,785	1,709,782	1,703,980	1,702,611	1,693,128	1,914,192	2,070,227	2,108,721

Source: Data are from MPR's analysis of the Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations—Monthly Contract and Enrollment Summary Report released each month by CMS on its website at: http://www.cms.hhs.gov/MCRAdvPartDEnrolData/

Table B. 2. Medicare Advantage Enrollment, Month-to-Month Percentage Change, 2006-2008

	Nov-Dec 2006	Dec-Jan 2006-2007	Jan-Feb 2007	Feb-Mar 2007	Mar-Apr 2007	Apr-May 2007	May-June 2007	June-July 2007	July-Aug 2007	Aug-Sep 2007	Sept-Oct 2007	Oct-Nov 2007	Nov-Dec 2007	Dec-Jan 2007-2008	Jan-Feb 2008	Feb-Mar 2008
Total MA	0.64%	1.81%	7.17%	0.82%	1.89%	1.34%	0.64%	1.29%	0.85%	0.61%	0.33%	0.37%	0.29%	2.41%	4.17%	1.11%
MA-PD	0.61%	2.01%	4.05%	0.93%	1.29%	1.06%	0.37%	1.16%	0.57%	0.77%	0.51%	0.55%	0.46%	2.21%	4.11%	1.05%
MA	0.81%	0.53%	27.59%	0.23%	5.09%	2.81%	2.03%	1.97%	2.23%	-0.14%	-0.56%	-0.54%	-0.55%	3.44%	4.47%	1.39%
Local CCP	0.28%	-0.32%	1.28%	0.43%	0.57%	0.83%	0.24%	0.52%	0.25%	0.46%	0.46%	0.40%	0.29%	4.37%	3.22%	0.89%
PFFS	3.48%	21.21%	27.75%	3.08%	8.39%	4.24%	2.16%	3.67%	3.60%	0.00%	-0.34%	-0.08%	-0.56%	13.06%	8.15%	1.86%

Source: Data are MPR's analysis from the Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations—Monthly Contract and Enrollment Summary Report released each month by CMS on its website at: http://www.cms.hhs.gov/MCRAdvPartDEnrolData/

APPENDIX B.3

ANALYSIS OF CONSISTENCY OF CONTRACT AND ENROLLMENT COUNTS, BY DATA SOURCE AND DEFINITION

Comparison of Counts from Different Data Sources. The shifts in data sources over time on availability, and between availability and enrollment, result in some differences in the number of contracts used in various analyses. Table B.3 provides an analysis of counts by definitions and data sources for March 2007, and Table B.4 provides the same analysis for March 2008. Both analyses use CMS's monthly summary report (and the relevant public State/County/Contract file that applies to that time period) to show how the number of contracts and enrollees changes with various exclusions made to the data. We then compare the data from that source, with exclusions, to the contract counts obtained from the alternative data source used to enhance the timeliness of estimates for contract availability.

Using 2007 data, we examine below the consistency across sources (Table B.3). We start by examining results from the CMS Monthly Summary Report and how consistent it is with the more detailed monthly State/County/Contract file that forms the basis for the analysis file we constructed for ASPE under this contract.

- ***CMS Monthly Summary Report.*** This is the data source that provides the most comprehensive and timely perspective on MA contracts and enrollment nationwide. MPR uses this source for its Monthly Tracking Report prepared under a contract with the Kaiser Family Foundation and circulated widely by e-mail and posted on the Kaiser Family Foundation website. The summary report distinguishes between MA contracts and "other prepaid contracts." The CMS Monthly Report's MA contracts do not distinguish between HMOs and local PPOs or PSO plans, although we show these data here because they are useful in interpreting later exclusions. In March 2007, 474 of the 604 contracts were authorized under the MA program, versus other "prepaid categories." In the other category, CMS includes contracts for "pilots" authorized under the pilot Health Supports Program. We have viewed this inclusion as problematic, since contractors are not fully capitated for medical care costs under the pilot, although their fees are at risk, based on savings under the contract.

- ***State/County/Contract (SCC) File.*** This file and the Summary Report are related, and it would seem they should have the same counts. MPR's analysis of the publicly downloaded file for March 2007 shows that this is true, for the most part. The number of MA contracts and their distribution is identical. There are 10 fewer "other prepaid" contracts. The main difference appears to be that pilot contracts are not in the file, a practice we would support because of its appropriateness. There are 15 pilot contracts, but only a net difference of 10 between the files. This is because the SCC file includes 2 additional demonstrations and 3 "other prepaid" contracts for which identifiers were missing. The SCC enrollment shows that MA contracts contribute most of the enrollment included in private plans in Medicare (7.5 million of 8.2 million). For this reason, small inconsistencies between counts of "other prepaid contracts" probably are of little substantive concern.

- ***SCC File Excluding Puerto Rico and the Territories.*** Historically, MPR has done most of its analysis including data only for the 50 states and the District of Columbia. MA is not a factor in American Territories, and Puerto Rico has a number of unique characteristics that argue for its separate consideration. The SCC does not include variables on the service area for a contract, and we stopped merging these data to the file when we began to use other sources to examine availability. If one excludes

Table A.3. MA Contracts and Enrollment, Various Definitions and Sources, March 2007

	Contracts									
	CMS Monthly Summary Report	MPR Using SCC (Making no exclusions)		MPR Using SCC (Excluding Territories based on FIPS in SCC)		MPR Using SCC (Excluding Territories based on Service Area from Plan Finder)		MPR Using SCC (Excluding Territories based on Service Area from Plan Finder, SNP-Only, & Employer Direct)		MPR Availability Tables (source: Plan Finder)
	Contract Count	Contract Count	Enrollment	Contract Count	Enrollment	Contract Count	Enrollment	Contract Count	Enrollment	Contract Count
Medicare Advantage Contracts										
Local CCPs	410	410	6,047,796	410	5,711,176	394	5,710,309	331	5,592,563	317
HMO	291	291	5,608,345	291	5,295,129	277	5,294,262	226	5,203,362	214
PPO (including PSO)	119	119	439,451	119	416,047	117	416,047	105	389,201	103
PFFS Total	48	48	1,338,675	47	1,338,453	46	1,338,453	45	1,329,296	45
PFFS	47	47	1,329,518	46	1,329,296	45	1,329,296	45	1,329,296	NA
Employer Direct PFFS	1	1	9,157	1	9,157	1	9,157	0	0	NA
Regional PPOs	14	14	118,030	14	118,030	14	118,030	11	112,191	11
MSA	2	2	1,346	2	1,346	2	1,346	2	1,346	2
Total – All MA Contracts (Local CCPs, PFFS, Regional PPOs, and MSA)	**474**	**474**	**7,505,847**	**473**	**7,169,005**	**456**	**7,168,138**	**389**	**7,035,396**	**375**
Other "Prepaid" Contracts										
1876 Cost	27	27	304,988	27	304,988	27	304,988	27	304,988	21
1833 Cost (HCPP)	13	13	69,864	13	69,864	13	69,864	13	69,864	NA
Demos	38	40	209,424	40	209,424	40	209,424	27	173,908	40
PACE	37	37	12,180	37	12,180	37	12,180	37	12,180	39
Pilot (2)	15	0	0	0	0	0	0	0	0	NA
Unknown		3	0	2	0	2	0	3	0	
Subtotal: Other "Prepaid" Contracts	**130**	**120**	**596,456**	**119**	**596,456**	**119**	**596,456**	**107**	**560,940**	**100**
Total "Prepaid" Contracts (1)	**604**	**594**	**8,102,303**	**592**	**7,765,461**	**575**	**7,764,594**	**496**	**7,596,336**	**475**

Source: MPR analysis of various CMS Public Data Files.

(1) Totals include beneficiaries enrolled in employer/union-only group plans (contracts with "800 series" plan IDs).

(2) Pilots refer to contracts to provide care management services for fee-for-service beneficiaries with chronic conditions. The data for this product are included, since they are part of the total monthly Medicare payment.

CMS Monthly Summary Report = Used in MPR's Monthly Tracking Report; SCC = Monthly State/County/Contract file.

Table B.4. MA Contracts and Enrollment, Various Definitions and Sources, March 2008

	Contracts									
	CMS Monthly Summary Report	MPR Using SCC (Making no exclusions)		MPR Using SCC (Excluding Territories based on FIPS in SCC)		MPR Using SCC (Excluding Territories based on Service Area from Plan Finder)		MPR Using SCC (Excluding Territories based on Service Area from Plan Finder, SNP-Only, & Employer Direct)		MPR Availability (source: Landscape)
	Contract Count	Contract Count	Enrollment	Contract Count	Enrollment	Contract Count	Enrollment	Contract Count	Enrollment	Contract Count
Medicare Advantage Contracts										
Local CCPs	509	509	6,841,318	508	6,478,583	493	6,502,079	386	6,171,333	386
HMO	368	368	6,253,728	367	5,925,682	355	5,949,178	264	5,648,009	266
PPO (including PSO)	141	141	587,590	141	552,901	138	552,901	122	523,324	120
PFFS Total	79	78	2,043,973	78	2,042,125	75	2,043,838	73	2,032,587	67
PFFS	77	76	2,032,722	76	2,032,587	73	2,032,587	73	2,032,587	NA
Employer Direct PFFS	2	2	11,251	2	9,538	2	11,251	0	0	NA
Regional PPOs	14	14	253,214	14	253,214	14	253,214	11	191,051	11
MSA	9	9	1,706	9	1,706	9	1,706	9	1,706	9
Total – All MA Contracts (Local CCPs, PFFS, Regional PPOs, and MSA)	**611**	**610**	**9,140,211**	**609**	**8,775,628**	**597**	**8,800,837**	**479**	**8,396,677**	**473**
Other "Prepaid" Contracts										
1876 Cost	25	25	267,616	25	267,616	25	267,616	25	267,616	16
1833 Cost (HCPP)	13	13	66,781	13	66,781	13	66,781	13	66,781	NA
Demos	17	19	3,979	19	3,979	19	3,979	16	3,448	15
PACE	48	46	13,539	46	13,539	46	13,539	46	13,539	NA
Pilot (2)	13	0	0	0	0	0	0	0	0	NA
Unknown		3	0	3	0	3	0	3	0	
Subtotal: Other "Prepaid" Contracts	**116**	**120**	**351,915**	**106**	**351,915**	**106**	**351,915**	**103**	**351,384**	**31**
Total "Prepaid" Contracts (1)	**727**	**730**	**9,492,126**	**715**	**9,127,543**	**697**	**9,152,752**	**582**	**8,748,061**	**504**

Source: MPR analysis of various CMS Public Data Files.

CMS Monthly Summary Report = Used in MPR's Monthly Tracking Report.

SCC = The Monthly State/County/Contract file for March 2008.

Puerto Rico from the files based on exclusion of contracts with Puerto Rico enrollment *only*, the number of contracts in the SCC is reduced by only two—one fewer PFFS contract and one fewer unknown "other prepaid" contract. However, we know from experience that there are more contracts that target Puerto Rico only. If we also exclude all contracts in the 2007 Plan Finder that show only a Puerto Rico service area, additional contracts are eliminated, but only about 1,000 more enrollees are so excluded. We therefore infer that the additionally excluded contracts legitimately should be excluded, because they mainly serve Puerto Rico and should not count toward availability in the 50 states. The Puerto Rico adjustment results in 18 fewer MA contracts (456 versus 474) and 1 less "other" contract, with a net elimination of 337,709 enrollees in March 2007. *These are the data included in the analysis file we will provide to ASPE under this contract, and they are also the data used in calculating its enrollment and penetration rates.*

- ***MPR's Exclusions in Looking at Availability, and the Comparability between the SCC File and Plan Finder.*** In concept, we sought to base the analysis of MA availability on all of the previous contracts (excluding Puerto Rico), with two exceptions—SNP-only contracts and contracts for employer-direct PFFS. The rationale is that these contracts do not provide plans available to the population overall. The Plan Finder data show 14 fewer MA contracts than are included in the SCC when this definition is applied, and 7 fewer "other prepaid" contracts. This means that our analysis of availability in 2007 is based on 475 versus 496 contracts.[20] The difference between the two files appears to reflect (1) 14 fewer HMO or local PPO contracts in the Plan Finder; (2) the exclusion of the 13 HCPP contracts from the Plan Finder; and (3) small differences in the number of 1876 cost contracts, demonstrations, and other contracts in each file. We speculate that the difference between the two files in terms of HMOs and local PPOs could be because some MA contracts may be closed for enrollment, or are new and still under review for approval, and so not included in the Plan Finder. We doubt the difference is of major substantive importance, since the two files agree 96 percent of the time. For reference, the contracts excluded from the SCC because they are SNP-only or employer-direct had just 168,258 MA enrollees in March 2007 (the difference between enrollment with the full set of contracts outside of Puerto Rico and the subset excluding SNP-only and employer-direct contracts).

Table B.4 shows the same analysis for March 2008, except that the Landscape File rather than the Plan Finder was used for availability. In 2008, there was one fewer PFFS contract in the SCC than in the Monthly Summary Report, but a net difference of 4 more "other prepaid" contracts in the SCC, resulting in 730 SCC contracts versus 727 in the Monthly Summary Report. The Puerto Rico exclusion eliminates an additional 33 contracts, using the fuller definition described previously. This results in a net of 591 MA contracts and 106 "other prepaid" contracts, for a total of 697 with 9.2 million enrollees, of whom 8.8 million are in

[20] The actual number of total contracts used for trending purposes in Chapter II is 396 for March 2007, not 475. The MA contracts included are identical to those in the full count from the Plan Finder, and these are most emphasized in the analysis. The 396 include cost contracts, but not PACE and "other" or demonstration contracts, since these are excluded from some data sources.

contracts specifically authorized under the MMA. *As noted previously, these are the 2008 data incorporated into the analysis file provided to ASPE and used in the enrollment analysis.* Had we used this file to examine availability, we would have based that analysis (after excluding SNP-only and employer-direct plans) on 582 contracts, 479 of which were MA contracts (versus "other prepaid"). Instead, we used the Landscape File because it was available in fall 2007. The number of contracts in that file is very close to that in the SCC, with the same exclusions. The Landscape File yields a total of 473 versus 479 contracts, a difference of six.[21] As before, we speculate that this reflects the exclusion from the Landscape File of new contracts still being approved, as well as unknown factors. There is a larger difference in the number of "other prepaid" contracts—the Landscape shows 31 versus 103 in the SCC, with exclusions. Most of these are categories we exclude from analysis, or that we do not expect to influence the overall findings because the contract types tend to be offered in counties where other contracts also operate. For this reason, although the total number of contracts differs between the two files (504 in Landscape versus 582 in the SCC), we do not believe the differences have much influence on the analysis, if any.[22]

[21] There are six fewer PFFS and 2 fewer local PPO contracts, but 2 more HMO contracts.

[22] The total number of contracts used in Table II.1 is 489, not 504, because 15 demonstration contracts are further excluded from that comparison.

APPENDIX B.4

ROLE OF GROUP PLANS IN THE MA MARKET

APPENDIX TABLE B.5

EMPLOYER-ONLY ENROLLMENT SUMMARY, MA ONLY
(As of CMS July 2007 Annual Plan Report)

Employer-Only Enrollment by Plan Type	
HMO/HMOPOS	939,682
PFFS	241,935
Local PPO	47,472
1,876 Cost contracts	42,910
HCPP – 1,833 Cost contracts	41,300
Employer/Union-Only Direct Contract PFFS	10,574
SHMO	5,039
RPPO	1,516
PSO (State License)	908
MSA	0
MSA Demonstration	0
PSO (Federal Waiver)	0
Total	**1,331,336**
Employer Enrollment by Contract Start Date	
Before 1990	661,566
1990-1999	333,250
2000 or later	336,520
All Years	**1,331,336**
Top 15 Companies, by Employer-Only Enrollment	
Kaiser	374,672
UHC- Secure Horizons	128,527
BCBS OF MICHIGAN	115,815
Aetna	77,292
Humana	60,415
HIP of NY	60,268
Highmark	56,180
Health Net	42,857
United Mine Workers	41,300
Rochester Area HMO	35,572
Coventry	35,031
Independence Blue Cross	22,798
Group Health Coop	22,402
WellPoint	18,214
Excellus, Inc.	16,761
Employer-Only Enrollment among the Blues	
BCBS of Michigan	115,815
Independence	22,798
WellPoint	18,214
Horizon BS of NJ	7,837
Capital Blue Cross	5,902
BCBS of Massachusetts	5,157
BCBS of Florida	4,327
BS of Puerto Rico	2,941
BCBS of Rhode Island	1,523
BCBS of Tennessee	30
BCBS of Idaho Health Services	22

APPENDIX TABLE B.5b

TOP 15 COMPANIES, BY EMPLOYER-ONLY ENROLLMENT, PLAN TYPE, AND CONTRACT EFFECTIVE DATE (As of CMS July 2007 Annual Report)

Company	Contract Number (number of plans with enrollment in contract)	Plan Type	Contract Effective Date	Total Enrollment
Kaiser Permanente	H9003 (2)	HMO/HMOPOS	04/01/1980	25,854
	H0630 (4)	HMO/HMOPOS	01/01/1986	20,212
	H1230 (3)	HMO/HMOPOS	05/01/1986	13,288
	H6360 (1)	1876 Cost	01/01/1987	3,947
	H0524 (8)	HMO/HMOPOS	08/01/1987	291,032
	H2150 (1)	1876 Cost	01/01/1991	15,487
	H1170 (2)	HMO/HMOPOS	01/01/1997	4,852
			Kaiser enrollment	**374,672**
UHC- Secure Horizons	H9011 (1)	HMO/HMOPOS	10/01/1982	1,146
	H0543 (4)	HMO/HMOPOS	06/01/1985	46,006
	H3805 (3)	HMO/HMOPOS	01/01/1986	1,415
	H0303 (3)	HMO/HMOPOS	04/01/1986	24,600
	H0609 (2)	HMO/HMOPOS	07/01/1986	9,873
	H5005 (2)	HMO/HMOPOS	03/01/1987	4,609
	H4102 (1)	HMO/HMOPOS	03/01/1987	3,614
	H4590 (2)	HMO/HMOPOS	11/01/1987	4,119
	H3749 (2)	HMO/HMOPOS	01/01/1991	2,636
	H3107 (1)	HMO/HMOPOS	10/01/1991	302
	H3307 (1)	HMO/HMOPOS	10/01/1991	402
	H2654 (4)	HMO/HMOPOS	10/01/1992	8,437
	H2949 (3)	HMO/HMOPOS	10/01/1992	1,359
	H0151 (1)	HMO/HMOPOS	02/01/1995	593
	H5253 (1)	HMO/HMOPOS	08/01/1995	2,471
	H1080 (1)	HMO/HMOPOS	01/01/1996	295
	H3659 (1)	HMO/HMOPOS	05/01/1996	3,278
	H3456 (1)	HMO/HMOPOS	06/01/1997	1,475
	H4456 (2)	HMO/HMOPOS	07/01/1997	5,992
	H2803 (1)	HMO/HMOPOS	04/01/2003	84
	H0316 (1)	HMO/HMOPOS	09/01/2004	11
	H2408 (1)	PFFS	09/01/2004	1,162
	H5435 (3)	PFFS	09/01/2005	4,466
	R5287 (1)	RPPO	01/01/2006	23
	R5342 (1)	RPPO	01/01/2006	159
			UHC-Secure Horizons enrollment	**128,527**
BCBS of Michigan	H2319 (2)	PFFS	07/01/2005	113,229
	H5883 (3)	HMO/HMOPOS	01/01/2006	2,586
			BCBS of MI enrollment	**115,815**
Aetna Inc.	H3931 (2)	HMO/HMOPOS	11/01/1985	9,815
	H0523 (2)	HMO/HMOPOS	05/01/1986	936
	H3312 (2)	HMO/HMOPOS	10/01/1986	4,029
	H3152 (2)	HMO/HMOPOS	09/01/1993	8,121
	H5414 (1)	HMO/HMOPOS	01/01/2005	421
	H2112 (1)	HMO/HMOPOS	02/01/2005	184

Table B.5b *(continued)*

Company	Contract Number (number of plans with enrollment in contract)	Plan Type	Contract Effective Date	Total Enrollment
	H0318 (1)	HMO/HMOPOS	07/01/2005	103
	H1109 (1)	HMO/HMOPOS	07/01/2005	261
	H3623 (1)	HMO/HMOPOS	07/01/2005	31
	H4910 (1)	HMO/HMOPOS	07/01/2005	11
	H1110 (1)	Local PPO	08/01/2005	56
	H4523 (1)	HMO/HMOPOS	08/01/2005	725
	H4524 (1)	Local PPO	08/01/2005	117
	H5437 (1)	Local PPO	08/01/2005	179
	H5510 (1)	Local PPO	01/01/2006	688
	H5512 (1)	Local PPO	01/01/2006	717
	H5521 (1)	Local PPO	01/01/2006	988
	H5531 (1)	Local PPO	01/01/2006	112
	H5736 (2)	PFFS	01/01/2006	49,711
	R5595 (1)	RPPO	01/01/2006	19
	H5793 (1)	HMO/HMOPOS	01/01/2007	68
			Aetna enrollment	**77,292**
Humana	H1406 (2)	HMO/HMOPOS	07/01/1985	1,799
	H1036 (3)	HMO/HMOPOS	02/01/1986	4,570
	H0307 (1)	HMO/HMOPOS	04/01/1988	28
	H2649 (1)	HMO/HMOPOS	01/01/1990	1,766
	H1951 (1)	HMO/HMOPOS	06/01/1994	2,454
	H1804 (2)	PFFS	01/01/2003	48,670
	H1716 (1)	Local PPO	01/01/2005	25
	H5415 (1)	Local PPO	01/01/2005	48
	H1906 (1)	PFFS	05/01/2005	103
	H5683 (1)	PFFS	01/01/2006	41
	H5826 (8)	RPPO	01/01/2006	911
			Humana enrollment	**60,415**
HIP of New York	H3330 (3)	HMO/HMOPOS	07/01/1987	60,268
			HIP of NY enrollment	**60,268**
Highmark	H3957 (2)	HMO/HMOPOS	03/01/1995	43,185
	H3916 (2)	Local PPO	05/01/2003	11,627
	H5106 (1)	Local PPO	07/01/2005	1,368
			Highmark enrollment	**56,180**
Health Net	H0351 (1)	HMO/HMOPOS	03/01/1992	1,038
	H0562 (4)	HMO/HMOPOS	10/01/1992	36,984
	H3366 (1)	HMO/HMOPOS	03/01/1996	99
	H0755 (2)	HMO/HMOPOS	12/01/1996	4,528
	H5721 (1)	PFFS	01/01/2007	11
	H5996 (1)	PFFS	01/01/2007	197
			Health Net enrollment	**42,857**
United Mine Workers	90091	HCPP – 1833 Cost	02/01/1974	41,300
			United Mine Workers enrollment	**41,300**
Rochester Area HMO	H3305 (2)	HMO/HMOPOS	11/01/1985	35,533
	H3346 (2)	Local PPO	09/01/2005	39
			Rochester HMO enrollment	**35,572**

Table B.5b *(continued)*

Company	Contract Number (number of plans with enrollment in contract)	Plan Type	Contract Effective Date	Total Enrollment
Coventry	H2663 (5)	HMO/HMOPOS	11/01/1995	4,035
	H3959 (2)	HMO/HMOPOS	01/01/1996	7,787
	H2672 (2)	HMO/HMOPOS	05/01/1999	1,535
	H5509 (2)	Local PPO	01/01/2006	632
	H5517 (1)	Local PPO	01/01/2006	5,282
	H5522 (1)	Local PPO	01/01/2006	2,354
	H0846 1)	PFFS	01/01/2007	8,399
	H5227 (1)	PFFS	01/01/2007	5,007
			Coventry enrollment	**35,031**
Independence Blue Cross	H3952 (2)	HMO/HMOPOS	01/01/1993	17,307
	H3156 (2)	HMO/HMOPOS	10/01/1995	985
	H3909 (2)	Local PPO	01/01/2002	4,506
			Independence enrollment	**22,798**
Group Health Cooperative	H5050 (2)	HMO/HMOPOS	01/01/1989	22,402
			Group Health enrollment	**22,402**
WellPoint	H0564 (1)	HMO/HMOPOS	06/01/1993	962
	H3655 (2)	HMO/HMOPOS	10/01/1994	7,279
	H3370 (1)	HMO/HMOPOS	07/01/1996	4,593
	H1849 (1)	HMO/HMOPOS	01/01/1998	1,413
	H0540 (1)	PFFS	04/01/2003	233
	H5419 (1)	PFFS	02/01/2005	639
	R5941 (2)	RPPO	01/01/2006	266
	H1689 (2)	PFFS	01/01/2007	2,636
	H5304 (1)	PFFS	01/01/2007	193
			WellPoint enrollment	**18,214**
Excellus, Inc.	H3351 (4)	HMO/HMOPOS	01/01/1990	13,904
	H3356 (1)	1876 Cost	01/01/1993	512
	H3335 (10)	Local PPO	07/01/2004	2,345
			Excellus enrollment	**16,761**

Source: MPR analysis for the Kaiser Family Foundation from CMS' July 2007 Annual Plan Report.

APPENDIX TABLE B.5c

SNP ENROLLMENT ALLOCATION

State	2007/07		2008/03	
	Allocated Enrollment	Percent of Total Enrollment	Allocated Enrollment	Percent of Total Enrollment
Arizona	5056	87.474	8476	84.305
California	608	0.332		
District of Columbia	383	91.408	678	77.397
Delaware			291	67.674
Georgia	8689	58.288	14989	57.559
Iowa	40	100	56	10.606
Illinois	353	7.028	647	9.472
Kansas			139	25.319
Louisiana	1126	59.015		
Maryland	3894	43.132	6374	55.639
Michigan	21	1.453		
Minnesota	9837	27.468		
Missouri	2732	76.206	6427	71.379
Mississippi	2	0.175		
North Dakota	56	100		
Nebraska	156	100	196	100
New Mexico	325	47.724	569	49.009
Ohio	278	5.318		
Oregon			331	1.811
South Carolina	6346	95.774	16793	96.119
Texas	702	1.512	1363	1.895
Virginia			11	1.727
Washington			25	0.688
Total	40604	4.24	57365	5.1

Source: MPR analysis of CMS' public data.

Note: Allocation of SNP enrollment by state is proportionate to the distribution of total of enrollment for contracts in that state.

APPENDIX C

2007 MA PLAN BENEFITS AND PREMIUMS

Table C.1. Number of Medicare Advantage Plans with Prescription Drug Benefits (MA-PDs) and Without (MA-Only), Offered by Segment, by Contract Type, 2006-2008

	All MA			MA-PDs									MA-Only		
				All			Lowest Premium			Other					
	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008	2006	2007	2008
Total Plans, excluding SNPs[a]	1,865	2,813	3,307	1,349	2,086	2,232	981	1,227	1,387	368	859	845	516	727	1,075
Health Maintenance Organization	1,228	1,392	1,517	892	1,064	1,138	650	668	769	242	396	369	336	328	379
Local Preferred Provider Organization[b]	367	377	462	284	298	384	203	189	238	81	109	146	83	79	78
Private Fee-for-Service	201	996	1,271	126	690	676	102	344	354	24	346	322	75	306	595
Regional Preferred Provider Organization	69	42	43	47	34	34	26	26	26	21	8	8	22	8	9
Medical Savings Account	NA	6	14	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	6	14
Total Special Needs Plans	242	438	769	242	438	769	193	337	526	49	101	243	NA	NA	NA

Source: MPR analysis of publicly available data from CMS's 2006-2008 Medicare Options Compare files. Group plans excluded.

Note: This table duplicates Table VII.1. We include it here both to assist users in the interpreting 21007 data and to maintain consistency in Table numbers between 2007 and 2008 so that comparisons can more easily be made.

[a]Data were segmented separately for SNP and non-SNP plans, with the lowest premium assigned separately for SNP and non-SNP plans. SNPs are not included in the "All" column.

[b]The Local PPO count includes 23 PSOs in 2006, 30 in 2007, and 34 in 2008.

Table C.2. Total Premiums for Lowest Premium and Other MA-PDs, Unweighted by Type of Plan, 2007

	All MA-PD Plans						Lowest Premium MA-PD Plans						Other MA-PD Plans					
	All MA-PD Plans	HMO	Local PPO	PFFS	Regional PPO	SNP[a]	All Types[a]	HMO	Local PPO	PFFS	Regional PPO	SNP[a]	All Other MA-PD Plans	HMO	Local PPO	PFFS	Regional PPO	SNP[a]
Mean Total Premium	$57.05	$43.08	$71.04	$71.95	$68.89	$48.31	$29.79	$16.46	$54.17	$40.01	$60.05	$38.14	$95.98	$87.99	$100.28	$103.72	$97.60	$82.25
Mean if Premium More than Zero	$81.90	$76.52	$83.34	$86.95	$80.76	$55.58	$61.54	$54.16	$70.61	$61.16	$74.35	$46.09	$95.98	$87.99	$100.28	$103.72	$97.60	$82.11
Distribution																		
Zero	30.3	43.7	14.8	17.2	14.7	12.6	51.6	69.6	23.3	34.6	19.2	16.3	0.0	0.0	0.0	0.0	0.0	0.0
Includes Reduced Part B Premium	6.4	11.8	2.3	0.1	0.0	4.1	8.6	14.7	3.7	0.3	0.0	4.5	3.3	7.1	0.0	0.0	0.0	3.0
$1 to $19	3.8	2.4	3.7	5.8	5.9	3.0	5.5	2.7	4.8	11.3	7.7	3.9	1.3	2.0	1.8	0.3	0.0	0.0
$20 to $49.99	20.8	21.1	18.5	21.7	11.8	46.1	16.0	13.8	20.6	18.3	7.7	48.1	27.6	33.3	14.7	25.1	25.0	39.6
$50 to $99.99	25.4	21.4	33.2	26.8	52.9	32.0	20.4	11.4	34.9	27.0	57.7	31.2	32.6	38.4	30.3	26.6	37.5	34.7
$100 or more	19.7	11.4	29.9	28.4	14.7	6.4	6.5	2.5	16.4	8.7	7.7	0.6	38.5	26.3	53.2	48.0	37.5	25.7
Number of Contract Segments	2,086	1,064	298	690	34	438	1,227	668	189	344	26	337	859	396	109	346	8	101

Source: MPR analysis of publicly available data from CMS's 2006-2008 Medicare Options Compare files. Group plans excluded. Premiums are the combined Part C (MA) and Part D (prescription drug) premium after rebates have been applied.

[a]Data were segmented separately for SNP and non-SNP plans, with lowest premium assigned separately for SNP and non-SNP plans. The "all types" column excludes SNPs to avoid double-counting plans within the same contract, where both SNP and non-SNP are offered.

Table C.3a. Prescription Drug Coverage in All MA-PD Plans, Unweighted, by Type of Plan, 2007

		All MA-PD Plans				
	All Types[a]	HMO	Local PPO	PFFS	Regional PPO	SNP
Mean Drug Premium	$17.56	$14.27	$24.70	$19.18	$24.86	$20.86
Distribution						
Zero	34.0	46.7	17.8	22.5	14.7	17.1
Under $20	19.8	16.7	17.1	25.7	20.6	19.2
$20 to $29.99	22.8	17.4	31.2	26.4	44.1	53.2
$30 to $39.99	11.9	10.1	17.1	12.5	11.8	6.2
$40 to $49.99	7.9	6.0	8.4	11.0	0.0	1.1
$50 or more	3.6	3.1	8.4	2.0	8.8	3.2
Initial Deductible						
None	89.5	88.3	84.2	93.3	94.1	51.8
Reduced	2.1	2.3	4.7	0.7	0.0	1.4
Standard Amount ($265)	8.4	9.4	11.1	5.9	5.9	46.8
Tiered Copayments						
Yes	93.4	92.8	93.3	94.1	100.0	56.2
No	6.6	7.2	6.7	5.9	0.0	43.8
Benefits in Coverage Gap						
None	73.4	63.3	59.4	94.6	79.4	87.9
Generic Only	21.5	29.0	33.9	4.6	17.6	3.7
Generic/Brand	5.1	7.6	6.7	0.7	2.9	8.4
Percent with Mail Order	22.2	28.9	19.8	12.3	35.3	32.0
Number of Contract Segments	2,086	1,064	298	690	34	438

Source: MPR analysis of publicly available data from CMS's 2006-2008 Medicare Options Compare files. Group plans excluded.

[a]Data were segmented separately for SNP and non-SNP plans, with lowest premium assigned separately for SNP and non-SNP plans. The "all types" column excludes SNPs to avoid double-counting plans within the same contract, where both SNP and non-SNP are offered.

Table C.3b. Prescription Drug Coverage in Lowest-Premium MA-PD Plans, Unweighted, by Type of Plan, 2007

		Lowest Premium MA-PD Plans				
	All Types[a]	HMO	Local PPO	PFFS	Regional PPO	SNP
Mean Drug Premium	$10.44	$5.81	$18.00	$14.62	$18.95	$18.24
Distribution						
Zero	53.5	71.9	25.9	35.8	19.2	20.2
Under $20	19.4	13.2	23.8	28.8	23.1	19.6
$20 - $29.99	17.5	11.4	35.4	17.2	50.0	54.3
$30 - $39.99	5.4	2.4	10.1	8.4	7.7	5.3
$40 - $49.99	3.7	1.0	3.2	9.6	0.0	0.0
$50 or more	0.4	0.1	1.6	0.3	0.0	0.6
Initial Deductible						
None	87.9	91.0	77.8	86.9	96.2	46.9
Reduced	2.6	1.9	7.4	1.5	0.0	1.5
Standard Amount ($265)	9.5	7.0	14.8	11.6	3.8	51.6
Tiered Copayments						
Yes	92.7	94.9	91.5	88.4	100.0	51.6
No	7.3	5.1	8.5	11.6	0.0	48.4
Benefits in Coverage Gap						
None	79.1	70.2	72.5	98.8	96.2	92.3
Generic Only	15.4	22.5	19.6	0.3	3.8	3.3
Generic/Brand	5.5	7.3	7.9	0.9	0.0	4.5
Percent with Mail Order	25.8	32.2	21.7	15.1	30.8	31.5
Number of Contract Segments	1,227	668	189	344	26	337

Source: MPR analysis of publicly available data from CMS's 2006-2008 Medicare Options Compare files. Group plans excluded.

[a]Data were segmented separately for SNP and non-SNP plans, with lowest premium assigned separately for each. The "all types" column excludes SNPs to avoid double-counting plans within the same contract, where both SNPs and non-SNPs are offered.

Table C.3c. Prescription Drug Coverage in "Other" MA-PD Plans, Unweighted, by Type of Plan, 2007

		"Other" MA-PD Plans				
	All Types[a]	HMO	Local PPO	PFFS	Regional PPO	SNP
Mean Drug Premium	$27.73	$28.54	$36.32	$23.71	$44.06	$29.59
Distribution						
Zero	6.2	4.3	3.7	9.2	0.0	6.9
Under $20	20.4	22.7	5.5	22.5	12.5	17.8
$20 to $29.99	30.3	27.5	23.9	35.5	25.0	49.5
$30 to $39.99	21.2	23.0	29.4	16.5	25.0	8.9
$40 to $49.99	13.9	14.4	17.4	12.4	0.0	5.0
$50 or more	8.1	8.1	20.2	3.8	37.5	11.9
Initial Deductible						
None	91.7	83.8	95.4	99.7	87.5	68.3
Reduced	1.3	2.8	0.0	0.0	0.0	1.0
Standard Amount ($265)	7.0	13.4	4.6	0.3	12.5	30.7
Tiered Copayments						
Yes	94.4	89.1	96.3	99.7	100.0	71.3
No	5.6	10.9	3.7	0.3	0.0	28.7
Benefits in Coverage Gap						
None	65.2	51.8	36.7	90.5	25.0	73.3
Generic Only	30.2	40.2	58.7	9.0	62.5	5.0
Generic/Brand	4.7	8.1	4.6	0.6	12.5	21.8
Percent with Mail Order	17.1	23.2	16.5	9.5	50.0	33.7
Number of Contract Segments	859	396	109	346	8	101

Source: MPR analysis of publicly available data from CMS's 2006-2008 Medicare Options Compare files. Group plans excluded.

[a]Data were segmented separately for SNP and non-SNP plans, with lowest premium assigned separately for SNP and non-SNP plans. The "all types" column excludes SNPs to avoid double-counting plans within the same contract, where both SNP and non-SNP are offered.

Table C.4a. Copayments for Medical and Hospital Services in All MA-PD Plans, Unweighted, by Type of Plan, 2007

		All MA-PD Plans by Type				
	All Types[a]	HMO	Local PPO[b]	PFFS	Regional PPO[b]	SNP[a]
Primary Care Physician						
Mean Copayment	$9.68	$8.44	$11.93	$10.57	$10.74	$0.00
None	22.4	27.0	10.8	21.3	2.9	86.2
Less than $5	8.6	12.1	13.1	1.6	2.9	4.7
$5.01 to $10	33.9	35.0	30.3	31.2	82.4	8.4
$10.01 to $15	26.0	18.5	24.6	39.3	2.9	0.3
$15.01 to $25	8.0	6.6	20.2	4.9	8.8	0.0
$25.01 or more	1.1	0.8	1.0	1.6	0.0	0.5
Varies	0.9	1.4	1.3	0.0	0.0	0.0
Coinsurance	10.6	0.5	67.8	0.1	41.2	25.3
Specialist Visit						
Mean Copayment	$21.76	$20.51	$21.56	$23.60	$25.29	$0.00
None	12.4	9.0	5.4	21.2	0.0	46.2
Less than $5	2.0	2.5	4.4	0.3	0.0	2.9
$5.01 to $10	6.6	8.5	4.7	4.1	14.7	34.4
$10.01 to $15	8.3	11.2	14.9	1.5	0.0	4.9
$15.01 to $25	31.3	41.8	43.9	9.6	32.4	8.4
$25.01 or more	39.4	27.0	26.7	63.4	52.9	3.2
Varies	0.8	1.3	1.0	0.0	0.0	0.9
Coinsurance	10.8	0.7	68.5	0.1	41.2	33.6
Emergency Room						
None	10.3	4.8	1.3	25.5	0.0	19.5
Less than $20	0.1	0.2	0.0	0.0	0.0	0.0
$20.01 to $40	2.7	3.0	1.7	2.8	0.0	7.3
$40.01 to $50	87.0	92.0	97.0	71.8	100.0	73.2
$50.01 to $74.01	0.0	0.0	0.0	0.0	0.0	0.0
$75 or more	0.0	0.0	0.0	0.0	0.0	0.0
Coinsurance	0.0	0.0	0.0	0.0	0.0	0.0
Any Cost Sharing						
Hospital Admission	92.7	89.5	94.6	96.5	100.0	72.8
Hospital Outpatient	82.1	81.8	93.0	77.5	88.2	61.6
X-ray	79.5	70.0	70.5	97.0	100.0	49.5
Lab	65.9	50.6	64.1	89.0	91.2	44.1
Number of Contract Segments	2,086	1,064	298	690	34	438

Source: MPR analysis of publicly available data from CMS's 2006-2008 Medicare Options Compare files. Group plans excluded.

[a]Data were segmented separately for SNP and non-SNP plans, with lowest premium assigned separately for SNP and non-SNP plans. The "all types" column excludes SNPs to avoid double-counting plans within the same contract, where both SNP and non-SNP are offered.

[b]In PPOs, cost sharing is described for in-network benefits, to the extent feasible. The 2007 Plan Finder is not clear as to the circumstances in which copayments vs. coinsurance, or both, apply.

Table C.4b. Copayments for Medical and Hospital Services in Lowest Premium MA-PD Plans, Unweighted, by Type of Plan, 2007[a]

		Lowest Premium MA-PD Plans, by Plan Type				
	All Types[a]	HMO	Local PPO[b]	PFFS	Regional PPO[b]	SNP[a]
Primary Care Physician						
Mean Copayment	$10.11	$7.91	$12.30	$13.11	$10.96	$0.00
Distribution						
None	19.7	33.2	9.6	0.3	3.8	86.8
Less than $5	9.2	12.3	12.8	1.7	3.8	4.9
$5.01 - $10	34.0	27.9	29.8	44.9	76.9	7.3
$10.01 - $15	27.4	18.9	26.1	46.4	3.8	0.3
$15.01 - $25	8.2	6.5	20.7	4.4	11.5	0.0
$25.01 or more	1.5	1.2	1.1	2.3	0.0	0.7
Varies	1.0	1.5	1.1	0.0	0.0	0.0
Coinsurance	11.5	0.7	68.3	0.3	23.1	26.1
Specialist Visit						
Mean Copayment	$24.82	$21.49	$23.57	$31.69	$28.27	$0.00
Distribution						
None	5.6	8.6	5.9	0.0	0.0	46.3
Less than $5	2.5	3.5	2.7	0.6	0.0	3.1
$5.01 - $10	5.7	9.0	2.7	0.9	3.8	36.2
$10.01 - $15	7.1	9.2	12.3	0.9	0.0	3.9
$15.01 - $25	29.6	35.5	38.5	13.7	26.9	7.0
$25.01 or more	49.5	34.3	38.0	84.0	69.2	3.5
Varies	1.2	1.8	1.6	0.0	0.0	0.9
Coinsurance	11.8	1.0	69.3	0.3	23.1	35.0
Emergency Room						
None	3.0	4.7	1.1	0.4	0.0	21.5
Less than $20	0.0	0.0	0.0	0.0	0.0	0.0
$20.01 - $40	2.7	4.2	1.1	0.4	0.0	9.1
$40.01 - $50	94.3	91.1	97.9	99.2	100.0	69.5
$50.01 - $74.01	0.0	0.0	0.0	0.0	0.0	0.0
$75 or more	0.0	0.0	0.0	0.0	0.0	0.0
Coinsurance	0.0	0.0	0.0	0.0	0.0	0.0
Any Cost Sharing						
Hospital Admission	94.9	92.5	94.7	99.4	100.0	73.9
Hospital Outpatient	90.5	85.0	94.7	98.5	92.3	62.9
X-Ray	81.0	73.4	75.7	97.4	100.0	55.5
Lab	67.7	56.4	67.2	87.5	100.0	48.1
Number of Contract Segments	1,227	668	189	344	26	337

Source: MPR analysis of publicly available data from CMS's 2006-2008 Medicare Options Compare files. Group plans excluded.

.[a]Data were segmented separately for SNPs and non-SNPs, with lowest premium assigned separately for each. The "all types" column excludes SNPs to avoid double-counting plans within the same contract, where both SNPs and non-SNPs are offered.

[b]In PPOs, cost sharing is described for in-network benefits, to the extent feasible. The 2007 Plan Finder is not clear as to the circumstances in which copayments vs. coinsurance, or both, apply.

Table C.4c. Copayments for Medical and Hospital Services in "Other" MA-PD Plans, Unweighted, by Type of Plan, 2007

		"Other" MA-PD Plans by Type				
	All Types[a]	HMO	Local PPO[b]	PFFS	Regional PPO[b]	SNP[a]
Primary Care Physician						
Mean Copayment	$9.07	$9.34	$11.28	$8.05	$10.00	$0.00
None	26.3	16.7	12.8	42.2	0.0	84.2
Less than $5	7.7	11.6	13.8	1.4	0.0	4.2
$5.01 to $10	33.6	47.0	31.2	17.6	100.0	11.6
$10.01 to $15	24.1	17.9	22.0	32.4	0.0	0.0
$15.01 to $25	7.8	6.8	19.3	5.5	0.0	0.0
$25.01 or more	0.5	0.0	0.9	0.9	0.0	0.0
Varies	0.8	1.3	1.8	0.0	0.0	0.0
Coinsurance	9.4	0.0	67.0	0.0	100.0	22.8
Specialist Visit						
Mean Copayment	$17.42	$18.88	$18.12	$15.58	$15.63	$0.00
None	22.0	9.6	4.6	42.2	0.0	46.1
Less than $5	1.4	1.0	7.3	0.0	0.0	2.2
$5.01 to $10	7.9	7.6	8.3	7.2	50.0	29.2
$10.01 to $15	10.0	14.6	19.3	2.0	0.0	7.9
$15.01 to $25	33.6	52.5	53.2	5.5	50.0	12.4
$25.01 or more	25.0	14.6	7.3	43.1	0.0	2.2
Varies	0.2	0.5	0.0	0.0	0.0	1.0
Coinsurance	9.4	0.0	67.0	0.0	100.0	28.7
Emergency Room						
None	20.0	5.1	1.8	44.8	0.0	13.8
Less than $20	0.2	0.5	0.0	0.0	0.0	0.0
$20.01 to $40	2.6	1.0	2.8	4.6	0.0	2.1
$40.01 to $50	77.1	93.4	95.4	50.6	100.0	84.0
$50.01 to $74.01	0.0	0.0	0.0	0.0	0.0	0.0
$75 or more	0.0	0.0	0.0	0.0	0.0	0.0
Coinsurance	0.0	0.0	0.0	0.0	0.0	0.0
Any Cost Sharing						
Hospital Admission	89.5	84.3	94.5	93.6	100.0	69.3
Hospital Outpatient	70.1	76.3	89.9	56.6	75.0	57.4
X-ray	77.3	64.4	61.5	96.5	100.0	29.7
Lab	63.2	40.7	58.7	90.5	62.5	30.7
Number of Contract Segments	859	396	109	346	8	101

Source: MPR analysis of publicly available data from CMS's 2006-2008 Medicare Options Compare files. Group plans excluded.

[a]Data were segmented separately for SNP and non-SNP plans, with lowest premium assigned separately for SNP and non-SNP plans. The "all types" column excludes SNPs to avoid double-counting plans within the same contract, where both SNP and non-SNP are offered.

[b]In PPOs, cost sharing is described for in-network benefits, to the extent feasible. The 2007 Plan Finder is not clear as to the circumstances in which copayments vs. coinsurance, or both, apply.

Table C.5. Percent of MA-PDs with an Out-of-Pocket Annual Limit on Spending, Unweighted, by Plan Type, 2007

	All MA-PDs		HMO		Local PPOs		PFFS[a]		Regional PPOs	
	Lowest Premium	Other	Lowest Premium	Other	Lowest Premium	Other	Lowest Premium	Other	Lowest Premium	Other
No Limit	45.6%	54.7%	63.6%	66.2%	50.8%	33.0%	11.0%	49.7%	0.0%	0.0%
$1,000 or less	1.5	2.2	1.2	2.8	4.8	7.3	0.3	0.0	0.0	0.0
$1,001-$2,500	4.6	11.6	6.4	18.2	6.9	18.3	0.0	2.0	0.0	12.5
$2,501-$4,000	35.0	15.6	25.6	8.6	25.9	36.7	59.3	16.5	19.2	37.5
$4,001-$5,000	11.0	14.8	3.1	3.3	6.9	3.7	28.8	31.8	7.7	0
Over $5,000	2.4	1.0	0.0	1.0	4.8	0.9	0.6	0.0	73.1	50.0
Number of contract segments	1,227	859	668	396	189	109	344	346	26	8

Source: MPR analysis of publicly available data from CMS's 2006-2008 Medicare Options Compare files. Group plans excluded.

Note: Limit may apply only to in-network benefits. (If out-of-network benefits exist, they typically have a higher limit, if there is a limit.)

[a]Among lowest premium MA-only PFFS plans, 16.3% have no limit, 5.0% have a limit of $1,000 or less, 0.0% have a limit between $1,001 and $2,500, and 78.8% have a limit between $2,501 and $5,000.

Table C.6. Out-of-Network Cost-Sharing Requirements in Local and Regional PPOs, 2007 (Lowest Premium MA-PDs Plans, Unweighted)

	Local PPOs	Regional PPOs
Separate Out-of-Network Deductible for Physician Care		
None	46.0%	26.9%
$150 or less	11.8	0.0
$151 - $250	23.5	0.0
$251 - $999	49.0	94.7
$1,000 or more	15.7	5.3
Primary Care Visits		
Copayment	96.0	96.2
Coinsurance		
20 percent	2.3	3.8
25 percent	0.6	0.0
30 percent	1.1	0.0
Other	0.0	0.0
Specialist Visits		
Copayment	97.8	100.0
Coinsurance		
20 percent	1.7	0.0
25 percent	0.0	0.0
30 percent	0.0	0.0
Other	0.6	0.0
Hospital In-Patient Services		
No cost sharing	64.6	23.1
Deductible	1.1	0.0
Copayment		
Per day	0.0	0.0
Per stay	6.9	61.5
Both	0.0	0.0
Coinsurance only	6.9	3.8
20 percent	61.5	0.0
25 percent	1.9	0.0
30 percent	36.5	50.0
Other	0.0	50.0
Coinsurance and Copay	20.6	11.5
Number of Contract Segments	189	26

Source: MPR analysis of publicly available data from CMS's 2006-2008 Medicare Options Compare files. Group plans excluded.

.

Table C.7. Cost Sharing in PFFS Plans, Unweighted by Type, 2007

Cost Sharing	All PFFS Plans	Lowest Premium PFFS Plans	
		All PFFS Plans	MA-PD Only
Primary Care Physician Visit			
None	16.8%	0.9%	0.3%
Deductible	12.1	2.1	0.0
Coinsurance			
Less than 20%	0.0	0.0	0.0
Exactly 20%	0.1	0.2	0.3
20% or More	0.0	0.0	0.0
Copayment			
$10 or Less	32.6	44.8	46.5
$11 - $15	31.4	43.4	46.2
$16 - $25	5.4	5.7	4.4
More than $25	1.4	2.6	2.3
Varies	0.1	0.2	0.0
Specialist Physician Visit			
None	16.7	0.7	0.0
Deductible	12.1	2.1	0.0
Coinsurance			
Less than 20%	0.0	0.0	0.0
Exactly 20%	0.1	0.2	0.3
20% or More	0.0	0.0	0.0
Copayment			
$10 or Less	8.6	2.6	1.5
$11 - $15	1.9	1.2	0.9
$16 - $25	10.3	14.6	13.7
More than $25	50.1	78.3	83.7
Varies	0.1	0.2	0.0
Hospital Inpatient Stay			
None	5.1	1.2	0.6
Deductible	12.2	2.4	0.3
Coinsurance	0.0	0.0	0.0
Copayment Per Stay			
$1 - $150	3.2	0.5	0.3
$150 or Higher	15.2	24.1	29.1
Copayment Per Day	76.5	74.3	70.1
$100 or less (Day 1)	36.5	3.8	0.8
$101 - $200 (Day 1)	34.0	37.1	25.3
$201 or more (Day 1)	29.5	59.0	73.9
Different Copay Day 2	0.0	0.0	0.0
Different Copay Day 10	51.8	75.2	89.6
Limit on Days	40.7	47.6	51.7
Percentage With an Out-of-Pocket Maximum on Total Out-of-Pocket Spending Per Year			
$1000 or Less	3.0	1.2	0.3
$1001 to $2500	2.3	0.0	0.0
$2501 to $4000	35.6	60.8	59.3
$4001 to $5000	22.1	25.5	28.8
More than $5000	0.2	0.5	0.6
Percentage with No Out-of-Pocket Maximum	36.7	12.0	11.0
Number of Contract Segments	1,271	424	344

Source: MPR analysis of publicly available data from CMS's 2006-2008 Medicare Options Compare files. Group plans excluded.

Table C.8. Estimated Out-of-Pocket Costs for Hospital and Physician Services in Lowest Premium and Other MA-PD Plans, Unweighted, by Type, 2007

Estimated Out-of-Pocket Costs for Hospital and Physician Services by Health	All (except SNP)	HMO	Local PPO	PFFS	Regional PPO	SNP[a]
All MA-PD						
All	$446	$406	$623	$415	$778	[b]
Healthy	153	149	354	60	417	53
Episodic Needs	845	753	1,019	888	1,297	601
Chronic Needs	1,954	1,734	1,948	2,264	2,576	1,441
Lowest Premium MA-PDs						
All	$509	$414	$680	$569	$884	[b]
Healthy	150	115	370	77	462	59
Episodic Needs	1,001	822	1,144	1,234	1,495	629
Chronic Needs	2,337	1,953	2,183	3,117	2,982	1,508
"Other" MA-PDs						
All	$358	$393	$525	$262	$433	[b]
Healthy	157	208	325	44	271	34
Episodic Needs	621	639	801	544	654	508
Chronic Needs	1,407	1,365	1,540	1,417	1,258	1,218
Number of Contract Segments						
All	2,086	1,064	298	690	34	438
Lowest Premium	1,227	668	189	344	26	337
Other	859	396	109	346	8	101

Source: MPR analysis of publicly available data from CMS's 2006-2008 Medicare Options Compare files. Group plans excluded.

Note: This analysis uses methodology from HealthMetrix Inc. to calculate out-of-pocket costs estimates for each of the three categories of enrollees (Part D costs are not included.). Estimates involve use assumptions for physician services and hospitalizations within each health need category that are applied to the structure of the plan's benefits and cost sharing. Previous to 2005, HealthMetrix called the three categories "good," "fair," and "poor" health. The "all" estimate is a standardized weighted composite of the three categories of beneficiaries using weights drawn from the Medicare Current Beneficiary Survey (community residing beneficiaries). The "all" row assumes 71.51 percent are "healthy," 19.04 percent have "episodic needs," and 8.90 percent have "chronic needs." (CMS 2003, Table II.7). Using weights that are beneficiary rather than enrollee based is a change from prior work to reflect the extensive growth in MA that is not reflected yet in MCBS data. The change affects only the "All" row.

[a]Data were segmented separately for SNP and non-SNP plans, with lowest premium assigned separately for SNP and non-SNP plans. The "all types" column excludes SNPs to avoid double-counting plans within the same contract, where both SNP and non-SNP are offered. Most SNP enrollees are dually eligible, something not factored into the out-of-pocket estimates.

[b]No data are available on the distribution of such enrollees by type.

Table C.9. Supplemental Benefits in Lowest Premium and "Other" MA-PD Plans, Unweighted, by Type of Plan, 2007

	All MA-PD Plans						Lowest Premium MA-PD Plans						Other MA-PD Plans					
	All[a]	HMO	Local PPO	PFFS	Regional PPO	SNP[a]	All[a]	HMO	Local PPO	PFFS	Regional PPO	SNP[a]	All Other	HMO	Local PPO	PFFS	Regional PPO	SNP[a]
Percent With																		
Preventive dental	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Vision benefits	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hearing benefits	99.3	99.0	99.0	99.9	100.0	91.1	99.0	98.8	98.4	99.7	100.0	90.2	99.7	99.2	100.0	100.0	100.0	94.1
Physical exam	99.6	99.4	99.7	99.9	100.0	97.0	99.3	99.1	99.5	99.7	100.0	96.1	100.0	100.0	100.0	100.0	100.0	100.0
Podiatry benefits	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Chiropractic benefits	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of Contract Segments	2,086	1,064	298	690	34	438	1,227	668	189	344	26	337	859	396	109	346	8	101

Source: MPR analysis of publicly available data from CMS's 2006-2008 Medicare Options Compare files. Group plans excluded.

[a]Data were segmented separately for SNP and non-SNP plans. Basic flags were assigned separately for SNP and non-SNP plans. SNPs are not included in the "All" column.

Table C.10. Overview of Premiums and Benefits, All MA-Only Plans, Unweighted, by Contract Type, 2007 (SNP Plans Excluded)

	All MA-Only	HMO	Local PPO	PFFS	Regional PPO	MSA
Average Monthly Premium	$24.97	$22.48	$42.38	$24.01	$10.25	$0.00
Distribution						
Zero	58.7%	57.0%	29.1%	66.7%	87.5%	100.0
$1 - $49	18.4	22.6	29.1	12.1	0.0	0.0
$50 or more	22.8	20.4	41.8	21.2	12.5	0.0
Percent with Cost Sharing for Hospital Admissions[a]						
None	8.3	7.9	5.1	8.8	0.0	50.0
Deductible	0.8	1.5	1.3	0.0	0.0	0.0
Coinsurance	8.8	6.1	54.4	0.0	12.5	0.0
Deductible and coinsurance	17.2	0.9	1.3	39.5	0.0	0.0
Copayment	64.9	83.5	38.0	51.6	87.5	50.0
Cost Sharing for Primary Care Visits[a]						
None	12.4	18.0	6.3	6.5	0.0	100.0
Deductible	24.3	4.0	48.1	39.5	62.5	0.0
Coinsurance	22.8	0.3	54.4	39.5	12.5	0.0
Copayment	70.2	81.7	87.3	53.9	100.0	0.0
Cost Sharing for Specialist Visits[a]						
Requires Referral	100%	100%	100%	0%	100.0	100.0
Deductible	24.3	4.0	48.1	39.5	62.5	0.0
Coinsurance	22.8	0.3	54.4	39.5	12.5	0.0
Copayment	75.2	90.9	96.2	53.9	100.0	0.0
Percent that Cover						
Preventive dental	100.0	100.0	100.0	100.0	100.0	NA
Vision benefits	100.0	100.0	100.0	100.0	100.0	NA
Hearing benefits	99.7	100.0	97.5	100.0	100.0	NA
Physical exam	99.2	100.0	100.0	100.0	100.0	NA
Podiatry benefits	100.0	100.0	100.0	100.0	100.0	NA
Chiropractic benefits	100.0	100.0	100.0	100.0	100.0	NA
Percent with Any Out-of-pocket Limit	45.7	36.6	68.4	49.0	100.0	100.0
Number of Contract Segments	727	328	79	306	8	6

Source: MPR analysis of publicly available data from CMS's 2006-2008 Medicare Options Compare files. Group plans excluded. Premiums are after rebates have been applied.

[a]In-network benefits are described in instances where out-of-network benefits are offered.