Table 12.1
Health Maintenance Organization (HMO) and Cost Contract Enrollment Growth: Selected Calendar Years 1990-2011

Year	Medicare HMO and Cost Enrollment
	Number in Millions
1990	1.8
1994	2.6
1995	3.0
1996	3.8
1997	4.7
1998	6.3
1999	6.7
2000	6.6
2001	5.8
2002	5.2
2003	5.0
2004	5.2
2005	5.6
2006	6.3
2007	6.6
2008	7.5
2009	8.3
2010	9.2
2011	10.8

NOTES: Medicare enrollment numbers are for December of each year, except in 1996 (August data). For all years, the Medicare enrollment includes enrollment in Risk plans - including HMO, Preferred Provider Organizations (PPO), and Provider Sponsored Organizations (PSO) - and in Cost plans other than Health Care Prepayment Plans (HCPP). For 2004 and 2005, the Medicare enrollment includes enrollment in PPO that were demonstrations. For all years, the Medicare enrollment excludes enrollment in Private Fee-for-Service plans (PFFS) and demonstrations that were not PPO. For 2006-current year of reporting, the Medicare enrollment excludes enrollment in Regional PPO.

SOURCE: Centers for Medicare & Medicaid Services, Center for Drug and Health Plan Choice: Medicare Advantage data are from the Medicare Managed Care Contract (MMCC) Summary reports for 1990-current year of reporting; data development by the Office of Information Products and Data Analytics.

Table 12.2
Percent of Medicare Population with Access to at Least One Risk/ Medicare+Choice (M+C)/Medicare Advantage (MA) CCP (1993-2011), Private Fee-for-Service (PFFS) (2000-2011), or M+C/MA Plan of Either Type (2000-2011)

Year	Population with Risk/M+C/MA CCP Access	Population with M+C/MA PFFS Access	Population with Access to M+C/MA Plan of Either Type
		Percent	
1993	49	NA	49
1994	57	NA	57
1995	61	NA	61
1996	68	NA	68
1997	72	NA	72
1998	74	NA	74
1999	72	NA	72
2000	69	38	84
2001	63	38	82
2002	62	36	79
2003	59	36	79
2004	61	31	75
2005	79	76	97
2006	80	81	99
2007	83	100	100
2008	90	100	100
2009	90	100	100
2010	92	100	100
2011	93	61	99

NOTES: PFFS became available in 2000. For 2005 and after, data are as of December and eligibles include Part D eligibles (Part A or Part B eligibles) as of the previous December, that reside in the 50 states, the District of Columbia, or the protectorates. CCP refers to coordinated care plans which include Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Provider Sponsored Organizations (PSO), and prior to 2006, PPO demonstrations. Medical Savings Account plans (MSA) and Regional PPOs (RPPO) were not included. Plans available only to employer or union retirees were excluded from computation of access. Special Needs Plans (SNP) were included in computation of access. PFFS plans include Religious Fraternal Benefit (RFB)-PFFS plans. NA is not applicable.

SOURCES: Centers for Medicare & Medicaid Services, Center for Drug and Health Plan Choice: Analysis of plan data from the Plan Information Control System, 1993-2000; Geographic Service Area Reports, 2000-2005; Health Plan Management System (HPMS) 2006-current year of reporting; data development by the Office of Information Products and Data Analytics .

Table 12.3
Medicare Risk/Medicare+Choice/Medicare Advantage Contracts: Calendar Years 1987-2011

Year	Risk Contracts
1987	161
1988	154
1989	131
1990	96
1991	93
1992	95
1993	109
1994	154
1995	183
1996	241
1997	307
1998	346
1999	309
2000	266
2001	179
2002	155
2003	151
2004	154
2005	302
2006	367
2007	408
2008	509
2009	521
2010	510
2011	509

NOTE: Data are as of December of each year. For all years, only active RISK contracts, including Local Coordinated Care Plans (CCP), Preferred Provider Organizations (PPO), and Provider Sponsored Organizations (PSO) are included. All other organization types, Private Fee-for-Service plans (PFFS), Program of All-Inclusive Care for the Elderly (PACE), COST, PPO, PPO DEMO, and Regional PPO (RPPO) are excluded. The 2009 data reflects approximately 20 consolidations. That is, if an entire contract consolidated (and consequently, did not reappear for 2010) then that contract was not counted in the number of risk plans.

SOURCE: Centers for Medicare & Medicaid Services, Center for Drug and Health Plan Choice: Data from the Medicare Managed Care Contract (MMCC) Summary reports, 1987-current year of reporting; data development by the Office of Information Products and Data Analytics.

Table 12.4
Risk/Local Coordinated Care Plans (CCP) Contracts Non-Renewals, by Percent of Plans: Calendar Years 1986-2011

Year	Non-Renewals
	Percent
1986	5
1987	18
1988	22
1989	29
1990	15
1991	13
1992	8
1993	4
1994	1
1995	0
1996	1
1997	3
1998	13
1999	13
2000	25
2001	13
2002	6
2003	4
2004	2
2005	1
2006	4
2007	3
2008	3
2009	8
2010	3
2011	2

NOTES: The percentages in the table only refer to Local CCP non-renewals and terminations including conversion to cost plans; however, service area reductions are not included. Local CCP includes Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and Provider Sponsored Organizations (PSO) but excludes Regional PPO and Private Fee For Service plans (PFFS). The 1989 figure includes 29 plans with no enrollees. The data for 1999 are based on the number of plans as of August 1999; for other years the data are as of December. The data for 2000 and 2001 are adjusted for contract consolidations (23 in 2001; 3 in 2002). The data for 2002 include one Medicare+Choice alternative payment demonstration project. The data for 2009 reflects approximately 20 consolidations. That is, if an entire contract consolidated (and hence did not reappear in 2010) that consolidated contract did not count in either the denominator (the number of plans) or numerator (the number of terminations).

SOURCE: Centers for Medicare & Medicaid Services, Center for Drug and Health Plan Choice: Analysis of Health Plan Management System (HPMS) Non-Renewal Reports, 1986-current year of reporting; data development by the Office of Information Products and Data Analytics.

Table 12.5
Number and Percent of Medicare+Choice/Medicare Advantage Coordinated Care Plans (CCP) Contracts Available to Beneficiaries: Calendar Years 1998 and 2011

Number of Contracts Available	1998	2011
	Percent	
0	26	7
1	11	7
2 to 4	25	23
5 to 9	24	36
10 or More	15	27

NOTES: Percents may not add to 100 because of rounding. The data shown represent CCP contracts which include Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Provider Sponsored Organizations (PSO), and exclude plans available only to employer or union-sponsored retirees. Special Needs Plans (SNP) were included. Medical Savings Account (MSA) plans and Regional PPOs (RPPO) were excluded. In computing access, full eligible counts were used in partial counties of a service area. Eligibles include all Part D eligibles (either Part A or Part B eligibles) that reside in the 50 states, the Distraict of Columbia, or the protectorates.

SOURCES: Centers for Medicare & Medicaid Services, Center for Drug and Health Plan Choice: Analysis of plan data from the Plan Information Control System (PICS), March 1998 and the Health Plan Management System (HPMS), December 2011; data development by the Office of Information Products and Data Analytics.

Table 12.6
Percent Distribution of Disabled and Aged Beneficiaries in Medicare Advantage Plans and Fee-for-Service: December 2011

Enrollment	Total	Aged	Disabled
		Percent	
Medicare Advantage	100.0	87.8	12.2
Fee-for-Service	100.0	82.0	18.0

NOTES: Medicare Advantage enrollment includes all plan types except for Prescription Drug Plans and Regional PPOs (RPPO). Special Needs Plans (SNP), employer only plans, and Employer Direct PFFS plans are included in the analysis. Eligibles include all Part D eligibles (Part A or Part B eligibles) that reside in the 50 states, the District of Columbia, or the protectorates.

SOURCES: Centers for Medicare & Medicaid Services, Center for Drug and Health Plan Choice: Analysis of plan data from the Health Plan Management System (HPMS) and the Monthly Membership Reports; data development by the Office of Information Products and Data Analytics.

Table 12.7
Percent Distribution of Disabled and Aged Beneficiaries, Medicare Advantage Plans Versus Fee-for-Service: December 2011

Beneficiary	Medicare Advantage	Fee-for-Service
	Percent	
Disabled	100	100
Male		
Under 35 Years	2	5
35-44 Years	6	8
45-54 Years	14	17
55-59 Years	11	11
60-64 Years	15	12
Female		
Under 35 Years	2	4
35-44 Years	6	7
45-54 Years	14	15
55-59 Years	12	10
60-64 Years	17	11
Aged	100	100
Male		
65-69 Years	14	14
70-74 Years	11	11
75-79 Years	8	8
80-84 Years	5	6
85 Years or Over	3	5
Female		
65-69 Years	18	15
70-74 Years	13	12
75-79 Years	11	10
80-84 Years	8	9
85 Years or Over	7	10

NOTES: Percents may not add to 100 because of rounding. The methodology to compute the penetration rate was changed beginning with 2005 data and may yield results that are not exactly comparable to earlier years. The data includes employer only plans, Employer Direct PFFS plans, and Special Needs Plans (SNP). Regional PPOs (RPPO) and Prescription Drug Plans (PDP) were excluded. Eligibles include Part D eligibles (Part A or Part B eligibles) that reside in the 50 states, the District of Columbia, or the protectorates.

SOURCE: Centers for Medicare & Medicaid Services, Center for Drug and Health Plan Choice: Analysis of plan data from the Monthly Membership Reports; data development by the Office of Information Products and Data Analytics.

Table 12.8
Medicare Advantage and Other Private Health Plan Penetration, (Percent of Medicare Beneficiaries Enrolled), by Geographic Area: December 2011

Geographic Area	Health Plan Penetration	Geographic Area	Health Plan Penetration
	Percent		Percent
Alabama	20.7	Nebraska	11.5
Alaska	0.6	Nevada	30.7
Arizona	36.6	New Hampshire	6.1
Arkansas	15.0	New Jersey	13.3
California	36.3	New Mexico	26.3
Colorado	33.4	New York	31.4
Connecticut	19.9	North Carolina	17.8
Delaware	4.1	North Dakota	10.8
District of Columbia	9.8	Ohio	34.0
Florida	32.2	Oklahoma	14.9
Georgia	22.5	Oregon	40.7
Hawaii	48.0	Pennsylvania	38.1
Idaho	28.9	Puerto Rico	68.8
Illinois	9.2	Rhode Island	34.6
Indiana	17.6	South Carolina	16.5
Iowa	13.2	South Dakota	10.6
Kansas	11.4	Tennessee	25.7
Kentucky	17.1	Texas	20.2
Louisiana	24.2	Utah	35.1
Maine	14.0	Vermont	5.7
Maryland	8.2	Virgin Islands	0.7
Massachusetts	17.8	Virginia	14.2
Michigan	24.5	Washington	26.1
Minnesota	45.5	West Virginia	22.3
Mississippi	9.7	Wisconsin	30.5
Missouri	21.7	Wyoming	5.7
Montana	14.9		
Guam	0.2		
American Samoa	1.6		
Northern Mariana Islands	0.0		

NOTES: Medicare Advantage enrollment includes data from all plan types, except for data from Prescription Drug Plans (PDP), Pilot Plans, and Employer/Union Only Direct Contract PDP Plans, which were excluded. Regional Preferred Provider Organizations (RPPO), Special Needs Plans (SNP), Employer only plans, and employer direct PFFS plans were included. For this report, eligibles include Part D eligibles (Part A or Part B eligibles) that reside in the 50 states, the District of Columbia, or the protectorates.

SOURCE: Centers for Medicare & Medicaid Services, Center for Drug and Health Plan Choice: penetration reports; data development by the Office of Information Products and Data Analytics.

Table 12.9
Historical Prevalence of Zero Premiums and Drug Coverage in Medicare Risk/Medicare+Choice Contracts: Calendar Years 1987-1998

Year	Contracts with Zero Premium Basic Package	Contracts with Drugs in Basic Package
	Percent	
1987	10	NA
1988	13	NA
1989	9	NA
1990	18	35
1991	25	33
1992	23	NA
1993	25	32
1994	33	38
1995	51	50
1996	65	61
1997	69	68
1998	70	67

NOTE: NA is not available.

SOURCES: Centers for Medicare & Medicaid Services, Office of Information Products and Data Analysis: Analysis of Medicare Managed Care Contract (MMCC) Summary reports for 1990-1998 and the adjusted community rate proposals for 1987-1989.

Table 12.10
Changes in Access to or Coverage Under a Zero Premium Plan: Calendar Years 1999-2011

Year	Medicare+Choice/Medicare Advantage Coordinated Care Plans (CCP)	
	Overall Medicare Population with Access to Zero Premium	Enrollees with Zero Premium Plan
	Percent	
1999	61	68
2000	53	61
2001	39	45
2002	34	39
2003	29	38
2004	40	48 [1]
2005	42	58 [1]
2006	61	52 [2]
2007	69	50 [2, 3]
2008	80 [4]	51 [2, 3]
2009	81 [4]	52 [2, 3]
2010	81 [4]	50 [2, 3]
2011	76 [4]	48 [2, 3]

[1]A change in methodology applies beginning in 2004. Because health plans are reporting enrollments by benefit package to CMS when an organization offers more than one benefit package in a given county, the 2004 and 2005 figures for enrollees choosing Zero-premium plans show enrollment at the actual "plan" level (that is, by benefit package). In prior years, enrollees were assigned to Zero-premium plans if one was offered by the organization in the county of residence of the individual. The figures for 2004 and 2005 would be a higher number if the methodology used in prior years were continued for 2004 and thereafter.

[2]For 2006-current year of reporting the following conventions were observed: Zero premium refers to both zero Part C premium and zero Part D premium for MA-PD plans, or, zero Part C premium for MA-only plans. CCP includes Special Needs Plans (SNP), but excludes Employer only plans. Only plans with plan type Health Maintenance Organizations (HMO), HMO Point of Service (HMOPOS), Preferred Provider Organizations (PPO), and Provider Sponsored Organizations (PSO) were included in the analysis. Enrollee coverage is percent of actual CCP enrollment with zero premium.

[3]For 2007-current year of reporting the Part B only plans were excluded from the computation of the Medicare population access (since no new Part B enrollees are allowed and consequently access to new enrollees is not provided). The effect of this exclusion was negligible since there are so few Part B only enrollees.

[4]Eligibles consist of all December Part D eligibles (Part A or Part B eligibles) that reside in the 50 states, the District of Columbia, or the protectorates. Eligibles with miscoded counties were excluded.

NOTES: The 2005 data are as of March 2005. The 2006-current year of reporting, data are as of December of that year.

SOURCES: Centers for Medicare & Medicaid Services, Center for Drug and Health Plan Choice: Analysis of submitted bids from the Health Plan Management System (HPMS); data development by the Office of Information Products and Data Analytics.

Table 12.11
Access to Medicare+Choice (M+C)/Medicare Advantage (MA) Coordinated Care Plans (CCP), Private Fee-for-Service (PFFS) Plans, or Preferred Provider Organization (PPO) Demonstration Projects, Rural Areas, by Type of Coverage: Calendar Years 1999-2011

Year	Any M+C/MA CCP, PFFS Plan, or PPO Demo Plan	Any M+C/MA CCP Plan	Any Zero Premium Plan	Any Plan with Drug Coverage
		Percent		
1999	---	23	14	19
2000	62	21	9	16
2001[1]	60	14	4	8
2002	59	13	2	9
2003	59	13	2	8
2004[2]	62	15	13	26
2005[2, 4]	97	40	54	94
2006[3, 4]	98	41	55	94
2007[3, 4]	100	48	90	100
2008[3, 4]	100	59	91 [5]	100
2009[3, 4]	100	65	100 [5]	96
2010[3, 4]	99	72	83 [5]	99
2011[3, 4]	98	74	82 [5]	96

[1]Includes 53 counties, with 99,000 beneficiaries, where PFFS became available in December 2001.

[2]The 2004 and 2005 data reflect the reclassification of the metropolitan statistical area (MSA) status of a number of counties. There was a net reduction in the number of Medicare beneficiaries residing in non-MSA (rural) counties of about one million. About 1.5 million beneficiaries were in the counties changing from non-MSA to MSA status, and about half a million beneficiaries were in counties that changed from MSA status to non-MSA status (generally because of being assigned to the new category of micropolitan areas).

[3]The 2006 and 2007 data used the same definition of rural that CMS had used in a number of other published studies. It was felt that for purposes of consistency this definition should be used: Metropolitan areas were considered urban while micropolitan areas and areas that were neither metropolitan nor micropolitan were considered rural. This usage was continued in later years.

[4]The 2005 data are as of October 2005. The 2006-current year of reporting data are as of December. In all years, only plans available to all Medicare beneficiaries in a county are included. That is, plans such as those available only to members of an employer group, are excluded. In 2006-current year of reporting the first two columns used Local CCP and PFFS plan types. Employer only plans were excluded. However, Special Need Plans (SNPs), were included in the computations since SNPs either targeted local enrollees and/or allowed disproportionate shares of non-targeted enrollees. In 2006-current year of reporting the Zero-premium and Drug-Coverage column data included all plan types except Prescription Drug Coverage plans, Employer Direct plans, and Regional PPO. The 2007-current year of reporting data also excluded Part B only, ESRD I, ESRD II and SHMO Demos, since these plans provided access to a very limited population. The Zero-premium plans only included plans with both a zero part C premium and a zero part D premium. Eligibles are December 2011 Part D eligibles (Part A or Part B eligibles) residing in the 50 states, the District of Columbia, or the five protectorates. Miscoded eligibles are excluded.

[5]MSA plans have been excluded from the computation of rural access to zero premium plans. Although MSA plans are one type of Medicare Advantage plan, prior to 2007 there was no enrollment in MSA plans. In 2008, the MSA plans provided 99% access to rural eligibles but only had roughly 3,500 enrollees. Enrollment for subsequent years through the present has been similar: Only a few plans with only a few thousand enrollees. Consequently, including them in the analysis would be misleading since they provide access that is disproportionate to their actual enrollment.

NOTES: ESRD is End Stage Renal Disease. SHMO is Social Health Maintenance Organization.

SOURCES: Centers for Medicare & Medicaid Services, Center for Drug and Health Plan Choice: Analysis of Health Plan Management System (HPMS) data; MedPAC Annual Reports 1999 and 2000; data development by the Office of Information Products and Data Analytics.