

HEALTH CARE FINANCING ADMINISTRATION

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REMARKS:

Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
ARIZONA								
Apache	PREMIER HEALTHCARE, INC.	6,400	-	0	\$379.84	\$401.61	5.7%	Rural
Graham	PREMIER HEALTHCARE, INC.	4,300	1,200	0	\$385.96	\$424.25	9.9%	Rural
Greenlee	PREMIER HEALTHCARE, INC.	1,100	200	0	\$380.97	\$420.38	10.3%	Rural
Maricopa	BLUE CROSS/SHIELD OF ARIZ	365,000	10,200	7	\$509.45	\$524.36	2.9%	MSA
Maricopa	UNITED HEALTHCARE OF ARIZONA	365,000	5,000	7	\$509.45	\$524.36	2.9%	MSA
Mohave	HEALTH PLAN OF NEVADA, INC.	32,800	3,500	1	\$493.65	\$522.27	5.8%	MSA
Navajo	PREMIER HEALTHCARE, INC.	11,000	100	0	\$381.70	\$425.81	11.6%	Rural
Pima	BLUE CROSS/SHIELD OF ARIZ	126,400	3,300	5	\$482.99	\$499.04	3.3%	MSA
Pima	HUMANA HEALTH PLAN, INC.	126,400	1,600	5	\$482.99	\$499.04	3.3%	MSA
Pinal	BLUE CROSS/SHIELD OF ARIZ	24,700	400	5	\$540.92	\$551.74	2.0%	MSA
Pinal	HUMANA HEALTH PLAN, INC.	24,700	2,300	5	\$540.92	\$551.74	2.0%	MSA
Pinal	UNITED HEALTHCARE OF ARIZONA	24,700	100	5	\$540.92	\$551.74	2.0%	MSA
Santa Cruz	PREMIER HEALTHCARE, INC.	4,700	-	1	\$379.84	\$412.07	8.5%	Rural
Yuma	PREMIER HEALTHCARE, INC.	18,200	3,000	0	\$477.96	\$505.13	5.7%	MSA
AZ Total			30,900					
Total Enrollees With No Other M+C Plan			4,500					

NOTES: Numbers may not add due to rounding. Data as of July 15, based on information HCFA received from Medicare+Choice plans.

MSA= Metropolitan Statistical Area

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
ARKANSAS								
Pulaski	HEALTHSOURCE, ARKANSAS, INC.	51,600	2,200	1	\$486.79	\$498.44	2.4%	MSA
Pulaski	UNITED HEALTHCARE OF ARKANSAS, INC.	51,600	200	1	\$486.79	\$498.44	2.4%	MSA
AR Total			2,400					
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
CALIFORNIA								
Calaveras	NATIONAL MED, INC.	8,100	100	0	\$496.79	\$525.27	5.7%	Rural
Kern	CIGNA HEALTHCARE OF CALIFORNIA	75,200	-	7	\$532.77	\$549.94	3.2%	MSA
Kern	UNITED HEALTHCARE OF CALIFORNIA-SOU	75,200	400	7	\$532.77	\$549.94	3.2%	MSA
Los Angeles	CIGNA HEALTHCARE OF CALIFORNIA	1,003,300	400	10	\$647.70	\$660.65	2.0%	MSA
Los Angeles	UNITED HEALTHCARE OF CALIFORNIA-SOU	1,003,300	500	10	\$647.70	\$660.65	2.0%	MSA
Madera	HEALTH NET	18,000	300	2	\$431.63	\$473.12	9.6%	MSA
Madera	PACIFICARE OF CALIFORNIA, INC.	18,000	1,100	2	\$431.63	\$473.12	9.6%	MSA
Mariposa	HEALTH NET	3,100	-	1	\$458.26	\$493.66	7.7%	Rural
Mariposa	HEALTH NET	3,100	-	1	\$458.26	\$493.66	7.7%	Rural
Mariposa	PACIFICARE OF CALIFORNIA, INC.	3,100	500	1	\$458.26	\$493.66	7.7%	Rural
Mered	PACIFICARE OF CALIFORNIA, INC.	20,100	1,400	1	\$496.27	\$521.82	5.1%	MSA
Mono	CIGNA HEALTHCARE OF CALIFORNIA	800	0	0	\$422.10	\$465.03	10.2%	Rural
Orange	UNITED HEALTHCARE OF CALIFORNIA-SOU	289,300	100	10	\$595.82	\$609.63	2.3%	MSA
Riverside	UNITED HEALTHCARE OF CALIFORNIA-SOU	200,900	300	9	\$537.00	\$553.64	3.1%	MSA
San Bernardino	BLUE CROSS OF CALIFORNIA	170,000	0	9	\$554.46	\$565.55	2.0%	MSA
San Bernardino	UNITED HEALTHCARE OF CALIFORNIA-SOU	170,000	300	9	\$554.46	\$565.55	2.0%	MSA
San Diego	CIGNA HEALTHCARE OF CALIFORNIA	346,600	1,900	6	\$538.09	\$563.76	4.8%	MSA
San Luis Obispo	BLUE CROSS OF CALIFORNIA	39,600	1,900	1	\$402.25	\$452.55	12.5%	MSA
Tuolumne	NATIONAL MED, INC.	11,100	1,400	0	\$418.10	\$463.30	10.8%	Rural
Ventura	AETNA U.S.HEALTHCARE OF CALIFORNIA IN	85,300	1,000	5	\$518.54	\$545.69	5.2%	MSA
Ventura	CIGNA HEALTHCARE OF CALIFORNIA	85,300	1,300	5	\$518.54	\$545.69	5.2%	MSA
CA Total			13,000					
Total Enrollees With No Other M+C Plan			1,500					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
COLORADO								
Adams	CIGNA HEALTHCARE OF COLORADO, INC.	38,800	700	4	\$498.56	\$513.59	3.0%	MSA
Adams	QUAL-MED, INC., DENVER	38,800	1,900	4	\$498.56	\$513.59	3.0%	MSA
Arapahoe	CIGNA HEALTHCARE OF COLORADO, INC.	42,600	1,700	4	\$457.34	\$484.26	5.9%	MSA
Boulder	HMO COLORADO, INC	27,700	1,500	3	\$445.88	\$478.92	7.4%	MSA
Boulder	QUAL-MED, INC., DENVER	27,700	300	3	\$445.88	\$478.92	7.4%	MSA
Denver	CIGNA HEALTHCARE OF COLORADO, INC.	73,600	1,100	4	\$524.14	\$534.62	2.0%	MSA
Denver	QUAL-MED, INC., DENVER	73,600	2,700	4	\$524.14	\$534.62	2.0%	MSA
Douglas	CIGNA HEALTHCARE OF COLORADO, INC.	4,700	200	4	\$416.18	\$452.51	8.7%	MSA
El Paso	QUAL-MED, INC., COLORADO SPRINGS	52,400	200	1	\$440.42	\$472.16	7.2%	MSA
Jefferson	CIGNA HEALTHCARE OF COLORADO, INC.	53,900	2,300	4	\$445.05	\$475.87	6.9%	MSA
Pueblo	HMO COLORADO, INC	25,400	1,200	1	\$423.61	\$452.13	6.7%	MSA
Pueblo	QUAL-MED, INC., PUEBLO	25,400	700	1	\$423.61	\$452.13	6.7%	MSA
CO Total			14,600					
Total M+C Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
CONNECTICUT								
Fairfield	CONNECTICARE, INC	126,000	2,100	4	\$520.91	\$546.20	4.9%	MSA
Fairfield	KAISER FOUNDATION HEALTH PLAN OF CT I	126,000	900	4	\$520.91	\$546.20	4.9%	MSA
Hartford	KAISER FOUNDATION HEALTH PLAN OF CT I	141,800	2,100	6	\$501.73	\$525.95	4.8%	MSA
Middlesex	KAISER FOUNDATION HEALTH PLAN OF CT I	23,000	100	3	\$440.80	\$482.64	9.5%	MSA
Tolland	KAISER FOUNDATION HEALTH PLAN OF CT I	15,000	200	2	\$510.98	\$541.27	5.9%	MSA
Tolland	PHYSICIANS HEALTH SERVICE OF CT., INC.	15,000	1,000	2	\$510.98	\$541.27	5.9%	MSA
Windham	PHYSICIANS HEALTH SERVICE OF CT., INC.	16,100	2,100	0	\$470.56	\$505.42	7.4%	Rural
CT Total			8,600					
Total Enrollees With No Other M+C Plan			2,100					

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County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/MSA
FLORIDA								
Brevard	HUMANA MEDICAL PLAN, INC	95,900	3,000	1	\$511.40	\$527.54	3.2%	MSA
Broward	FLORIDA HEALTH CHOICE, INC.	256,300	1,700	11	\$676.64	\$690.17	2.0%	MSA
Charlotte	CIGNA HEALTHCARE OF FLORIDA, INC.	39,200	100	2	\$545.09	\$555.99	2.0%	MSA
Charlotte	HEALTH OPTIONS, INC.	39,200	-	2	\$545.09	\$555.99	2.0%	MSA
Dixie	AV-MED HEALTH PLAN INC	2,600	300	0	\$471.81	\$493.45	4.6%	Rural
Hernando	CIGNA HEALTHCARE OF FLORIDA, INC.	41,700	100	2	\$531.82	\$542.69	2.0%	MSA
Hernando	HIP HEALTH PLAN OF FLORIDA, INC.	41,700	900	2	\$531.82	\$542.69	2.0%	MSA
Hillsborough	HIP HEALTH PLAN OF FLORIDA, INC.	136,500	500	7	\$506.36	\$521.34	3.0%	MSA
Lake	COMMUNITY HEALTH CARE SYSTEMS, INC.	60,100	2,100	0	\$462.73	\$489.82	5.9%	MSA
Lee	CIGNA HEALTHCARE OF FLORIDA, INC.	101,100	200	3	\$496.18	\$516.74	4.1%	MSA
Levy	AV-MED HEALTH PLAN INC	6,700	1,100	0	\$438.55	\$466.21	6.3%	Rural
Manatee	CIGNA HEALTHCARE OF FLORIDA, INC.	54,900	1,500	1	\$444.23	\$476.27	7.2%	MSA
Martin	FLORIDA HEALTH CHOICE, INC.	34,100	5,500	1	\$514.64	\$536.70	4.3%	MSA
Orange	COMMUNITY HEALTH CARE SYSTEMS, INC.	106,200	800	6	\$542.46	\$553.31	2.0%	MSA
Osceola	COMMUNITY HEALTH CARE SYSTEMS, INC.	21,600	100	6	\$584.26	\$595.95	2.0%	MSA
Palm Beach	FLORIDA HEALTH CHOICE, INC.	243,100	1,000	10	\$588.84	\$600.62	2.0%	MSA
Pasco	HIP HEALTH PLAN OF FLORIDA, INC.	86,500	700	7	\$561.24	\$572.46	2.0%	MSA
Pinellas	HIP HEALTH PLAN OF FLORIDA, INC.	210,500	700	7	\$520.29	\$533.00	2.4%	MSA
Saint Lucie	FLORIDA HEALTH CHOICE, INC.	40,800	6,600	0	\$570.85	\$582.27	2.0%	MSA
Sarasota	CIGNA HEALTHCARE OF FLORIDA, INC.	104,900	300	2	\$474.63	\$500.10	5.4%	MSA
Seminole	AV-MED HEALTH PLAN INC	39,000	1,600	5	\$521.66	\$536.05	2.8%	MSA
Seminole	COMMUNITY HEALTH CARE SYSTEMS, INC.	39,000	100	5	\$521.66	\$536.05	2.8%	MSA
Volusia	AV-MED HEALTH PLAN INC	102,500	500	2	\$454.78	\$481.63	5.9%	MSA
FL Total			29,300					
Total Enrollees With No Other M+C Plan			10,100					

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GEORGIA								
Butts	KAISER FOUNDATION HP OF GA, INC.	2,800	100	0	\$504.57	\$520.84	3.2%	Rural
Hall	KAISER FOUNDATION HP OF GA, INC.	15,700	200	0	\$464.58	\$491.42	5.8%	Rural
Newton	KAISER FOUNDATION HP OF GA, INC.	7,700	100	1	\$560.83	\$572.05	2.0%	MSA
Spalding	KAISER FOUNDATION HP OF GA, INC.	8,900	100	1	\$466.07	\$491.23	5.4%	MSA
Spalding	UNITED HEALTHCARE OF GEORGIA, INC.	8,900	900	1	\$466.07	\$491.23	5.4%	MSA
GA Total			1,400					
Total Enrollees With No Other M+C Plan			300					

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County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
ILLINOIS								
Cook	ACCORD HEALTH PLAN	694,300	600	4	\$581.87	\$593.51	2.0%	MSA
Du Page	ACCORD HEALTH PLAN	95,300	-	2	\$481.80	\$509.42	5.7%	MSA
Kankakee	HUMANA HEALTH PLAN, INC.	16,700	1,300	0	\$501.63	\$515.42	2.7%	MSA
IL Total			2,000					
Total Enrollees With No Other M+C Plan			1,300					

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County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County^	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
IOWA								
Pottawattamie	EXCLUSIVE HEALTHCARE, INC.	14,200	1,400	1	\$427.53	\$458.62	7.3%	MSA
IA Total			1,400					
Total Enrollees With No Other M+C Plan			0					

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KANSAS								
Johnson	CIGNA HEALTHCARE OF KANSAS/MISSOURI	47,700	300	6	\$488.18	\$506.41	3.7%	MSA
Johnson	UNITED HEALTHCARE OF THE MIDWEST, IN	47,700	300	6	\$488.18	\$506.41	3.7%	MSA
Leavenworth	HUMANA KANSAS CITY, INC.	7,100	400	1	\$485.35	\$503.12	3.7%	MSA
Miami	HUMANA KANSAS CITY, INC.	3,600	300	1	\$470.05	\$494.24	5.1%	MSA
Wyandotte	CIGNA HEALTHCARE OF KANSAS/MISSOURI	23,200	-	6	\$528.64	\$539.21	2.0%	MSA
Wyandotte	UNITED HEALTHCARE OF THE MIDWEST, IN	23,200	200	6	\$528.64	\$539.21	2.0%	MSA
KS Total			1,400					
Total Enrollees With No Other M+C Plan			0					

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LOUISIANA								
Allen	OCHSNER HEALTH PLAN	3,500	300	0	\$490.50	\$503.20	2.6%	Rural
Ascension	UNITED HEALTH CARE OF LOUISIANA	7,000	1,000	4	\$688.13	\$701.89	2.0%	MSA
Assumption	OCHSNER HEALTH PLAN	3,100	100	2	\$585.65	\$597.36	2.0%	Rural
Avoyelles	OCHSNER HEALTH PLAN	7,200	900	0	\$384.96	\$421.89	9.6%	Rural
Beauregard	OCHSNER HEALTH PLAN	4,800	700	0	\$450.15	\$469.41	4.3%	Rural
Bienville	OCHSNER HEALTH PLAN	3,200	400	0	\$427.73	\$456.69	6.8%	Rural
Bossier	OCHSNER HEALTH PLAN	11,300	1,500	0	\$466.24	\$489.39	5.0%	MSA
Caddo	OCHSNER HEALTH PLAN	39,500	3,300	0	\$463.40	\$485.94	4.9%	MSA
Calcasieu	OCHSNER HEALTH PLAN	26,300	2,100	0	\$523.17	\$533.63	2.0%	MSA
Cameron	OCHSNER HEALTH PLAN	900	100	0	\$666.87	\$680.21	2.0%	Rural
Catahoula	OCHSNER HEALTH PLAN	2,100	200	0	\$436.64	\$460.52	5.5%	Rural
Claiborne	OCHSNER HEALTH PLAN	3,100	500	0	\$430.18	\$456.36	6.1%	Rural
Concordia	OCHSNER HEALTH PLAN	3,500	200	0	\$406.18	\$435.12	7.1%	Rural
De Soto	OCHSNER HEALTH PLAN	4,400	500	0	\$403.48	\$437.17	8.3%	Rural
East Baton Rouge	UNITED HEALTH CARE OF LOUISIANA	46,400	5,700	4	\$563.22	\$574.48	2.0%	MSA
East Feliciana	UNITED HEALTH CARE OF LOUISIANA	2,900	300	2	\$538.09	\$548.85	2.0%	Rural
Evangeline	OCHSNER HEALTH PLAN	6,300	300	1	\$500.11	\$510.94	2.2%	Rural
Grant	OCHSNER HEALTH PLAN	2,900	200	0	\$499.96	\$512.32	2.5%	Rural
Iberville	UNITED HEALTH CARE OF LOUISIANA	4,600	600	2	\$576.84	\$588.38	2.0%	Rural
Jefferson	UNITED HEALTH CARE OF LOUISIANA	63,800	3,600	5	\$660.91	\$674.13	2.0%	MSA
Jefferson Davis	OCHSNER HEALTH PLAN	5,100	500	0	\$433.70	\$456.76	5.3%	Rural
Lafourche	UNITED HEALTH CARE OF LOUISIANA	12,000	200	3	\$575.35	\$586.86	2.0%	MSA
La Salle	OCHSNER HEALTH PLAN	2,600	100	0	\$530.92	\$541.54	2.0%	Rural
Lincoln	OCHSNER HEALTH PLAN	5,400	-	0	\$461.22	\$481.29	4.4%	Rural
Livingston	UNITED HEALTH CARE OF LOUISIANA	9,100	1,900	4	\$656.44	\$669.57	2.0%	MSA
Natchitoches	OCHSNER HEALTH PLAN	5,800	800	0	\$391.04	\$426.32	9.0%	Rural
Orleans	UNITED HEALTH CARE OF LOUISIANA	69,600	1,900	5	\$638.50	\$651.27	2.0%	MSA
Plaquemines	UNITED HEALTH CARE OF LOUISIANA	3,200	100	3	\$757.12	\$772.26	2.0%	MSA
Pointe Coupee	OCHSNER HEALTH PLAN	3,500	200	1	\$387.52	\$423.73	9.3%	Rural
Rapides	OCHSNER HEALTH PLAN	20,600	1,400	0	\$468.06	\$487.53	4.2%	MSA

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Red River	OCHSNER HEALTH PLAN	1,600	300	0	\$428.10	\$456.73	6.7%	Rural
Sabine	OCHSNER HEALTH PLAN	4,300	700	0	\$418.55	\$450.17	7.6%	Rural
Saint Bernard	UNITED HEALTH CARE OF LOUISIANA	11,200	100	5	\$748.92	\$763.90	2.0%	MSA
Saint Charles	UNITED HEALTH CARE OF LOUISIANA	5,100	300	5	\$662.70	\$675.95	2.0%	MSA
Saint James	OCHSNER HEALTH PLAN	2,900	100	2	\$578.39	\$589.96	2.0%	MSA
Saint James	UNITED HEALTH CARE OF LOUISIANA	2,900	100	2	\$578.39	\$589.96	2.0%	MSA
St John The Baptist	UNITED HEALTH CARE OF LOUISIANA	4,300	100	4	\$655.51	\$668.62	2.0%	MSA
Saint Landry	OCHSNER HEALTH PLAN	15,000	100	1	\$475.51	\$492.02	3.5%	MSA
Saint Tammany	UNITED HEALTH CARE OF LOUISIANA	22,300	300	5	\$656.77	\$669.91	2.0%	MSA
Vernon	OCHSNER HEALTH PLAN	4,900	600	0	\$569.12	\$580.50	2.0%	Rural
Washington	UNITED HEALTH CARE OF LOUISIANA	8,100	400	2	\$662.00	\$675.24	2.0%	Rural
Webster	OCHSNER HEALTH PLAN	8,300	800	0	\$476.56	\$498.03	4.5%	MSA
West Baton Rouge	UNITED HEALTH CARE OF LOUISIANA	2,600	500	3	\$558.28	\$569.45	2.0%	MSA
West Feliciana	OCHSNER HEALTH PLAN	1,000	100	1	\$515.02	\$525.32	2.0%	Rural
LA Total			34,000					
Total Enrollees With No Other M+C Plan			15,900					

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SEP-13-1999

12:59

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P. 14/38

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
MARYLAND								
Allegany	FREE STATE HEALTH PLAN	15,600	800	0	\$574.23	\$585.71	2.0%	MSA
Calvert	FREE STATE HEALTH PLAN	7,200	800	0	\$495.45	\$517.03	4.4%	MSA
Caroline	FREE STATE HEALTH PLAN	4,600	900	0	\$416.87	\$448.08	7.5%	Rural
Carroll	FREE STATE HEALTH PLAN	19,700	1,900	2	\$500.93	\$519.96	3.8%	MSA
Cecil	FREE STATE HEALTH PLAN	10,100	700	0	\$532.84	\$548.76	3.0%	MSA
Cecil	UNITED HEALTHCARE OF THE MID-ATLANTI	10,100	700	0	\$532.84	\$548.76	3.0%	MSA
Charles	FREE STATE HEALTH PLAN	10,000	200	3	\$587.79	\$599.55	2.0%	MSA
Dorchester	FREE STATE HEALTH PLAN	5,800	1,100	0	\$455.06	\$478.16	5.1%	Rural
Frederick	FREE STATE HEALTH PLAN	19,400	500	1	\$441.48	\$477.87	8.2%	MSA
Garrett	FREE STATE HEALTH PLAN	4,600	300	0	\$476.26	\$493.83	3.7%	Rural
Kent	FREE STATE HEALTH PLAN	4,600	700	0	\$460.96	\$483.27	4.8%	Rural
Queen Annes	FREE STATE HEALTH PLAN	4,800	700	0	\$442.27	\$468.85	6.0%	MSA
Saint Marys	FREE STATE HEALTH PLAN	8,200	500	0	\$516.85	\$527.19	2.0%	Rural
Somerset	FREE STATE HEALTH PLAN	4,000	500	0	\$379.84	\$413.12	8.8%	Rural
Talbot	FREE STATE HEALTH PLAN	7,200	1,300	0	\$407.34	\$440.65	8.2%	Rural
Washington	FREE STATE HEALTH PLAN	20,400	1,100	0	\$396.70	\$439.26	10.7%	MSA
Wicomico	FREE STATE HEALTH PLAN	12,000	1,600	0	\$397.14	\$433.53	9.2%	Rural
Worcester	FREE STATE HEALTH PLAN	9,900	1,200	0	\$384.33	\$423.58	10.2%	Rural
MD Total			15,500					
Total Enrollees With No Other M+C Plan			12,900					

NOTES: Numbers may not add due to rounding. Data as of July 15, based on information HCFA received from Medicare+Choice plans.

MSA= Metropolitan Statistical Area

*A "-" in this column indicates fewer than 50 enrollees were affected.

Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
MASSACHUSETTS								
Franklin	HARVARD PILGRIM HEALTH CARE	11,800	600	2	\$426.56	\$467.86	9.7%	Rural
Hampden	HARVARD PILGRIM HEALTH CARE	77,800	2,300	3	\$445.95	\$479.61	7.5%	MSA
Hampshire	HARVARD PILGRIM HEALTH CARE	20,600	700	2	\$420.20	\$462.21	10.0%	MSA
Worcester	UNITED HEALTH PLANS OF NEW ENGLAND,	114,300	2,100	4	\$548.27	\$559.24	2.0%	MSA
MA Total			5,600					
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
MINNESOTA								
Anoka	MEDICA	22,300	3,000	2	\$411.10	\$453.31	10.3%	MSA
MN Total			3,000					
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
MISSOURI								
Cass	CIGNA HEALTHCARE OF KANSAS/MISSOURI	10,300	300	6	\$454.94	\$479.90	5.5%	MSA
Clay	CIGNA HEALTHCARE OF KANSAS/MISSOURI	23,000	-	6	\$501.56	\$519.84	3.6%	MSA
Clay	UNITED HEALTHCARE OF THE MIDWEST, IN	23,000	100	6	\$501.56	\$519.84	3.6%	MSA
Jackson	CIGNA HEALTHCARE OF KANSAS/MISSOURI	97,400	900	6	\$525.22	\$535.72	2.0%	MSA
Jackson	UNITED HEALTHCARE OF THE MIDWEST, IN	97,400	600	6	\$525.22	\$535.72	2.0%	MSA
Platte	CIGNA HEALTHCARE OF KANSAS/MISSOURI	7,000	-	6	\$470.24	\$493.90	5.0%	MSA
Platte	UNITED HEALTHCARE OF THE MIDWEST, IN	7,000	-	6	\$470.24	\$493.90	5.0%	MSA
MO Total			1,900					
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
NEBRASKA								
Douglas	EXCLUSIVE HEALTHCARE, INC.	60,300	4,400	1	\$450.20	\$471.42	4.7%	MSA
Sarpy	EXCLUSIVE HEALTHCARE, INC.	7,300	1,000	0	\$390.97	\$428.48	9.6%	MSA
NE Total			5,400					
Total Enrollees With No Other M+C Plan			1,000					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
NEVADA								
Clark	HUMANA HEALTH PLAN, INC.	155,000	8,900	2	\$530.04	\$554.90	4.7%	MSA
Nye	HUMANA HEALTH PLAN, INC.	6,500	700	1	\$478.87	\$513.76	7.3%	MSA
NV Total			9,600					
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
NEW HAMPSHIRE								
Cheshire	HEALTHSOURCE NEW HAMPSHIRE, INC.	11,400	300	0	\$379.84	\$417.34	9.9%	Rural
Hillsborough	HEALTHSOURCE NEW HAMPSHIRE, INC.	46,900	7,900	2	\$414.91	\$462.80	11.5%	MSA
Merrimack	HEALTHSOURCE NEW HAMPSHIRE, INC.	19,400	2,100	0	\$407.11	\$454.94	11.7%	MSA
Rockingham	HEALTHSOURCE NEW HAMPSHIRE, INC.	32,600	3,100	2	\$438.13	\$479.31	9.4%	MSA
NH Total			13,400					
Total Enrollees With No Other M+C Plan			2,400					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
NEW JERSEY								
Atlantic	CIGNA HEALTHCARE OF NEW JERSEY, INC.	38,300	-	3	\$553.57	\$564.89	2.0%	MSA
Atlantic	PHYSICIANS HEALTH SERVICES OF NJ., INC.	38,300	-	3	\$553.57	\$564.89	2.0%	MSA
Bergen	PHYSICIANS HEALTH SERVICES OF NJ., INC.	142,900	700	5	\$527.72	\$559.77	6.1%	MSA
Bergen	UNITED HEALTHCARE OF NEW JERSEY, INC.	142,900	800	5	\$527.72	\$559.77	6.1%	MSA
Burlington	CIGNA HEALTHCARE OF NEW JERSEY, INC.	57,600	-	5	\$537.40	\$552.60	2.8%	MSA
Burlington	PHYSICIANS HEALTH SERVICES OF NJ., INC.	57,600	-	5	\$537.40	\$552.60	2.8%	MSA
Camden	CIGNA HEALTHCARE OF NEW JERSEY, INC.	73,900	-	6	\$581.83	\$593.47	2.0%	MSA
Camden	PHYSICIANS HEALTH SERVICES OF NJ., INC.	73,900	-	6	\$581.83	\$593.47	2.0%	MSA
Cape May	CIGNA HEALTHCARE OF NEW JERSEY, INC.	22,300	0	3	\$563.74	\$575.01	2.0%	MSA
Cumberland	PHYSICIANS HEALTH SERVICES OF NJ., INC.	22,700	-	3	\$522.51	\$545.22	4.3%	MSA
Essex	PHYSICIANS HEALTH SERVICES OF NJ., INC.	105,900	200	6	\$564.71	\$578.68	2.5%	MSA
Essex	UNITED HEALTHCARE OF NEW JERSEY, INC.	105,900	700	6	\$564.71	\$578.68	2.5%	MSA
Gloucester	CIGNA HEALTHCARE OF NEW JERSEY, INC.	31,700	-	3	\$579.98	\$591.58	2.0%	MSA
Gloucester	PHYSICIANS HEALTH SERVICES OF NJ., INC.	31,700	-	3	\$579.98	\$591.58	2.0%	MSA
Hudson	PHYSICIANS HEALTH SERVICES OF NJ., INC.	75,000	100	5	\$550.22	\$572.80	4.1%	MSA
Hudson	UNITED HEALTHCARE OF NEW JERSEY, INC.	75,000	400	5	\$550.22	\$572.80	4.1%	MSA
Hunterdon	CIGNA HEALTHCARE OF NJ, INC.	13,600	100	3	\$494.52	\$516.24	4.4%	MSA
Hunterdon	PHYSICIANS HEALTH SERVICES OF NJ., INC.	13,600	-	3	\$494.52	\$516.24	4.4%	MSA
Mercer	CIGNA HEALTHCARE OF NEW JERSEY, INC.	52,300	-	4	\$578.80	\$590.38	2.0%	MSA
Mercer	PHYSICIANS HEALTH SERVICES OF NJ., INC.	52,300	100	4	\$578.80	\$590.38	2.0%	MSA
Middlesex	PHYSICIANS HEALTH SERVICES OF NJ., INC.	98,500	400	5	\$544.63	\$558.12	2.5%	MSA
Monmouth	CIGNA HEALTHCARE OF NJ, INC.	88,200	400	4	\$523.09	\$542.02	3.6%	MSA
Morris	CIGNA HEALTHCARE OF NJ, INC.	58,500	400	4	\$494.71	\$525.78	6.3%	MSA
Morris	PHYSICIANS HEALTH SERVICES OF NJ., INC.	58,500	100	4	\$494.71	\$525.78	6.3%	MSA
Ocean	CIGNA HEALTHCARE OF NEW JERSEY, INC.	118,900	-	4	\$505.24	\$534.05	5.7%	MSA
Passaic	PHYSICIANS HEALTH SERVICES OF NJ., INC.	66,500	200	6	\$505.13	\$537.18	6.3%	MSA
Salem	PHYSICIANS HEALTH SERVICES OF NJ., INC.	10,800	-	3	\$573.16	\$584.62	2.0%	MSA
Somerset	CIGNA HEALTHCARE OF NJ, INC.	32,500	200	4	\$456.64	\$491.08	7.5%	MSA
Somerset	PHYSICIANS HEALTH SERVICES OF NJ., INC.	32,500	100	4	\$456.64	\$491.08	7.5%	MSA
Sussex	CIGNA HEALTHCARE OF NJ, INC.	15,500	100	3	\$473.00	\$511.04	8.0%	MSA

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
Sussex	PHYSICIANS HEALTH SERVICES OF NJ., INC.	15,500	-	3	\$473.00	\$511.04	8.0%	MSA
Union	PHYSICIANS HEALTH SERVICES OF NJ., INC.	81,600	200	6	\$526.59	\$545.04	3.5%	MSA
Union	UNITED HEALTHCARE OF NEW JERSEY, INC.	81,600	400	6	\$526.59	\$545.04	3.5%	MSA
Warren	CIGNA HEALTHCARE OF NJ, INC.	15,600	100	3	\$557.83	\$568.99	2.0%	MSA
Warren	PHYSICIANS HEALTH SERVICES OF NJ., INC.	15,600	-	3	\$557.83	\$568.99	2.0%	MSA
NJ Total			5,700					
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining 1999	Rate 1999	2000 Rate	99-00 Growth	Rural/ MSA
NEW MEXICO								
Los Alamos	PRESBYTERIAN HEALTH PLAN	2,200	-	1	\$379.84	\$423.74	11.6%	MSA
NM Total			-					
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
NEW YORK								
Albany	CAPITAL AREA COMMUNITY HP	46,500	2,200	2	\$397.05	\$426.70	7.5%	MSA
Albany	HUM/HEALTHCARE SYSTEMS, INC.	46,500	100	2	\$397.05	\$426.70	7.5%	MSA
Dutchess	CAPITAL AREA COMMUNITY HP	40,900	3,600	2	\$447.06	\$485.41	8.6%	MSA
Dutchess	PHYSICIANS HLTH SVC OF NY, INC	40,900	200	2	\$447.06	\$485.41	8.6%	MSA
Essex	HUM/HEALTHCARE SYSTEMS, INC.	7,500	100	0	\$379.84	\$406.73	7.1%	Rural
Franklin	HUM/HEALTHCARE SYSTEMS, INC.	7,900	100	0	\$379.84	\$401.61	5.7%	Rural
Nassau	UNITED HEALTHCARE OF NEW YORK, INC.	224,700	1,400	8	\$610.30	\$622.51	2.0%	MSA
Orange	PHYSICIANS HLTH SVC OF NY, INC	42,200	100	3	\$489.40	\$524.02	7.1%	MSA
Putnam	PHYSICIANS HLTH SVC OF NY, INC	10,500	200	1	\$611.39	\$628.30	2.8%	MSA
Queens	VYTRA HEALTHCARE	287,700	900	10	\$685.46	\$699.17	2.0%	MSA
Rensselaer	CAPITAL AREA COMMUNITY HP	24,300	2,400	2	\$424.93	\$451.95	6.4%	MSA
Rensselaer	HUM/HEALTHCARE SYSTEMS, INC.	24,300	-	2	\$424.93	\$451.95	6.4%	MSA
Rockland	PHYSICIANS HLTH SVC OF NY, INC	39,900	100	4	\$605.07	\$630.25	4.2%	MSA
Saratoga	CAPITAL AREA COMMUNITY HP	26,600	2,900	2	\$389.80	\$426.15	9.3%	MSA
Schenectady	CAPITAL AREA COMMUNITY HP	29,800	2,300	1	\$379.84	\$414.50	9.1%	MSA
Schenectady	HUM/HEALTHCARE SYSTEMS, INC.	29,800	-	1	\$379.84	\$414.50	9.1%	MSA
Suffolk	OXFORD HEALTH PLANS (NEW YORK) INC.	199,000	9,100	6	\$568.77	\$592.30	4.1%	MSA
Suffolk	UNITED HEALTHCARE OF NEW YORK, INC.	199,000	1,900	6	\$568.77	\$592.30	4.1%	MSA
Ulster	CAPITAL AREA COMMUNITY HP	27,700	4,100	1	\$444.27	\$476.85	7.3%	Rural
Westchester	CAPITAL AREA COMMUNITY HEALTH PLAN	141,300	2,500	4	\$584.38	\$608.47	4.1%	MSA
Westchester	CIGNA HEALTHCARE OF NEW YORK	141,300	800	4	\$584.38	\$608.47	4.1%	MSA
Westchester	PHYSICIANS HLTH SVC OF NY, INC	141,300	3,600	4	\$584.38	\$608.47	4.1%	MSA
NY Total			38,700					
Total Enrollees With No Other M+C Plan			200					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
OHIO								
Allen	FAMILY HEALTH PLAN, INC.	17,400	0	0	\$381.18	\$422.39	10.8%	MSA
Ashland	AETNA U.S. HEALTHCARE, INC.	7,700	300	0	\$379.84	\$401.61	5.7%	Rural
Ashtabula	CIGNA HEALTHCARE OF OHIO, INC.	17,700	1,600	0	\$488.46	\$503.62	3.1%	MSA
Ashtabula	QUALCHOICE HEALTH PLAN	17,700	300	0	\$488.46	\$503.62	3.1%	MSA
Auglaize	FAMILY HEALTH PLAN, INC.	8,300	0	0	\$426.06	\$457.02	7.3%	MSA
Clark	PACIFICARE OF OHIO, INC.	24,900	600	2	\$462.41	\$487.66	5.5%	MSA
Crawford	AETNA U.S. HEALTHCARE, INC.	8,500	100	1	\$421.76	\$451.18	7.0%	MSA
Cuyahoga	CIGNA HEALTHCARE OF OHIO, INC.	244,800	300	8	\$564.30	\$575.59	2.0%	MSA
Delaware	COMMUNITY HEALTH PLAN OF OHIO	8,600	400	1	\$416.36	\$450.01	8.1%	MSA
Fairfield	COMMUNITY HEALTH PLAN OF OHIO	15,400	100	0	\$431.16	\$461.07	6.9%	MSA
Geauga	CIGNA HEALTHCARE OF OHIO, INC.	9,400	-	5	\$462.62	\$484.81	4.8%	MSA
Geauga	QUALCHOICE HEALTH PLAN	9,400	500	5	\$462.62	\$484.81	4.8%	MSA
Hocking	COMMUNITY HEALTH PLAN OF OHIO	4,200	100	0	\$481.58	\$497.03	3.2%	Rural
Jackson	COMMUNITY HEALTH PLAN OF OHIO	5,400	100	0	\$382.78	\$423.46	10.6%	Rural
Knox	AETNA U.S. HEALTHCARE, INC.	8,600	100	1	\$417.11	\$446.24	7.0%	Rural
Lake	CIGNA HEALTHCARE OF OHIO, INC.	36,100	600	5	\$493.40	\$506.72	2.7%	MSA
Lorain	CIGNA HEALTHCARE OF OHIO, INC.	40,000	400	4	\$505.27	\$522.63	3.4%	MSA
Lorain	QUALCHOICE HEALTH PLAN	40,000	300	4	\$505.27	\$522.63	3.4%	MSA
Lucas	HEALTH ALLIANCE PLAN OF MICHIGAN	69,700	-	3	\$593.15	\$605.01	2.0%	MSA
Mahoning	CIGNA HEALTHCARE OF OHIO, INC.	53,200	100	3	\$498.40	\$508.37	2.0%	MSA
Marion	COMMUNITY HEALTH PLAN OF OHIO	10,900	-	0	\$460.07	\$484.55	5.3%	Rural
Montgomery	PACIFICARE OF OHIO, INC.	95,200	3,600	3	\$485.54	\$497.25	2.4%	MSA
Perry	COMMUNITY HEALTH PLAN OF OHIO	5,500	-	0	\$447.86	\$471.56	5.3%	Rural
Pike	COMMUNITY HEALTH PLAN OF OHIO	4,400	100	0	\$391.41	\$429.80	9.8%	Rural
Putnam	FAMILY HEALTH PLAN, INC.	5,100	0	0	\$381.13	\$422.20	10.8%	Rural
Richland	AETNA U.S. HEALTHCARE, INC.	21,600	100	1	\$388.10	\$424.49	9.4%	MSA
Ross	COMMUNITY HEALTH PLAN OF OHIO	11,100	700	0	\$396.69	\$435.24	9.7%	Rural
Stark	CIGNA HEALTHCARE OF OHIO, INC.	68,100	600	6	\$409.41	\$439.09	7.2%	MSA
Stark	SUMMACARE INC.	68,100	1,800	6	\$409.41	\$439.09	7.2%	MSA
Summit	CIGNA HEALTHCARE OF OHIO, INC.	85,700	-	8	\$558.78	\$569.96	2.0%	MSA

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
Summit	QUALCHOICE HEALTH PLAN	85,700	100	8	\$558.78	\$569.96	2.0%	MSA
Trumbull	CIGNA HEALTHCARE OF OHIO, INC.	39,400	100	2	\$554.20	\$565.28	2.0%	MSA
Union	COMMUNITY HEALTH PLAN OF OHIO	3,900	-	1	\$465.90	\$488.07	4.8%	Rural
Van Wert	FAMILY HEALTH PLAN, INC.	4,600	0	0	\$379.84	\$401.61	5.7%	Rural
Vinton	COMMUNITY HEALTH PLAN OF OHIO	1,800	-	0	\$412.13	\$444.25	7.8%	Rural
Wood	HEALTH ALLIANCE PLAN OF MICHIGAN	14,700	0	2	\$477.92	\$498.46	4.3%	MSA
OH Total			13,000					
Total Enrollees With No Other M+C Plan			3,200					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
OKLAHOMA								
Cherokee	BLUELINCS HMO, INC.	5,600	-	1	\$405.87	\$437.35	7.8%	Rural
Comanche	BLUELINCS HMO, INC.	12,700	-	0	\$399.09	\$433.95	8.7%	MSA
Cotton	BLUELINCS HMO, INC.	1,300	-	0	\$379.84	\$417.64	10.0%	Rural
Garvin	BLUELINCS HMO, INC.	6,100	100	1	\$425.51	\$449.90	5.7%	Rural
Grady	BLUELINCS HMO, INC.	6,400	100	3	\$379.84	\$401.61	5.7%	Rural
Kiowa	BLUELINCS HMO, INC.	2,400	-	0	\$390.31	\$422.23	8.2%	Rural
Lincoln	BLUELINCS HMO, INC.	4,900	100	1	\$379.84	\$401.61	5.7%	Rural
McCain	BLUELINCS HMO, INC.	3,900	100	3	\$427.52	\$453.93	6.2%	MSA
McIntosh	BLUELINCS HMO, INC.	4,800	100	1	\$379.84	\$412.92	8.7%	Rural
Muskogee	BLUELINCS HMO, INC.	12,900	200	1	\$392.44	\$426.92	8.8%	Rural
Payne	BLUELINCS HMO, INC.	8,200	300	1	\$403.95	\$434.68	7.6%	Rural
Rogers	BLUELINCS HMO, INC.	7,600	100	2	\$467.47	\$484.50	3.6%	MSA
Tillman	BLUELINCS HMO, INC.	2,000	-	0	\$398.48	\$429.28	7.7%	Rural
OK Total			1,200					
Total Enrollees With No Other M+C Plan			-					

NOTES: Numbers may not add due to rounding. Data as of July 15, based on information HCFA received from Medicare+Choice plans.

MSA= Metropolitan Statistical Area

*A "-" in this column indicates fewer than 50 enrollees were affected.

Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
OREGON								
Douglas	PROVIDENCE HEALTH PLAN	20,600	700	0	\$379.84	\$413.15	8.8%	Rural
Jackson	PACIFICARE OF OREGON II	32,400	1,400	1	\$379.84	\$401.61	5.7%	MSA
Yamhill	PACIFICARE OF OREGON, INC.	11,100	1,000	2	\$379.84	\$425.86	12.1%	MSA
OR Total			3,100					
Total Enrollees With No Other M+C Plan			700					

NOTES: Numbers may not add due to rounding. Data as of July 15, based on information HCFA received from Medicare+Choice plans.

MSA= Metropolitan Statistical Area

*A "-" in this column indicates fewer than 50 enrollees were affected.

Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
PENNSYLVANIA								
Bucks	CIGNA HEALTHCARE OF PENNSYLVANIA, IN	79,500	0	3	\$598.89	\$610.87	2.0%	MSA
Chester	CIGNA HEALTHCARE OF PENNSYLVANIA, IN	50,600	-	3	\$532.32	\$553.66	4.0%	MSA
Columbia	HEALTHAMERICA OF CENTRAL PA.	12,100	400	2	\$445.90	\$463.56	4.0%	MSA
Delaware	CIGNA HEALTHCARE OF PENNSYLVANIA, IN	93,200	0	3	\$613.96	\$626.24	2.0%	MSA
Luzerne	HEALTHAMERICA OF CENTRAL PA.	70,600	300	3	\$499.28	\$511.96	2.5%	MSA
Lycoming	HEALTHAMERICA OF CENTRAL PA.	21,900	200	2	\$415.02	\$443.61	6.9%	MSA
Montgomery	CIGNA HEALTHCARE OF PENNSYLVANIA, IN	126,300	-	4	\$537.16	\$548.59	2.1%	MSA
Philadelphia	CIGNA HEALTHCARE OF PENNSYLVANIA, IN	248,200	0	4	\$732.70	\$747.35	2.0%	MSA
PA Total			800					
Total Enrollees With No Other M+C Plan			0					

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MSA= Metropolitan Statistical Area

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
RHODE ISLAND								
Newport	UNITED HEALTH PLANS OF NEW ENGLAND,	13,800	2,000	1	\$448.53	\$484.96	8.1%	MSA
RI Total			2,000					
Total Enrollees With No Other M+C Plan			0					

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MSA= Metropolitan Statistical Area

*A "-" in this column indicates fewer than 50 enrollees were affected.

Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
SOUTH CAROLINA								
Berkeley	COMPANION HEALTHCARE CORPORATION	11,500	200	0	\$427.60	\$455.71	6.6%	MSA
Charleston	COMPANION HEALTHCARE CORPORATION	43,700	600	0	\$464.16	\$480.38	3.5%	MSA
Dorchester	COMPANION HEALTHCARE CORPORATION	10,900	200	0	\$393.15	\$429.44	9.2%	MSA
SC Total			1,100					
Total Enrollees With No Other M+C Plan			1,100					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
TENNESSEE								
Davidson	UNITED HEALTHCARE OF TENNESSEE, INC.	75,000	100	3	\$537.13	\$547.87	2.0%	MSA
Fayette	UNITED HEALTHCARE OF TENNESSEE, INC.	3,300	-	0	\$461.23	\$476.86	3.4%	MSA
Hamilton	UNITED HEALTHCARE OF TENNESSEE, INC.	50,300	-	3	\$516.35	\$526.68	2.0%	MSA
Mcminn	TENNESSEE HEALTH CARE NETWORK, INC.	8,300	-	1	\$468.89	\$486.68	3.8%	Rural
Meigs	TENNESSEE HEALTH CARE NETWORK, INC.	1,700	-	0	\$476.98	\$494.49	3.7%	Rural
Robertson	UNITED HEALTHCARE OF TENNESSEE, INC.	7,100	-	2	\$514.95	\$527.44	2.4%	MSA
Shelby	UNITED HEALTHCARE OF TENNESSEE, INC.	109,400	400	0	\$482.03	\$491.67	2.0%	MSA
TN Total			700					
Total Enrollees With No Other M+C Plan			500					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
TEXAS								
Atascosa	HUMANA HP OF TEXAS	4,300	500	1	\$448.35	\$468.35	4.5%	Rural
Bee	HUMANA HP OF TEXAS	3,500	200	0	\$510.72	\$520.93	2.0%	Rural
Brazoria	HUMANA HP OF TEXAS	23,700	900	6	\$540.41	\$551.22	2.0%	MSA
Caldwell	HUMANA HP OF TEXAS	4,300	100	1	\$420.27	\$449.43	6.9%	MSA
Camp	HEALTHCARE PARTNERS PLANS, INC	2,300	100	0	\$458.54	\$478.99	4.5%	Rural
Cherokee	HEALTHCARE PARTNERS PLANS, INC	6,900	200	1	\$509.15	\$522.01	2.5%	Rural
Collin	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	23,400	100	4	\$536.72	\$547.45	2.0%	MSA
Comal	HUMANA HP OF TEXAS	12,500	200	2	\$379.84	\$415.47	9.4%	MSA
Dallas	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	208,000	700	4	\$534.86	\$545.56	2.0%	MSA
Dallas	HMO BLUE,NORTHEAST TEXAS	208,000	600	4	\$534.86	\$545.56	2.0%	MSA
Dallas	HUMANA HP OF TEXAS	208,000	8,100	4	\$534.86	\$545.56	2.0%	MSA
Denton	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	21,100	100	4	\$546.85	\$557.79	2.0%	MSA
Denton	HUMANA HP OF TEXAS	21,100	1,200	4	\$546.85	\$557.79	2.0%	MSA
Ellis	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	12,100	-	4	\$470.68	\$489.89	4.1%	MSA
Ellis	HMO BLUE,NORTHEAST TEXAS	12,100	100	4	\$470.68	\$489.89	4.1%	MSA
Fort Bend	HUMANA HP OF TEXAS	17,600	700	6	\$508.49	\$521.77	2.6%	MSA
Franklin	HEALTHCARE PARTNERS PLANS, INC	1,400	100	0	\$516.04	\$526.36	2.0%	Rural
Galveston	UNITED HEALTHCARE OF TEXAS, INC.-HOUS	31,400	-	7	\$604.02	\$616.10	2.0%	MSA
Grayson	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	18,800	1,300	1	\$427.91	\$456.96	6.8%	MSA
Gregg	HEALTHCARE PARTNERS PLANS, INC	19,500	400	0	\$420.81	\$451.63	7.3%	MSA
Harris	UNITED HEALTHCARE OF TEXAS, INC.-HOUS	281,700	100	7	\$619.21	\$631.59	2.0%	MSA
Hays	HUMANA HP OF TEXAS	8,100	600	2	\$395.22	\$429.58	8.7%	MSA
Henderson	HEALTHCARE PARTNERS PLANS, INC	10,200	1,100	0	\$489.59	\$507.26	3.6%	MSA
Hood	HUMANA HP OF TEXAS	7,900	700	3	\$468.73	\$492.86	5.1%	MSA
Hunt	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	11,000	100	2	\$461.60	\$484.39	4.9%	MSA
Johnson	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	15,300	-	4	\$479.19	\$502.06	4.8%	MSA
Johnson	HMO BLUE,NORTHEAST TEXAS	15,300	100	4	\$479.19	\$502.06	4.8%	MSA
Johnson	HUMANA HP OF TEXAS	15,300	-	4	\$479.19	\$502.06	4.8%	MSA
Kaufman	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	12,800	100	4	\$494.23	\$510.50	3.3%	MSA
Kleberg	HUMANA HP OF TEXAS	3,600	200	1	\$484.24	\$497.61	2.8%	Rural

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
Montgomery	UNITED HEALTHCARE OF TEXAS, INC.-HOUS	26,800	-	7	\$692.24	\$706.08	2.0%	MSA
Parker	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	9,600	-	3	\$464.57	\$488.76	5.2%	MSA
Rockwall	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	3,500	-	4	\$495.37	\$511.05	3.2%	MSA
Rusk	HEALTHCARE PARTNERS PLANS, INC	6,900	200	1	\$403.56	\$435.56	7.9%	Rural
Smith	HEALTHCARE PARTNERS PLANS, INC	27,400	1,300	1	\$434.21	\$462.56	6.5%	MSA
Somervell	HUMANA HP OF TEXAS	800	-	1	\$446.28	\$476.15	6.7%	Rural
Tarrant	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	133,400	300	4	\$514.29	\$529.17	2.9%	MSA
Tarrant	HMO BLUE, NORTHEAST TEXAS	133,400	200	4	\$514.29	\$529.17	2.9%	MSA
Tarrant	HUMANA HP OF TEXAS	133,400	4,000	4	\$514.29	\$529.17	2.9%	MSA
Travis	HUMANA HP OF TEXAS	62,100	6,000	2	\$429.19	\$457.95	6.7%	MSA
Upshur	HEALTHCARE PARTNERS PLANS, INC	6,000	400	0	\$472.74	\$492.42	4.2%	MSA
Van Zandt	HEALTHCARE PARTNERS PLANS, INC	8,300	300	1	\$462.37	\$484.52	4.8%	Rural
Williamson	HUMANA HP OF TEXAS	17,700	400	2	\$379.84	\$411.43	8.3%	MSA
Wood	HEALTHCARE PARTNERS PLANS, INC	8,200	500	0	\$439.66	\$465.92	6.0%	Rural
TX Total			31,700					
Total Enrollees With No Other M+C Plan			2,600					

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Medicare+Choice Enrollees Affected By No Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
VIRGINIA								
Chesapeake City	OPTIMA HEALTH PLAN	19,900	1,700	0	\$470.46	\$484.88	3.1%	MSA
Chesterfield	HEALTHKEEPERS, INC.	20,800	300	1	\$434.48	\$463.81	6.8%	MSA
Gloucester	OPTIMA HEALTH PLAN	4,500	100	0	\$379.98	\$414.28	9.0%	MSA
Goochland	HEALTHKEEPERS, INC.	2,000	100	1	\$409.50	\$445.19	8.7%	MSA
Hampton City	OPTIMA HEALTH PLAN	17,800	1,600	0	\$417.70	\$443.76	6.2%	MSA
Hanover	HEALTHKEEPERS, INC.	11,800	400	1	\$467.80	\$490.45	4.8%	MSA
Henrico	HEALTHKEEPERS, INC.	28,900	900	1	\$433.34	\$463.29	6.9%	MSA
Isle Of Wight	OPTIMA HEALTH PLAN	4,100	200	0	\$441.42	\$461.15	4.5%	MSA
James City	OPTIMA HEALTH PLAN	2,000	100	0	\$419.45	\$446.91	6.5%	MSA
Newport News City	OPTIMA HEALTH PLAN	21,300	1,200	0	\$394.53	\$423.90	7.4%	MSA
Norfolk City	OPTIMA HEALTH PLAN	29,900	3,100	0	\$459.44	\$470.52	2.4%	MSA
Portsmouth City	OPTIMA HEALTH PLAN	16,600	1,200	0	\$449.15	\$467.37	4.1%	MSA
Poquoson City	OPTIMA HEALTH PLAN	700	100	0	\$440.76	\$458.58	4.0%	MSA
Powhatan	HEALTHKEEPERS, INC.	2,200	-	1	\$437.47	\$467.99	7.0%	MSA
Richmond City	HEALTHKEEPERS, INC.	39,300	1,000	1	\$470.52	\$488.94	3.9%	MSA
Suffolk City	OPTIMA HEALTH PLAN	7,100	400	0	\$459.23	\$476.74	3.8%	MSA
Virginia Beach City	OPTIMA HEALTH PLAN	38,900	4,000	0	\$442.45	\$463.75	4.8%	MSA
Williamsburg City	OPTIMA HEALTH PLAN	6,400	200	0	\$460.96	\$479.54	4.0%	MSA
York	OPTIMA HEALTH PLAN	6,800	300	0	\$401.02	\$430.15	7.3%	MSA
VA Total			16,700					
Total Enrollees With No Other M+C Plan			13,900					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
WASHINGTON								
Clallam	GROUP HEALTH COOP OF PUGET SOUND	15,500	900	0	\$387.40	\$437.01	12.8%	Rural
Grays Harbor	FIRST CHOICE HEALTH PLAN	12,800	-	1	\$422.76	\$465.30	10.1%	Rural
Grays Harbor	OPTIONS HEALTH CARE, INC.	12,800	-	1	\$422.76	\$465.30	10.1%	Rural
Island	PACIFICARE OF WASHINGTON, INC.	8,700	200	2	\$379.84	\$429.61	13.1%	MSA
Kitsap	HEALTHPLUS	27,200	1,400	3	\$398.68	\$445.82	11.8%	MSA
Lewis	FIRST CHOICE HEALTH PLAN	12,700	-	6	\$424.26	\$466.57	10.0%	Rural
Mason	FIRST CHOICE HEALTH PLAN	9,400	-	2	\$448.82	\$486.29	8.3%	Rural
Pend Oreille	PACIFICARE OF WASHINGTON, INC.	2,100	400	0	\$379.84	\$422.93	11.3%	Rural
San Juan	OPTIONS HEALTH CARE, INC.	2,500	-	1	\$379.84	\$421.94	11.1%	Rural
Skagit	PACIFICARE OF WASHINGTON, INC.	16,800	600	2	\$421.87	\$467.91	10.9%	Rural
Spokane	GROUP HEALTH NORTHWEST	60,000	3,300	1	\$426.41	\$467.75	9.7%	MSA
Spokane	PACIFICARE OF WASHINGTON, INC.	60,000	3,500	1	\$426.41	\$467.75	9.7%	MSA
Stevens	PACIFICARE OF WASHINGTON, INC.	5,700	1,300	0	\$390.50	\$438.92	12.4%	Rural
Whatcom	OPTIONS HEALTH CARE, INC.	21,500	100	1	\$379.84	\$425.61	12.0%	MSA
WA Total			11,700					
Total Enrollees With No Other M+C Plan			2,600					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
WEST VIRGINIA								
Boone	CARELINK HEALTH PLANS	4,800	0	0	\$507.97	\$518.13	2.0%	Rural
Clay	CARELINK HEALTH PLANS	2,000	0	0	\$451.52	\$469.77	4.0%	Rural
Kanawha	CARELINK HEALTH PLANS	40,800	0	0	\$472.22	\$485.94	2.9%	MSA
Putnam	CARELINK HEALTH PLANS	6,500	0	0	\$433.03	\$459.31	6.1%	MSA
WY Total			0					
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
WISCONSIN								
Kenosha	PRIMECARE HEALTH PLAN, INC.	19,000	600	1	\$439.01	\$462.88	5.4%	MSA
Milwaukee	HUMANA WI HLTH ORGANIZATION INS COR	144,800	4,000	3	\$452.31	\$470.57	4.0%	MSA
Ozaukee	HUMANA WI HLTH ORGANIZATION INS COR	11,300	-	2	\$388.81	\$424.93	9.3%	MSA
Racine	HUMANA WI HLTH ORGANIZATION INS COR	28,400	-	0	\$379.84	\$415.43	9.4%	MSA
Racine	PRIMECARE HEALTH PLAN, INC.	28,400	2,000	0	\$379.84	\$415.43	9.4%	MSA
Sheboygan	HUMANA WI HLTH ORGANIZATION INS COR	17,800	100	0	\$379.84	\$401.61	5.7%	MSA
Wauworth	HUMANA WI HLTH ORGANIZATION INS COR	12,600	-	1	\$379.84	\$411.31	8.3%	Rural
Washington	HUMANA WI HLTH ORGANIZATION INS COR	14,600	-	2	\$379.84	\$411.74	8.4%	MSA
Waukesha	HUMANA WI HLTH ORGANIZATION INS COR	47,300	100	3	\$402.48	\$435.85	8.3%	MSA
WI Total			6,800					
Total Enrollees With No Other M+C Plan			2,100					

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HEALTH CARE FINANCING ADMINISTRATION



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PA
RI
MD

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REMARKS:

Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
ARIZONA								
Apache	PREMIER HEALTHCARE, INC.	6,400	-	0	\$379.84	\$401.61	5.7%	Rural
Graham	PREMIER HEALTHCARE, INC.	4,300	1,200	0	\$385.96	\$424.25	9.9%	Rural
Greenlee	PREMIER HEALTHCARE, INC.	1,100	200	0	\$380.97	\$420.38	10.3%	Rural
Maricopa	BLUE CROSS/SHIELD OF ARIZ	365,000	10,200	7	\$509.45	\$524.36	2.9%	MSA
Maricopa	UNITED HEALTHCARE OF ARIZONA	365,000	5,000	7	\$509.45	\$524.36	2.9%	MSA
Mohave	HEALTH PLAN OF NEVADA, INC.	32,800	3,500	1	\$493.65	\$522.27	5.8%	MSA
Navajo	PREMIER HEALTHCARE, INC.	11,000	100	0	\$381.70	\$425.81	11.6%	Rural
Pima	BLUE CROSS/SHIELD OF ARIZ	126,400	3,300	5	\$482.99	\$499.04	3.3%	MSA
Pima	HUMANA HEALTH PLAN, INC.	126,400	1,600	5	\$482.99	\$499.04	3.3%	MSA
Pinal	BLUE CROSS/SHIELD OF ARIZ	24,700	400	5	\$540.92	\$551.74	2.0%	MSA
Pinal	HUMANA HEALTH PLAN, INC.	24,700	2,300	5	\$540.92	\$551.74	2.0%	MSA
Pinal	UNITED HEALTHCARE OF ARIZONA	24,700	100	5	\$540.92	\$551.74	2.0%	MSA
Santa Cruz	PREMIER HEALTHCARE, INC.	4,700	-	1	\$379.84	\$412.07	8.5%	Rural
Yuma	PREMIER HEALTHCARE, INC.	18,200	3,000	0	\$477.96	\$505.13	5.7%	MSA
AZ Total			30,900					
Total Enrollees With No Other M+C Plan			4,500					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
ARKANSAS								
Pulaski	HEALTHSOURCE, ARKANSAS, INC.	51,600	2,200	1	\$486.79	\$498.44	2.4%	MSA
Pulaski	UNITED HEALTHCARE OF ARKANSAS, INC.	51,600	200	1	\$486.79	\$498.44	2.4%	MSA
AR Total			2,400					
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County ^a	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
CALIFORNIA								
Calaveras	NATIONAL MED, INC.	8,100	100	0	\$496.79	\$525.27	5.7%	Rural
Kern	CIGNA HEALTHCARE OF CALIFORNIA	75,200	-	7	\$532.77	\$549.94	3.2%	MSA
Kern	UNITED HEALTHCARE OF CALIFORNIA-SOU	75,200	400	7	\$532.77	\$549.94	3.2%	MSA
Los Angeles	CIGNA HEALTHCARE OF CALIFORNIA	1,003,300	400	10	\$647.70	\$660.65	2.0%	MSA
Los Angeles	UNITED HEALTHCARE OF CALIFORNIA-SOU	1,003,300	500	10	\$647.70	\$660.65	2.0%	MSA
Madera	HEALTH NET	18,000	300	2	\$431.63	\$473.12	9.6%	MSA
Madera	PACIFICARE OF CALIFORNIA, INC.	18,000	1,100	2	\$431.63	\$473.12	9.6%	MSA
Mariposa	HEALTH NET	3,100	-	1	\$458.26	\$493.66	7.7%	Rural
Mariposa	HEALTH NET	3,100	-	1	\$458.26	\$493.66	7.7%	Rural
Mariposa	PACIFICARE OF CALIFORNIA, INC.	3,100	500	1	\$458.26	\$493.66	7.7%	Rural
Merced	PACIFICARE OF CALIFORNIA, INC.	20,100	1,400	1	\$496.27	\$521.82	5.1%	MSA
Mono	CIGNA HEALTHCARE OF CALIFORNIA	800	0	0	\$422.10	\$465.03	10.2%	Rural
Orange	UNITED HEALTHCARE OF CALIFORNIA-SOU	289,300	100	10	\$595.82	\$609.63	2.3%	MSA
Riverside	UNITED HEALTHCARE OF CALIFORNIA-SOU	200,900	300	9	\$537.00	\$553.64	3.1%	MSA
San Bernardino	BLUE CROSS OF CALIFORNIA	170,000	0	9	\$554.46	\$565.55	2.0%	MSA
San Bernardino	UNITED HEALTHCARE OF CALIFORNIA-SOU	170,000	300	9	\$554.46	\$565.55	2.0%	MSA
San Diego	CIGNA HEALTHCARE OF CALIFORNIA	346,600	1,900	6	\$538.09	\$563.76	4.8%	MSA
San Luis Obispo	BLUE CROSS OF CALIFORNIA	39,600	1,900	1	\$402.25	\$452.55	12.5%	MSA
Tuolumne	NATIONAL MED, INC.	11,100	1,400	0	\$418.10	\$463.30	10.8%	Rural
Ventura	AETNA U.S.HEALTHCARE OF CALIFORNIA IN	85,300	1,000	5	\$518.54	\$545.69	5.2%	MSA
Ventura	CIGNA HEALTHCARE OF CALIFORNIA	85,300	1,300	5	\$518.54	\$545.69	5.2%	MSA
CA Total			13,000					
Total Enrollees With No Other M+C Plan			1,500					

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MSA= Metropolitan Statistical Area

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
COLORADO								
Adams	CIGNA HEALTHCARE OF COLORADO, INC.	38,800	700	4	\$498.56	\$513.59	3.0%	MSA
Adams	QUAL-MED, INC., DENVER	38,800	1,900	4	\$498.56	\$513.59	3.0%	MSA
Arapahoe	CIGNA HEALTHCARE OF COLORADO, INC.	42,600	1,700	4	\$457.34	\$484.26	5.9%	MSA
Boulder	HMO COLORADO, INC	27,700	1,500	3	\$445.88	\$478.92	7.4%	MSA
Boulder	QUAL-MED, INC., DENVER	27,700	300	3	\$445.88	\$478.92	7.4%	MSA
Denver	CIGNA HEALTHCARE OF COLORADO, INC.	73,600	1,100	4	\$524.14	\$534.62	2.0%	MSA
Denver	QUAL-MED, INC., DENVER	73,600	2,700	4	\$524.14	\$534.62	2.0%	MSA
Douglas	CIGNA HEALTHCARE OF COLORADO, INC.	4,700	200	4	\$416.18	\$452.51	8.7%	MSA
El Paso	QUAL-MED, INC., COLORADO SPRINGS	52,400	200	1	\$440.42	\$472.16	7.2%	MSA
Jefferson	CIGNA HEALTHCARE OF COLORADO, INC.	53,900	2,300	4	\$445.05	\$475.87	6.9%	MSA
Pueblo	HMO COLORADO, INC	25,400	1,200	1	\$423.61	\$452.13	6.7%	MSA
Pueblo	QUAL-MED, INC., PUEBLO	25,400	700	1	\$423.61	\$452.13	6.7%	MSA
CO Total			14,600					
Total M+C Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
CONNECTICUT								
Fairfield	CONNECTICARE, INC	126,000	2,100	4	\$520.91	\$546.20	4.9%	MSA
Fairfield	KAISER FOUNDATION HEALTH PLAN OF CT I	126,000	900	4	\$520.91	\$546.20	4.9%	MSA
Hartford	KAISER FOUNDATION HEALTH PLAN OF CT I	141,800	2,100	6	\$501.73	\$525.95	4.8%	MSA
Middlesex	KAISER FOUNDATION HEALTH PLAN OF CT I	23,000	100	3	\$440.80	\$482.64	9.5%	MSA
Tolland	KAISER FOUNDATION HEALTH PLAN OF CT I	15,000	200	2	\$510.98	\$541.27	5.9%	MSA
Tolland	PHYSICIANS HEALTH SERVICE OF CT., INC.	15,000	1,000	2	\$510.98	\$541.27	5.9%	MSA
Windham	PHYSICIANS HEALTH SERVICE OF CT., INC.	16,100	2,100	0	\$470.56	\$505.42	7.4%	Rural
CT Total			8,600					
Total Enrollees With No Other M+C Plan			2,100					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
FLORIDA								
Brevard	HUMANA MEDICAL PLAN, INC	95,900	3,000	1	\$511.40	\$527.54	3.2%	MSA
Broward	FLORIDA HEALTH CHOICE, INC.	256,300	1,700	11	\$676.64	\$690.17	2.0%	MSA
Charlotte	CIGNA HEALTHCARE OF FLORIDA, INC.	39,200	100	2	\$545.09	\$555.99	2.0%	MSA
Charlotte	HEALTH OPTIONS, INC.	39,200	-	2	\$545.09	\$555.99	2.0%	MSA
Dixie	AV-MED HEALTH PLAN INC	2,600	300	0	\$471.81	\$493.45	4.6%	Rural
Hernando	CIGNA HEALTHCARE OF FLORIDA, INC.	41,700	100	2	\$531.82	\$542.69	2.0%	MSA
Hernando	HIP HEALTH PLAN OF FLORIDA, INC.	41,700	900	2	\$531.82	\$542.69	2.0%	MSA
Hillsborough	HIP HEALTH PLAN OF FLORIDA, INC.	136,500	500	7	\$506.36	\$521.34	3.0%	MSA
Lake	COMMUNITY HEALTH CARE SYSTEMS, INC.	60,100	2,100	0	\$462.73	\$489.82	5.9%	MSA
Lee	CIGNA HEALTHCARE OF FLORIDA, INC.	101,100	200	3	\$496.18	\$516.74	4.1%	MSA
Levy	AV-MED HEALTH PLAN INC	6,700	1,100	0	\$438.55	\$466.21	6.3%	Rural
Manatee	CIGNA HEALTHCARE OF FLORIDA, INC.	54,900	1,500	1	\$444.23	\$476.27	7.2%	MSA
Martin	FLORIDA HEALTH CHOICE, INC.	34,100	5,500	1	\$514.64	\$536.70	4.3%	MSA
Orange	COMMUNITY HEALTH CARE SYSTEMS, INC.	106,200	800	6	\$542.46	\$553.31	2.0%	MSA
Osceola	COMMUNITY HEALTH CARE SYSTEMS, INC.	21,600	100	6	\$584.26	\$595.95	2.0%	MSA
Palm Beach	FLORIDA HEALTH CHOICE, INC.	243,100	1,000	10	\$588.84	\$600.62	2.0%	MSA
Pasco	HIP HEALTH PLAN OF FLORIDA, INC.	86,500	700	7	\$561.24	\$572.46	2.0%	MSA
Pinellas	HIP HEALTH PLAN OF FLORIDA, INC.	210,500	700	7	\$520.29	\$533.00	2.4%	MSA
Saint Lucie	FLORIDA HEALTH CHOICE, INC.	40,800	6,600	0	\$570.85	\$582.27	2.0%	MSA
Sarasota	CIGNA HEALTHCARE OF FLORIDA, INC.	104,900	300	2	\$474.63	\$500.10	5.4%	MSA
Seminole	AV-MED HEALTH PLAN INC	39,000	1,600	5	\$521.66	\$536.05	2.8%	MSA
Seminole	COMMUNITY HEALTH CARE SYSTEMS, INC.	39,000	100	5	\$521.66	\$536.05	2.8%	MSA
Volusia	AV-MED HEALTH PLAN INC	102,500	500	2	\$454.78	\$481.63	5.9%	MSA
FL Total			29,300					
Total Enrollees With No Other M+C Plan			10,100					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
GEORGIA								
Butts	KAISER FOUNDATION HP OF GA, INC.	2,800	100	0	\$504.57	\$520.84	3.2%	Rural
Hall	KAISER FOUNDATION HP OF GA, INC.	15,700	200	0	\$464.58	\$491.42	5.8%	Rural
Newton	KAISER FOUNDATION HP OF GA, INC.	7,700	100	1	\$560.83	\$572.05	2.0%	MSA
Spalding	KAISER FOUNDATION HP OF GA, INC.	8,900	100	1	\$466.07	\$491.23	5.4%	MSA
Spalding	UNITED HEALTHCARE OF GEORGIA, INC.	8,900	900	1	\$466.07	\$491.23	5.4%	MSA
GA Total			1,400					
Total Enrollees With No Other M+C Plan			300					

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County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
ILLINOIS								
Cook	ACCORD HEALTH PLAN	694,300	600	4	\$581.87	\$593.51	2.0%	MSA
Du Page	ACCORD HEALTH PLAN	95,300	-	2	\$481.80	\$509.42	5.7%	MSA
Kankakee	HUMANA HEALTH PLAN, INC.	16,700	1,300	0	\$501.63	\$515.42	2.7%	MSA
IL Total			2,000					
Total Enrollees With No Other M+C Plan			1,300					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
IOWA								
Pottawattamie	EXCLUSIVE HEALTHCARE, INC.	14,200	1,400	1	\$427.53	\$458.62	7.3%	MSA
IA Total			1,400					
Total Enrollees With No Other M+C Plan			0					

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County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
KANSAS								
Johnson	CIGNA HEALTHCARE OF KANSAS/MISSOURI	47,700	300	6	\$488.18	\$506.41	3.7%	MSA
Johnson	UNITED HEALTHCARE OF THE MIDWEST, IN	47,700	300	6	\$488.18	\$506.41	3.7%	MSA
Leavenworth	HUMANA KANSAS CITY, INC.	7,100	400	1	\$485.35	\$503.12	3.7%	MSA
Miami	HUMANA KANSAS CITY, INC.	3,600	300	1	\$470.05	\$494.24	5.1%	MSA
Wyandotte	CIGNA HEALTHCARE OF KANSAS/MISSOURI	23,200	-	6	\$528.64	\$539.21	2.0%	MSA
Wyandotte	UNITED HEALTHCARE OF THE MIDWEST, IN	23,200	200	6	\$528.64	\$539.21	2.0%	MSA
KS Total			1,400					
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
LOUISIANA								
Allen	OCHSNER HEALTH PLAN	3,500	300	0	\$490.50	\$503.20	2.6%	Rural
Ascension	UNITED HEALTH CARE OF LOUISIANA	7,000	1,000	4	\$688.13	\$701.89	2.0%	MSA
Assumption	OCHSNER HEALTH PLAN	3,100	100	2	\$585.65	\$597.36	2.0%	Rural
Avoyelles	OCHSNER HEALTH PLAN	7,200	900	0	\$384.96	\$421.89	9.6%	Rural
Beauregard	OCHSNER HEALTH PLAN	4,800	700	0	\$450.15	\$469.41	4.3%	Rural
Bienville	OCHSNER HEALTH PLAN	3,200	400	0	\$427.73	\$456.69	6.8%	Rural
Bossier	OCHSNER HEALTH PLAN	11,300	1,500	0	\$466.24	\$489.39	5.0%	MSA
Caddo	OCHSNER HEALTH PLAN	39,500	3,300	0	\$463.40	\$485.94	4.9%	MSA
Calcasieu	OCHSNER HEALTH PLAN	26,300	2,100	0	\$523.17	\$533.63	2.0%	MSA
Cameron	OCHSNER HEALTH PLAN	900	100	0	\$666.87	\$680.21	2.0%	Rural
Catahoula	OCHSNER HEALTH PLAN	2,100	200	0	\$436.64	\$460.52	5.5%	Rural
Claiborne	OCHSNER HEALTH PLAN	3,100	500	0	\$430.18	\$456.36	6.1%	Rural
Concordia	OCHSNER HEALTH PLAN	3,500	200	0	\$406.18	\$435.12	7.1%	Rural
De Soto	OCHSNER HEALTH PLAN	4,400	500	0	\$403.48	\$437.17	8.3%	Rural
East Baton Rouge	UNITED HEALTH CARE OF LOUISIANA	46,400	5,700	4	\$563.22	\$574.48	2.0%	MSA
East Feliciana	UNITED HEALTH CARE OF LOUISIANA	2,900	300	2	\$538.09	\$548.85	2.0%	Rural
~~Evangeline~~	OCHSNER HEALTH PLAN	6,300	300	1	\$500.11	\$510.94	2.2%	Rural
Grant	OCHSNER HEALTH PLAN	2,900	200	0	\$499.96	\$512.32	2.5%	Rural
Iberville	UNITED HEALTH CARE OF LOUISIANA	4,600	600	2	\$576.84	\$588.38	2.0%	Rural
Jefferson	UNITED HEALTH CARE OF LOUISIANA	63,800	3,600	5	\$660.91	\$674.13	2.0%	MSA
Jefferson Davis	OCHSNER HEALTH PLAN	5,100	500	0	\$433.70	\$456.76	5.3%	Rural
Lafourche	UNITED HEALTH CARE OF LOUISIANA	12,000	200	3	\$575.35	\$586.86	2.0%	MSA
La Salle	OCHSNER HEALTH PLAN	2,600	100	0	\$530.92	\$541.54	2.0%	Rural
Lincoln	OCHSNER HEALTH PLAN	5,400	-	0	\$461.22	\$481.29	4.4%	Rural
Livingston	UNITED HEALTH CARE OF LOUISIANA	9,100	1,900	4	\$656.44	\$669.57	2.0%	MSA
Natchitoches	OCHSNER HEALTH PLAN	5,800	800	0	\$391.04	\$426.32	9.0%	Rural
Orleans	UNITED HEALTH CARE OF LOUISIANA	69,600	1,900	5	\$638.50	\$651.27	2.0%	MSA
Plaquemines	UNITED HEALTH CARE OF LOUISIANA	3,200	100	3	\$757.12	\$772.26	2.0%	MSA
Pointe Coupee	OCHSNER HEALTH PLAN	3,500	200	1	\$387.52	\$423.73	9.3%	Rural
Rapides	OCHSNER HEALTH PLAN	20,600	1,400	0	\$468.06	\$487.53	4.2%	MSA

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
Red River	OCHSNER HEALTH PLAN	1,600	300	0	\$428.10	\$456.73	6.7%	Rural
Sabine	OCHSNER HEALTH PLAN	4,300	700	0	\$418.55	\$450.17	7.6%	Rural
Saint Bernard	UNITED HEALTH CARE OF LOUISIANA	11,200	100	5	\$748.92	\$763.90	2.0%	MSA
Saint Charles	UNITED HEALTH CARE OF LOUISIANA	5,100	300	5	\$662.70	\$675.95	2.0%	MSA
Saint James	OCHSNER HEALTH PLAN	2,900	100	2	\$578.39	\$589.96	2.0%	MSA
Saint James	UNITED HEALTH CARE OF LOUISIANA	2,900	100	2	\$578.39	\$589.96	2.0%	MSA
St John The Baptist	UNITED HEALTH CARE OF LOUISIANA	4,300	100	4	\$655.51	\$668.62	2.0%	MSA
Saint Landry	OCHSNER HEALTH PLAN	15,000	100	1	\$475.51	\$492.02	3.5%	MSA
Saint Tammany	UNITED HEALTH CARE OF LOUISIANA	22,300	300	5	\$656.77	\$669.91	2.0%	MSA
Vernon	OCHSNER HEALTH PLAN	4,900	600	0	\$569.12	\$580.50	2.0%	Rural
Washington	UNITED HEALTH CARE OF LOUISIANA	8,100	400	2	\$662.00	\$675.24	2.0%	Rural
Webster	OCHSNER HEALTH PLAN	8,300	800	0	\$476.56	\$498.03	4.5%	MSA
West Baton Rouge	UNITED HEALTH CARE OF LOUISIANA	2,600	500	3	\$558.28	\$569.45	2.0%	MSA
West Feliciana	OCHSNER HEALTH PLAN	1,000	100	1	\$515.02	\$525.32	2.0%	Rural
LA Total			34,000					
Total Enrollees With No Other M+C Plan			15,900					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
MARYLAND								
Allegany	FREE STATE HEALTH PLAN	15,600	800	0	\$574.23	\$585.71	2.0%	MSA
Calvert	FREE STATE HEALTH PLAN	7,200	800	0	\$495.45	\$517.03	4.4%	MSA
Caroline	FREE STATE HEALTH PLAN	4,600	900	0	\$416.87	\$448.08	7.5%	Rural
Carroll	FREE STATE HEALTH PLAN	19,700	1,900	2	\$500.93	\$519.96	3.8%	MSA
Cecil	FREE STATE HEALTH PLAN	10,100	700	0	\$532.84	\$548.76	3.0%	MSA
Cecil	UNITED HEALTHCARE OF THE MID-ATLANTI	10,100	700	0	\$532.84	\$548.76	3.0%	MSA
Charles	FREE STATE HEALTH PLAN	10,000	200	3	\$587.79	\$599.55	2.0%	MSA
Dorchester	FREE STATE HEALTH PLAN	5,800	1,100	0	\$455.06	\$478.16	5.1%	Rural
Frederick	FREE STATE HEALTH PLAN	19,400	500	1	\$441.48	\$477.87	8.2%	MSA
Garrett	FREE STATE HEALTH PLAN	4,600	300	0	\$476.26	\$493.83	3.7%	Rural
Kent	FREE STATE HEALTH PLAN	4,600	700	0	\$460.96	\$483.27	4.8%	Rural
Queen Annes	FREE STATE HEALTH PLAN	4,800	700	0	\$442.27	\$468.85	6.0%	MSA
Saint Marys	FREE STATE HEALTH PLAN	8,200	500	0	\$516.85	\$527.19	2.0%	Rural
Somerset	FREE STATE HEALTH PLAN	4,000	500	0	\$379.84	\$413.12	8.8%	Rural
Talbot	FREE STATE HEALTH PLAN	7,200	1,300	0	\$407.34	\$440.65	8.2%	Rural
Washington	FREE STATE HEALTH PLAN	20,400	1,100	0	\$396.70	\$439.26	10.7%	MSA
Wicomico	FREE STATE HEALTH PLAN	12,000	1,600	0	\$397.14	\$433.53	9.2%	Rural
Worcester	FREE STATE HEALTH PLAN	9,900	1,200	0	\$384.33	\$423.58	10.2%	Rural
MD Total			15,500					
Total Enrollees With No Other M+C Plan			12,900					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
MASSACHUSETTS								
Franklin	HARVARD PILGRIM HEALTH CARE	11,800	600	2	\$426.56	\$467.86	9.7%	Rural
Hampden	HARVARD PILGRIM HEALTH CARE	77,800	2,300	3	\$445.95	\$479.61	7.5%	MSA
Hampshire	HARVARD PILGRIM HEALTH CARE	20,600	700	2	\$420.20	\$462.21	10.0%	MSA
Worcester	UNITED HEALTH PLANS OF NEW ENGLAND,	114,300	2,100	4	\$548.27	\$559.24	2.0%	MSA
MA Total			5,600					
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
MINNESOTA								
Anoka	MEDICA	22,300	3,000	2	\$411.10	\$453.31	10.3%	MSA
MN Total			3,000					
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
MISSOURI								
Cass	CIGNA HEALTHCARE OF KANSAS/MISSOURI	10,300	300	6	\$454.94	\$479.90	5.5%	MSA
Clay	CIGNA HEALTHCARE OF KANSAS/MISSOURI	23,000	-	6	\$501.56	\$519.84	3.6%	MSA
Clay	UNITED HEALTHCARE OF THE MIDWEST, IN	23,000	100	6	\$501.56	\$519.84	3.6%	MSA
Jackson	CIGNA HEALTHCARE OF KANSAS/MISSOURI	97,400	900	6	\$525.22	\$535.72	2.0%	MSA
Jackson	UNITED HEALTHCARE OF THE MIDWEST, IN	97,400	600	6	\$525.22	\$535.72	2.0%	MSA
Platte	CIGNA HEALTHCARE OF KANSAS/MISSOURI	7,000	-	6	\$470.24	\$493.90	5.0%	MSA
Platte	UNITED HEALTHCARE OF THE MIDWEST, IN	7,000	-	6	\$470.24	\$493.90	5.0%	MSA
MO Total			1,900					
Total Enrollees With No Other M+C Plan			0					

NOTES: Numbers may not add due to rounding. Data as of July 15, based on information HCFA received from Medicare+Choice plans.

MSA= Metropolitan Statistical Area

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
NEBRASKA								
Douglas	EXCLUSIVE HEALTHCARE, INC.	60,300	4,400	1	\$450.20	\$471.42	4.7%	MSA
Sarpy	EXCLUSIVE HEALTHCARE, INC.	7,300	1,000	0	\$390.97	\$428.48	9.6%	MSA
NE Total			5,400					
Total Enrollees With No Other M+C Plan			1,000					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
NEVADA								
Clark	HUMANA HEALTH PLAN, INC.	155,000	8,900	2	\$530.04	\$554.90	4.7%	MSA
Nye	HUMANA HEALTH PLAN, INC.	6,500	700	1	\$478.87	\$513.76	7.3%	MSA
NV Total			9,600					
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
NEW HAMPSHIRE								
Cheshire	HEALTHSOURCE NEW HAMPSHIRE, INC.	11,400	300	0	\$379.84	\$417.34	9.9%	Rural
Hillsborough	HEALTHSOURCE NEW HAMPSHIRE, INC.	46,900	7,900	2	\$414.91	\$462.80	11.5%	MSA
Merrimack	HEALTHSOURCE NEW HAMPSHIRE, INC.	19,400	2,100	0	\$407.11	\$454.94	11.7%	MSA
Rockingham	HEALTHSOURCE NEW HAMPSHIRE, INC.	32,600	3,100	2	\$438.13	\$479.31	9.4%	MSA
NH Total			13,400					
Total Enrollees With No Other M+C Plan			2,400					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
NEW JERSEY								
Atlantic	CIGNA HEALTHCARE OF NEW JERSEY, INC.	38,300	-	3	\$553.57	\$564.89	2.0%	MSA
Atlantic	PHYSICIANS HEALTH SERVICES OF NJ., INC.	38,300	-	3	\$553.57	\$564.89	2.0%	MSA
Bergen	PHYSICIANS HEALTH SERVICES OF NJ., INC.	142,900	700	5	\$527.72	\$559.77	6.1%	MSA
Bergen	UNITED HEALTHCARE OF NEW JERSEY, INC.	142,900	800	5	\$527.72	\$559.77	6.1%	MSA
Burlington	CIGNA HEALTHCARE OF NEW JERSEY, INC.	57,600	-	5	\$537.40	\$552.60	2.8%	MSA
Burlington	PHYSICIANS HEALTH SERVICES OF NJ., INC.	57,600	-	5	\$537.40	\$552.60	2.8%	MSA
Camden	CIGNA HEALTHCARE OF NEW JERSEY, INC.	73,900	-	6	\$581.83	\$593.47	2.0%	MSA
Camden	PHYSICIANS HEALTH SERVICES OF NJ., INC.	73,900	-	6	\$581.83	\$593.47	2.0%	MSA
Cape May	CIGNA HEALTHCARE OF NEW JERSEY, INC.	22,300	0	3	\$563.74	\$575.01	2.0%	MSA
Cumberland	PHYSICIANS HEALTH SERVICES OF NJ., INC.	22,700	-	3	\$522.51	\$545.22	4.3%	MSA
Essex	PHYSICIANS HEALTH SERVICES OF NJ., INC.	105,900	200	6	\$564.71	\$578.68	2.5%	MSA
Essex	UNITED HEALTHCARE OF NEW JERSEY, INC.	105,900	700	6	\$564.71	\$578.68	2.5%	MSA
Gloucester	CIGNA HEALTHCARE OF NEW JERSEY, INC.	31,700	-	3	\$579.98	\$591.58	2.0%	MSA
Gloucester	PHYSICIANS HEALTH SERVICES OF NJ., INC.	31,700	-	3	\$579.98	\$591.58	2.0%	MSA
Hudson	PHYSICIANS HEALTH SERVICES OF NJ., INC.	75,000	100	5	\$550.22	\$572.80	4.1%	MSA
Hudson	UNITED HEALTHCARE OF NEW JERSEY, INC.	75,000	400	5	\$550.22	\$572.80	4.1%	MSA
Hunterdon	CIGNA HEALTHCARE OF NJ, INC.	13,600	100	3	\$494.52	\$516.24	4.4%	MSA
Hunterdon	PHYSICIANS HEALTH SERVICES OF NJ., INC.	13,600	-	3	\$494.52	\$516.24	4.4%	MSA
Mercer	CIGNA HEALTHCARE OF NEW JERSEY, INC.	52,300	-	4	\$578.80	\$590.38	2.0%	MSA
Mercer	PHYSICIANS HEALTH SERVICES OF NJ., INC.	52,300	100	4	\$578.80	\$590.38	2.0%	MSA
Middlesex	PHYSICIANS HEALTH SERVICES OF NJ., INC.	98,500	400	5	\$544.63	\$558.12	2.5%	MSA
Monmouth	CIGNA HEALTHCARE OF NJ, INC.	88,200	400	4	\$523.09	\$542.02	3.6%	MSA
Morris	CIGNA HEALTHCARE OF NJ, INC.	58,500	400	4	\$494.71	\$525.78	6.3%	MSA
Morris	PHYSICIANS HEALTH SERVICES OF NJ., INC.	58,500	100	4	\$494.71	\$525.78	6.3%	MSA
Ocean	CIGNA HEALTHCARE OF NEW JERSEY, INC.	118,900	-	4	\$505.24	\$534.05	5.7%	MSA
Passaic	PHYSICIANS HEALTH SERVICES OF NJ., INC.	66,500	200	6	\$505.13	\$537.18	6.3%	MSA
Salem	PHYSICIANS HEALTH SERVICES OF NJ., INC.	10,800	-	3	\$573.16	\$584.62	2.0%	MSA
Somerset	CIGNA HEALTHCARE OF NJ, INC.	32,500	200	4	\$456.64	\$491.08	7.5%	MSA
Somerset	PHYSICIANS HEALTH SERVICES OF NJ., INC.	32,500	100	4	\$456.64	\$491.08	7.5%	MSA
Sussex	CIGNA HEALTHCARE OF NJ, INC.	15,500	100	3	\$473.00	\$511.04	8.0%	MSA

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
Sussex	PHYSICIANS HEALTH SERVICES OF NJ., INC.	15,500	-	3	\$473.00	\$511.04	8.0%	MSA
Union	PHYSICIANS HEALTH SERVICES OF NJ., INC.	81,600	200	6	\$526.59	\$545.04	3.5%	MSA
Union	UNITED HEALTHCARE OF NEW JERSEY, INC.	81,600	400	6	\$526.59	\$545.04	3.5%	MSA
Warren	CIGNA HEALTHCARE OF NJ, INC.	15,600	100	3	\$557.83	\$568.99	2.0%	MSA
Warren	PHYSICIANS HEALTH SERVICES OF NJ., INC.	15,600	-	3	\$557.83	\$568.99	2.0%	MSA
NJ Total			5,700					
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
NEW MEXICO								
Los Alamos	PRESBYTERIAN HEALTH PLAN	2,200	-	1	\$379.84	\$423.74	11.6%	MSA
NM Total								
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
NEW YORK								
Albany	CAPITAL AREA COMMUNITY HP	46,500	2,200	2	\$397.05	\$426.70	7.5%	MSA
Albany	HUM/HEALTHCARE SYSTEMS, INC.	46,500	100	2	\$397.05	\$426.70	7.5%	MSA
Dutchess	CAPITAL AREA COMMUNITY HP	40,900	3,600	2	\$447.06	\$485.41	8.6%	MSA
Dutchess	PHYSICIANS HLTH SVC OF NY, INC	40,900	200	2	\$447.06	\$485.41	8.6%	MSA
Essex	HUM/HEALTHCARE SYSTEMS, INC.	7,500	100	0	\$379.84	\$406.73	7.1%	Rural
Franklin	HUM/HEALTHCARE SYSTEMS, INC.	7,900	100	0	\$379.84	\$401.61	5.7%	Rural
Nassau	UNITED HEALTHCARE OF NEW YORK, INC.	224,700	1,400	8	\$610.30	\$622.51	2.0%	MSA
Orange	PHYSICIANS HLTH SVC OF NY, INC	42,200	100	3	\$489.40	\$524.02	7.1%	MSA
Putnam	PHYSICIANS HLTH SVC OF NY, INC	10,500	200	1	\$611.39	\$628.30	2.8%	MSA
Queens	VYTRA HEALTHCARE	287,700	900	10	\$685.46	\$699.17	2.0%	MSA
Rensselaer	CAPITAL AREA COMMUNITY HP	24,300	2,400	2	\$424.93	\$451.95	6.4%	MSA
Rensselaer	HUM/HEALTHCARE SYSTEMS, INC.	24,300	-	2	\$424.93	\$451.95	6.4%	MSA
Rockland	PHYSICIANS HLTH SVC OF NY, INC	39,900	100	4	\$605.07	\$630.25	4.2%	MSA
Saratoga	CAPITAL AREA COMMUNITY HP	26,600	2,900	2	\$389.80	\$426.15	9.3%	MSA
Schenectady	CAPITAL AREA COMMUNITY HP	29,800	2,300	1	\$379.84	\$414.50	9.1%	MSA
Schenectady	HUM/HEALTHCARE SYSTEMS, INC.	29,800	-	1	\$379.84	\$414.50	9.1%	MSA
Suffolk	OXFORD HEALTH PLANS (NEW YORK) INC.	199,000	9,100	6	\$568.77	\$592.30	4.1%	MSA
Suffolk	UNITED HEALTHCARE OF NEW YORK, INC.	199,000	1,900	6	\$568.77	\$592.30	4.1%	MSA
Ulster	CAPITAL AREA COMMUNITY HP	27,700	4,100	1	\$444.27	\$476.85	7.3%	Rural
Westchester	CAPITAL AREA COMMUNITY HEALTH PLAN	141,300	2,500	4	\$584.38	\$608.47	4.1%	MSA
Westchester	CIGNA HEALTHCARE OF NEW YORK	141,300	800	4	\$584.38	\$608.47	4.1%	MSA
Westchester	PHYSICIANS HLTH SVC OF NY, INC	141,300	3,600	4	\$584.38	\$608.47	4.1%	MSA
NY Total			38,700					
Total Enrollees With No Other M+C Plan			200					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

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County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
OHIO								
Allen	FAMILY HEALTH PLAN, INC.	17,400	0	0	\$381.18	\$422.39	10.8%	MSA
Ashland	AETNA U.S. HEALTHCARE, INC.	7,700	300	0	\$379.84	\$401.61	5.7%	Rural
Ashtabula	CIGNA HEALTHCARE OF OHIO, INC.	17,700	1,600	0	\$488.46	\$503.62	3.1%	MSA
Ashtabula	QUALCHOICE HEALTH PLAN	17,700	300	0	\$488.46	\$503.62	3.1%	MSA
Auglaize	FAMILY HEALTH PLAN, INC.	8,300	0	0	\$426.06	\$457.02	7.3%	MSA
Clark	PACIFICARE OF OHIO, INC.	24,900	600	2	\$462.41	\$487.66	5.5%	MSA
Crawford	AETNA U.S. HEALTHCARE, INC.	8,500	100	1	\$421.76	\$451.18	7.0%	MSA
Cuyahoga	CIGNA HEALTHCARE OF OHIO, INC.	244,800	300	8	\$564.30	\$575.59	2.0%	MSA
Delaware	COMMUNITY HEALTH PLAN OF OHIO	8,600	400	1	\$416.36	\$450.01	8.1%	MSA
Fairfield	COMMUNITY HEALTH PLAN OF OHIO	15,400	100	0	\$431.16	\$461.07	6.9%	MSA
Geauga	CIGNA HEALTHCARE OF OHIO, INC.	9,400	-	5	\$462.62	\$484.81	4.8%	MSA
Geauga	QUALCHOICE HEALTH PLAN	9,400	500	5	\$462.62	\$484.81	4.8%	MSA
Hocking	COMMUNITY HEALTH PLAN OF OHIO	4,200	100	0	\$481.58	\$497.03	3.2%	Rural
Jackson	COMMUNITY HEALTH PLAN OF OHIO	5,400	100	0	\$382.78	\$423.46	10.6%	Rural
Knox	AETNA U.S. HEALTHCARE, INC.	8,600	100	1	\$417.11	\$446.24	7.0%	Rural
Lake	CIGNA HEALTHCARE OF OHIO, INC.	36,100	600	5	\$493.40	\$506.72	2.7%	MSA
Lorain	CIGNA HEALTHCARE OF OHIO, INC.	40,000	400	4	\$505.27	\$522.63	3.4%	MSA
Lorain	QUALCHOICE HEALTH PLAN	40,000	300	4	\$505.27	\$522.63	3.4%	MSA
Lucas	HEALTH ALLIANCE PLAN OF MICHIGAN	69,700	-	3	\$593.15	\$605.01	2.0%	MSA
Mahoning	CIGNA HEALTHCARE OF OHIO, INC.	53,200	100	3	\$498.40	\$508.37	2.0%	MSA
Marion	COMMUNITY HEALTH PLAN OF OHIO	10,900	-	0	\$460.07	\$484.55	5.3%	Rural
Montgomery	PACIFICARE OF OHIO, INC.	95,200	3,600	3	\$485.54	\$497.25	2.4%	MSA
Perry	COMMUNITY HEALTH PLAN OF OHIO	5,500	-	0	\$447.86	\$471.56	5.3%	Rural
Pike	COMMUNITY HEALTH PLAN OF OHIO	4,400	100	0	\$391.41	\$429.80	9.8%	Rural
Putnam	FAMILY HEALTH PLAN, INC.	5,100	0	0	\$381.13	\$422.20	10.8%	Rural
Richland	AETNA U.S. HEALTHCARE, INC.	21,600	100	1	\$388.10	\$424.49	9.4%	MSA
Ross	COMMUNITY HEALTH PLAN OF OHIO	11,100	700	0	\$396.69	\$435.24	9.7%	Rural
Stark	CIGNA HEALTHCARE OF OHIO, INC.	68,100	600	6	\$409.41	\$439.09	7.2%	MSA
Stark	SUMMACARE INC.	68,100	1,800	6	\$409.41	\$439.09	7.2%	MSA
Summit	CIGNA HEALTHCARE OF OHIO, INC.	85,700	-	8	\$558.78	\$569.96	2.0%	MSA

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MSA= Metropolitan Statistical Area

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
Summit	QUALCHOICE HEALTH PLAN	85,700	100	8	\$558.78	\$569.96	2.0%	MSA
Trumbull	CIGNA HEALTHCARE OF OHIO, INC.	39,400	100	2	\$554.20	\$565.28	2.0%	MSA
Union	COMMUNITY HEALTH PLAN OF OHIO	3,900	-	1	\$465.90	\$488.07	4.8%	Rural
Van Wert	FAMILY HEALTH PLAN, INC.	4,600	0	0	\$379.84	\$401.61	5.7%	Rural
Vinton	COMMUNITY HEALTH PLAN OF OHIO	1,800	-	0	\$412.13	\$444.25	7.8%	Rural
Wood	HEALTH ALLIANCE PLAN OF MICHIGAN	14,700	0	2	\$477.92	\$498.46	4.3%	MSA
OH Total			13,000					
Total Enrollees With No Other M+C Plan			3,200					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
OKLAHOMA								
Cherokee	BLUELINS HMO, INC.	5,600	-	1	\$405.87	\$437.35	7.8%	Rural
Comanche	BLUELINS HMO, INC.	12,700	-	0	\$399.09	\$433.95	8.7%	MSA
Cotton	BLUELINS HMO, INC.	1,300	-	0	\$379.84	\$417.64	10.0%	Rural
Garvin	BLUELINS HMO, INC.	6,100	100	1	\$425.51	\$449.90	5.7%	Rural
Grady	BLUELINS HMO, INC.	6,400	100	3	\$379.84	\$401.61	5.7%	Rural
Kiowa	BLUELINS HMO, INC.	2,400	-	0	\$390.31	\$422.23	8.2%	Rural
Lincoln	BLUELINS HMO, INC.	4,900	100	1	\$379.84	\$401.61	5.7%	Rural
Moclain	BLUELINS HMO, INC.	3,900	100	3	\$427.52	\$453.93	6.2%	MSA
Mcintosh	BLUELINS HMO, INC.	4,800	100	1	\$379.84	\$412.92	8.7%	Rural
Muskogee	BLUELINS HMO, INC.	12,900	200	1	\$392.44	\$426.92	8.8%	Rural
Payne	BLUELINS HMO, INC.	8,200	300	1	\$403.95	\$434.68	7.6%	Rural
Rogers	BLUELINS HMO, INC.	7,600	100	2	\$467.47	\$484.50	3.6%	MSA
Tillman	BLUELINS HMO, INC.	2,000	-	0	\$398.48	\$429.28	7.7%	Rural
OK Total			1,200					
Total Enrollees With No Other M+C Plan			-					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
OREGON								
Douglas	PROVIDENCE HEALTH PLAN	20,600	700	0	\$379.84	\$413.15	8.8%	Rural
Jackson	PACIFICARE OF OREGON II	32,400	1,400	1	\$379.84	\$401.61	5.7%	MSA
Yamhill	PACIFICARE OF OREGON, INC.	11,100	1,000	2	\$379.84	\$425.86	12.1%	MSA
OR Total			3,100					
Total Enrollees With No Other M+C Plan			700					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
PENNSYLVANIA								
Bucks	CIGNA HEALTHCARE OF PENNSYLVANIA, IN	79,500	0	3	\$598.89	\$610.87	2.0%	MSA
Chester	CIGNA HEALTHCARE OF PENNSYLVANIA, IN	50,600	-	3	\$532.32	\$553.66	4.0%	MSA
Columbia	HEALTHAMERICA OF CENTRAL PA.	12,100	400	2	\$445.90	\$463.56	4.0%	MSA
Delaware	CIGNA HEALTHCARE OF PENNSYLVANIA, IN	93,200	0	3	\$613.96	\$626.24	2.0%	MSA
Luzerne	HEALTHAMERICA OF CENTRAL PA.	70,600	300	3	\$499.28	\$511.96	2.5%	MSA
Lycoming	HEALTHAMERICA OF CENTRAL PA.	21,900	200	2	\$415.02	\$443.61	6.9%	MSA
Montgomery	CIGNA HEALTHCARE OF PENNSYLVANIA, IN	126,300	-	4	\$537.16	\$548.59	2.1%	MSA
Philadelphia	CIGNA HEALTHCARE OF PENNSYLVANIA, IN	248,200	0	4	\$732.70	\$747.35	2.0%	MSA
PA Total			800					
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
RHODE ISLAND								
Newport	UNITED HEALTH PLANS OF NEW ENGLAND,	13,800	2,000	1	\$448.53	\$484.96	8.1%	MSA
RI Total			2,000					
Total Enrollees With No Other M+C Plan			0					

NOTES: Numbers may not add due to rounding. Data as of July 15, based on information HCFA received from Medicare+Choice plans.

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
SOUTH CAROLINA								
Berkeley	COMPANION HEALTHCARE CORPORATION	11,500	200	0	\$427.60	\$455.71	6.6%	MSA
Charleston	COMPANION HEALTHCARE CORPORATION	43,700	600	0	\$464.16	\$480.38	3.5%	MSA
Dorchester	COMPANION HEALTHCARE CORPORATION	10,900	200	0	\$393.15	\$429.44	9.2%	MSA
SC Total			1,100					
Total Enrollees With No Other M+C Plan			1,100					

NOTES: Numbers may not add due to rounding. Data as of July 15, based on information HCFA received from Medicare+Choice plans.

MSA= Metropolitan Statistical Area

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
TENNESSEE								
Davidson	UNITED HEALTHCARE OF TENNESSEE, INC.	75,000	100	3	\$537.13	\$547.87	2.0%	MSA
Fayette	UNITED HEALTHCARE OF TENNESSEE, INC.	3,300	-	0	\$461.23	\$476.86	3.4%	MSA
Hamilton	UNITED HEALTHCARE OF TENNESSEE, INC.	50,300	-	3	\$516.35	\$526.68	2.0%	MSA
Mcminn	TENNESSEE HEALTH CARE NETWORK, INC.	8,300	-	1	\$468.89	\$486.68	3.8%	Rural
Meigs	TENNESSEE HEALTH CARE NETWORK, INC.	1,700	-	0	\$476.98	\$494.49	3.7%	Rural
Robertson	UNITED HEALTHCARE OF TENNESSEE, INC.	7,100	-	2	\$514.95	\$527.44	2.4%	MSA
Shelby	UNITED HEALTHCARE OF TENNESSEE, INC.	109,400	400	0	\$482.03	\$491.67	2.0%	MSA
TN Total			700					
Total Enrollees With No Other M+C Plan			500					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
TEXAS								
Atascosa	HUMANA HP OF TEXAS	4,300	500	1	\$448.35	\$468.35	4.5%	Rural
Bee	HUMANA HP OF TEXAS	3,500	200	0	\$510.72	\$520.93	2.0%	Rural
Brazoria	HUMANA HP OF TEXAS	23,700	900	6	\$540.41	\$551.22	2.0%	MSA
Caldwell	HUMANA HP OF TEXAS	4,300	100	1	\$420.27	\$449.43	6.9%	MSA
Camp	HEALTHCARE PARTNERS PLANS, INC	2,300	100	0	\$458.54	\$478.99	4.5%	Rural
Cherokee	HEALTHCARE PARTNERS PLANS, INC	6,900	200	1	\$509.15	\$522.01	2.5%	Rural
Collin	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	23,400	100	4	\$536.72	\$547.45	2.0%	MSA
Comal	HUMANA HP OF TEXAS	12,500	200	2	\$379.84	\$415.47	9.4%	MSA
Dallas	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	208,000	700	4	\$534.86	\$545.56	2.0%	MSA
Dallas	HMO BLUE,NORTHEAST TEXAS	208,000	600	4	\$534.86	\$545.56	2.0%	MSA
Dallas	HUMANA HP OF TEXAS	208,000	8,100	4	\$534.86	\$545.56	2.0%	MSA
Denton	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	21,100	100	4	\$546.85	\$557.79	2.0%	MSA
Denton	HUMANA HP OF TEXAS	21,100	1,200	4	\$546.85	\$557.79	2.0%	MSA
Ellis	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	12,100	-	4	\$470.68	\$489.89	4.1%	MSA
Ellis	HMO BLUE,NORTHEAST TEXAS	12,100	100	4	\$470.68	\$489.89	4.1%	MSA
Fort Bend	HUMANA HP OF TEXAS	17,600	700	6	\$508.49	\$521.77	2.6%	MSA
Franklin	HEALTHCARE PARTNERS PLANS, INC	1,400	100	0	\$516.04	\$526.36	2.0%	Rural
Galveston	UNITED HEALTHCARE OF TEXAS, INC.-HOUS	31,400	-	7	\$604.02	\$616.10	2.0%	MSA
Grayson	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	18,800	1,300	1	\$427.91	\$456.96	6.8%	MSA
Gregg	HEALTHCARE PARTNERS PLANS, INC	19,500	400	0	\$420.81	\$451.63	7.3%	MSA
Harris	UNITED HEALTHCARE OF TEXAS, INC.-HOUS	281,700	100	7	\$619.21	\$631.59	2.0%	MSA
Hays	HUMANA HP OF TEXAS	8,100	600	2	\$395.22	\$429.58	8.7%	MSA
Henderson	HEALTHCARE PARTNERS PLANS, INC	10,200	1,100	0	\$489.59	\$507.26	3.6%	MSA
Hood	HUMANA HP OF TEXAS	7,900	700	3	\$468.73	\$492.86	5.1%	MSA
Hunt	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	11,000	100	2	\$461.60	\$484.39	4.9%	MSA
Johnson	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	15,300	-	4	\$479.19	\$502.06	4.8%	MSA
Johnson	HMO BLUE,NORTHEAST TEXAS	15,300	100	4	\$479.19	\$502.06	4.8%	MSA
Johnson	HUMANA HP OF TEXAS	15,300	-	4	\$479.19	\$502.06	4.8%	MSA
Kaufman	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	12,800	100	4	\$494.23	\$510.50	3.3%	MSA
Kleberg	HUMANA HP OF TEXAS	3,600	200	1	\$484.24	\$497.61	2.8%	Rural

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MSA= Metropolitan Statistical Area

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
Montgomery	UNITED HEALTHCARE OF TEXAS, INC.-HOUS	26,800	-	7	\$692.24	\$706.08	2.0%	MSA
Parker	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	9,600	-	3	\$464.57	\$488.76	5.2%	MSA
Rockwall	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	3,500	-	4	\$495.37	\$511.05	3.2%	MSA
Rusk	HEALTHCARE PARTNERS PLANS, INC	6,900	200	1	\$403.56	\$435.56	7.9%	Rural
Smith	HEALTHCARE PARTNERS PLANS, INC	27,400	1,300	1	\$434.21	\$462.56	6.5%	MSA
Somervell	HUMANA HP OF TEXAS	800	-	1	\$446.28	\$476.15	6.7%	Rural
Tarrant	CIGNA HEALTHCARE OF TEXAS, INC.- N. TX	133,400	300	4	\$514.29	\$529.17	2.9%	MSA
Tarrant	HMO BLUE,NORTHEAST TEXAS	133,400	200	4	\$514.29	\$529.17	2.9%	MSA
Tarrant	HUMANA HP OF TEXAS	133,400	4,000	4	\$514.29	\$529.17	2.9%	MSA
Travis	HUMANA HP OF TEXAS	62,100	6,000	2	\$429.19	\$457.95	6.7%	MSA
Upshur	HEALTHCARE PARTNERS PLANS, INC	6,000	400	0	\$472.74	\$492.42	4.2%	MSA
Van Zandt	HEALTHCARE PARTNERS PLANS, INC	8,300	300	1	\$462.37	\$484.52	4.8%	Rural
Williamson	HUMANA HP OF TEXAS	17,700	400	2	\$379.84	\$411.43	8.3%	MSA
Wood	HEALTHCARE PARTNERS PLANS, INC	8,200	500	0	\$439.66	\$465.92	6.0%	Rural
TX Total			31,700					
Total Enrollees With No Other M+C Plan			2,600					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
VIRGINIA								
Chesapeake City	OPTIMA HEALTH PLAN	19,900	1,700	0	\$470.46	\$484.88	3.1%	MSA
Chesterfield	HEALTHKEEPERS, INC.	20,800	300	1	\$434.48	\$463.81	6.8%	MSA
Gloucester	OPTIMA HEALTH PLAN	4,500	100	0	\$379.98	\$414.28	9.0%	MSA
Goochland	HEALTHKEEPERS, INC.	2,000	100	1	\$409.50	\$445.19	8.7%	MSA
Hampton City	OPTIMA HEALTH PLAN	17,800	1,600	0	\$417.70	\$443.76	6.2%	MSA
Hanover	HEALTHKEEPERS, INC.	11,800	400	1	\$467.80	\$490.45	4.8%	MSA
Henrico	HEALTHKEEPERS, INC.	28,900	900	1	\$433.34	\$463.29	6.9%	MSA
Isle Of Wight	OPTIMA HEALTH PLAN	4,100	200	0	\$441.42	\$461.15	4.5%	MSA
James City	OPTIMA HEALTH PLAN	2,000	100	0	\$419.45	\$446.91	6.5%	MSA
Newport News City	OPTIMA HEALTH PLAN	21,300	1,200	0	\$394.53	\$423.90	7.4%	MSA
Norfolk City	OPTIMA HEALTH PLAN	29,900	3,100	0	\$459.44	\$470.52	2.4%	MSA
Portsmouth City	OPTIMA HEALTH PLAN	16,600	1,200	0	\$449.15	\$467.37	4.1%	MSA
Poquoson City	OPTIMA HEALTH PLAN	700	100	0	\$440.76	\$458.58	4.0%	MSA
Powhatan	HEALTHKEEPERS, INC.	2,200	-	1	\$437.47	\$467.99	7.0%	MSA
Richmond City	HEALTHKEEPERS, INC.	39,300	1,000	1	\$470.52	\$488.94	3.9%	MSA
Suffolk City	OPTIMA HEALTH PLAN	7,100	400	0	\$459.23	\$476.74	3.8%	MSA
Virginia Beach City	OPTIMA HEALTH PLAN	38,900	4,000	0	\$442.45	\$463.75	4.8%	MSA
Williamsburg City	OPTIMA HEALTH PLAN	6,400	200	0	\$460.96	\$479.54	4.0%	MSA
York	OPTIMA HEALTH PLAN	6,800	300	0	\$401.02	\$430.15	7.3%	MSA
VA Total			16,700					
Total Enrollees With No Other M+C Plan			13,900					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
WASHINGTON								
Clallam	GROUP HEALTH COOP OF PUGET SOUND	15,500	900	0	\$387.40	\$437.01	12.8%	Rural
Grays Harbor	FIRST CHOICE HEALTH PLAN	12,800	-	1	\$422.76	\$465.30	10.1%	Rural
Grays Harbor	OPTIONS HEALTH CARE, INC.	12,800	-	1	\$422.76	\$465.30	10.1%	Rural
Island	PACIFICARE OF WASHINGTON, INC.	8,700	200	2	\$379.84	\$429.61	13.1%	MSA
Kitsap	HEALTHPLUS	27,200	1,400	3	\$398.68	\$445.82	11.8%	MSA
Lewis	FIRST CHOICE HEALTH PLAN	12,700	-	6	\$424.26	\$466.57	10.0%	Rural
Mason	FIRST CHOICE HEALTH PLAN	9,400	-	2	\$448.82	\$486.29	8.3%	Rural
Pend Oreille	PACIFICARE OF WASHINGTON, INC.	2,100	400	0	\$379.84	\$422.93	11.3%	Rural
San Juan	OPTIONS HEALTH CARE, INC.	2,500	-	1	\$379.84	\$421.94	11.1%	Rural
Skagit	PACIFICARE OF WASHINGTON, INC.	16,800	600	2	\$421.87	\$467.91	10.9%	Rural
Spokane	GROUP HEALTH NORTHWEST	60,000	3,300	1	\$426.41	\$467.75	9.7%	MSA
Spokane	PACIFICARE OF WASHINGTON, INC.	60,000	3,500	1	\$426.41	\$467.75	9.7%	MSA
Stevens	PACIFICARE OF WASHINGTON, INC.	5,700	1,300	0	\$390.50	\$438.92	12.4%	Rural
Whatcom	OPTIONS HEALTH CARE, INC.	21,500	100	1	\$379.84	\$425.61	12.0%	MSA
WA Total			11,700					
Total Enrollees With No Other M+C Plan			2,600					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
WEST VIRGINIA								
Boone	CARELINK HEALTH PLANS	4,800	0	0	\$507.97	\$518.13	2.0%	Rural
Clay	CARELINK HEALTH PLANS	2,000	0	0	\$451.52	\$469.77	4.0%	Rural
Kanawha	CARELINK HEALTH PLANS	40,800	0	0	\$472.22	\$485.94	2.9%	MSA
Putnam	CARELINK HEALTH PLANS	6,500	0	0	\$433.03	\$459.31	6.1%	MSA
WV Total			0					
Total Enrollees With No Other M+C Plan			0					

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Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
WISCONSIN								
Kenosha	PRIMECARE HEALTH PLAN, INC.	19,000	600	1	\$439.01	\$462.88	5.4%	MSA
Milwaukee	HUMANA WI HLTH ORGANIZATION INS COR	144,800	4,000	3	\$452.31	\$470.57	4.0%	MSA
Ozaukee	HUMANA WI HLTH ORGANIZATION INS COR	11,300	-	2	\$388.81	\$424.93	9.3%	MSA
Racine	HUMANA WI HLTH ORGANIZATION INS COR	28,400	-	0	\$379.84	\$415.43	9.4%	MSA
Racine	PRIMECARE HEALTH PLAN, INC.	28,400	2,000	0	\$379.84	\$415.43	9.4%	MSA
Sheboygan	HUMANA WI HLTH ORGANIZATION INS COR	17,800	100	0	\$379.84	\$401.61	5.7%	MSA
Wauwatosa	HUMANA WI HLTH ORGANIZATION INS COR	12,600	-	1	\$379.84	\$411.31	8.3%	Rural
Washington	HUMANA WI HLTH ORGANIZATION INS COR	14,600	-	2	\$379.84	\$411.74	8.4%	MSA
Waukesha	HUMANA WI HLTH ORGANIZATION INS COR	47,300	100	3	\$402.48	\$435.85	8.3%	MSA
WI Total			6,800					
Total Enrollees With No Other M+C Plan			2,100					

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ANALYSIS OF BENEFITS OFFERED BY MEDICARE HMOs, 1999: COMPLEXITIES AND IMPLICATIONS

Prepared by:
Barents Group LLC

Prepared for:
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EXECUTIVE SUMMARY

Medicare HMOs offer benefits, such as prescription drug and dental coverage, beyond those offered under the traditional Medicare program, usually without the requirement that beneficiaries pay an additional premium. The availability of supplemental benefits makes HMOs attractive to many Medicare beneficiaries, in that they directly reduce the costs to beneficiaries of services generally not covered by the Medicare program. Thus, the number of Medicare beneficiaries enrolled in Medicare HMOs has grown almost fourfold in the past three years, from 1.8 million in December 1995 to almost 6.2 million in May 1999, or about 15 percent of all Medicare beneficiaries.

This study uses *Medicare Compare*, a Health Care Financing Administration database with relatively detailed information on basic and supplemental benefits offered by Medicare HMOs in their "basic" plan, to analyze the details of supplemental benefits offered and premiums charged, in 1999, by Medicare HMOs nationwide. The study assesses the generosity of selected benefits and the variation in benefits within and across markets. It also examines the implications of benefit variations on out-of-pocket spending for beneficiaries enrolled in Medicare HMOs, using illustrative examples.

Findings

The level of monthly premiums charged by Medicare HMOs, and the generosity of many supplemental benefits, varies widely.

Premiums. There is significant variation in premiums across HMOs. Most Medicare HMO enrollees (64 percent) are not charged a premium for the HMO's "basic" package; about 2 percent pay \$10 or less per month while 11 percent are in HMOs that charge more than \$45 per month, with an average premium of \$15.50 per month.

Physician and Other Medicare Required Services. Cost-sharing requirements for benefits covered under the traditional Medicare program tend to be similar across Medicare HMOs. For example, virtually all beneficiaries (96 percent) are not required to make per episode hospital copayments and 99 percent of beneficiaries are covered for 100 percent of the costs of SNF use up to 100 days. There was wide variation in copayment requirements for primary care physician office visits in 1999, however, with per-visit copayments ranging from \$2 to \$20 across plans, with an average copayment of \$5.94 per visit. In general, copayment requirements for specialist visits are similar to that for visits to primary care physicians. The average copayment for specialist visits is \$6.37.

Prescription Drugs. More than 8 of 10 Medicare HMO enrollees are in a plan that offers prescription drug benefits under the "basic" plan, but maximum annual drug limits vary widely. Nearly a quarter of all Medicare HMO enrollees with a drug benefit are in a plan that does not limit coverage, while 11 percent of those with drug coverage are in a plan with drug limits below

\$600. About half of Medicare HMO enrollees with drug coverage are in plans with annual drug limits between \$1,000 and \$2,999. The average annual limit for prescription drugs in 1999 is \$1,149.

The average generic copayment per prescription (in HMOs that offer a prescription drug benefit in their "basic plan") is \$6.42, with most beneficiaries enrolled in HMOs that charge between \$5 and \$10 per prescription. Copayment requirements for brand name drugs are higher than for generic drugs; with an average copayment of \$13.15 per prescription.

Hearing aids. The provision of hearing aids is a complex benefit in which HMOs impose various mixes of the number of units that may be purchased over a specified time period, the maximum amount that the plan will pay, and the share of total cost that the plan will cover. For example, some Medicare HMOs will pay 50 percent of the cost of one hearing aid annually, while others may impose an annual limit (e.g. \$250) on HMO payment for hearing aids.

The generosity of many benefits, especially prescription drug coverage, and the level of premiums charged by HMOs, vary widely within and across markets.

Most beneficiaries (61 percent) live in an area with two or more Medicare HMOs, and, thus, can choose among plans offering different benefit packages. Based on an examination of six specific counties across the United States, selected because they have a large number of Medicare beneficiaries and high levels of Medicare HMO enrollment, we found the generosity of benefits and level of premiums vary substantially within and across markets.¹

Within Market Areas. Monthly premiums and supplemental benefits in the basic plan offered by Medicare HMOs *within* market areas often differ significantly. Premiums in Cook County, Illinois, for example, range from \$0 per month to \$63 per month. Annual prescription drug benefits in Los Angeles County, while offered by all Medicare HMOs, vary from \$2,000 per year to 'unlimited' annual drug benefits. Copayments for brand-name drugs in Maricopa, AZ, range from \$5 to \$15 per prescription. The copayment requirements for hearing exams in Dade County range from \$0 to \$25. In Allegheny County, PA, the hearing aid benefit ranges from \$500 every two years to \$500 every three years.

Across Market Areas. Benefits offered under Medicare HMOs' basic plans also vary significantly *across* market areas. In Los Angeles, Dade and Maricopa County, none of the plans impose supplemental premiums, in contrast to plans in Cook, Allegheny and King County. In Dade County, FL, nine of 10 Medicare HMOs offer 'unlimited' drug coverage, compared with King County, WA, where none of the seven plans offer prescription drug coverage.

¹ Los Angeles County, CA; Dade County, FL; Maricopa County, AZ; Cook County, IL; Allegheny County, PA; and King County, WA

Variations in benefit design can expose beneficiaries to complex choices and have a significant impact on out-of-pocket spending.

To illustrate the effects of benefit design and generosity on out-of-pocket spending for prescription drugs and hearing aids, we constructed profiles of 'typical' Medicare beneficiaries.

Our analysis of potential out-of-pocket liability of an illustrative Medicare beneficiary with multiple health conditions requiring high use of prescription drugs indicates that, in the typical "least generous" HMO, she would incur out-of-pocket costs of \$5,358 for prescription drugs, with the HMO paying a maximum amount annually of \$600. In the typical "most generous" HMO, with no annual maximum, this enrollee would pay \$1,080 out-of-pocket and the HMO would pay \$4,878. The difference in out-of-pocket costs, depending on the HMO chosen by this beneficiary, is over \$4,300. An illustrative Medicare beneficiary with moderate prescription drug requirements would incur over \$2,700 in out-of-pocket costs in the "least generous" HMO, but only \$600 in out-of-pocket costs in the "most generous" HMO.

Analysis of out-of-pocket liability for hearing aid costs for an illustrative Medicare beneficiary requiring two hearing aids a year at a cost of \$1,100 each indicates that the beneficiary would incur \$1,450 in out-of-pocket costs in the "least generous" HMO offering the benefit and \$1,100 in costs in the "most generous" HMO offering the benefit.

These results illustrate the potential differences in liability that beneficiaries face (and must evaluate) in choosing among Medicare HMOs available to them.

Discussion

By law, all Medicare HMOs must offer basic Medicare benefits. Most offer a complex package of supplemental benefits, in addition to required Medicare benefits. These supplemental benefits are attractive to Medicare beneficiaries who often face significant out-of-pocket liability for these services. The analysis of selected benefits offered by Medicare HMOs in 1999 indicates that there are wide variations in the coverage for supplemental benefits that are offered. Medicare beneficiaries who must choose among HMOs and between HMOs and other supplemental insurance policies are faced with a complicated task in evaluating their choices and their implications for out-of-pocket spending.

The scope of prescription drug benefits offered by Medicare HMOs varies widely across plans. More than one in six Medicare HMO enrollees are in a plan without any drug coverage, while one in four are in a plan with an unlimited drug benefit. At a time when prescription drug costs are rising rapidly, the more generous Medicare HMOs may be the best alternative available to many Medicare beneficiaries facing high out-of-pocket costs for needed medications. The rapid increases in prescription drug costs, coupled with reductions in the growth of Medicare payments to plans, may place increasing financial pressures on Medicare HMOs, potentially jeopardizing the availability of relatively generous, affordable drug coverage under Medicare HMOs in the future.

Results of the study provide useful information for the current policy discussions about the complexities of choices available to Medicare beneficiaries and the information they need to make appropriate choices. In addition, it highlights the uneven availability of highly desired benefits under Medicare HMOs throughout the nation.

INTRODUCTION

The number of Medicare beneficiaries enrolled in Medicare HMOs has grown almost fourfold in the past three years, from 1.8 million in December 1995 to almost 6.2 million in May 1999, or about 15 percent of all Medicare beneficiaries. Medicare HMOs have sought to attract Medicare beneficiaries by offering benefits, such as prescription drug and dental coverage, beyond those offered as part of the traditional Medicare program, usually without the requirement that beneficiaries pay an additional premium. For the past several years, a growing number of plans have elected to offer supplemental benefits as part of their basic plan.² The availability of supplemental benefits makes HMOs attractive to many beneficiaries, in that plans directly reduce the costs to beneficiaries of services generally not covered by Medicare.

In choosing to enroll in a Medicare HMO, beneficiaries are expected to assess the value of the “package” of benefits that they are offered by HMOs in their area and to evaluate these plans relative to other options, such as traditional Medicare supplemented by a Medigap plan. There is some expectation that beneficiaries will examine and compare copayment requirements, plan maximums, and deductibles to understand key differences that could affect their coverage and financial liability. However, selecting a Medicare HMO is not necessarily easy, in that there is a great deal of variability in benefits, and associated cost-sharing requirements. Unlike Medigap products which offer beneficiaries a limited number of options with clearly defined benefits and cost-sharing requirements, the structure of supplemental benefits offered by Medicare HMOs typically varies from plan to plan. These differences can have a significant impact on beneficiary out-of-pocket spending.

The issue of the complexity of health plan benefit offerings has recently become more important from a policy context. The Balanced Budget Act of 1997 (BBA 97) made significant changes in the methodology used by HCFA to pay HMOs for enrolling Medicare beneficiaries beginning in 1998 and introduced additional reporting and administrative requirements for Medicare managed care plans. Under the BBA 97, increases in payments have been reduced in areas in which payments have historically been high and where enrollees have received relatively generous supplemental benefits with little or no additional premiums. In addition, HCFA will begin risk adjusting payments to Medicare managed care plans beginning in 2000 that is expected to further reduce payments for many HMOs. As a result, it is likely that these Medicare HMOs have felt (and will continue to feel) financial pressure to reduce benefits and increase member copayments and premiums. Changes in Medicare HMO benefits over time will make it even more important for beneficiaries to review benefits and cost-sharing requirements to understand and compare out-of-pocket expenses across plans in their area.

² Gold, Marsha, Amanda Smith, Anna Cook, and Portia Defilippes. *Medicare Managed Care: Preliminary Analysis of Trends in Benefits and Premiums, 1997-1999*. Mathematica Policy Research, Incorporated, June 1999.

The purpose of this paper is to examine the scope of benefits offered by Medicare HMOs in their basic plan. It examines the various features of Medicare HMO benefits – primarily focusing on cost-sharing requirements – to highlight the complexity of these offerings and the difficulty that Medicare beneficiaries may have in choosing among the Medicare managed care plans that serve their communities. This analysis uses data from HCFA's *1999 Medicare Compare* database and other sources to describe current features of available benefits and show the degree of variation that exists across health plans.

Methods

To date, there has been relatively little research that describes the supplemental benefits available to Medicare HMO enrollees other than information on whether various benefits are offered. Analyses of HMO benefits, both standard Medicare benefits and supplemental HMO offerings, have historically relied on HCFA's Monthly Report of Prepaid Health Plans. Benefit data from HCFA's Monthly Report of Prepaid Health Plans prior to January 1999 was dichotomous with respect to reporting benefits.³ The report simply presented a 'yes' or 'no' indicator to the question of whether or not a plan offered a given benefit. These data did not permit assessment of the generosity or limits on benefits or estimates of Medicare beneficiaries' potential out-of-pocket liability for specific benefits in different HMOs. With the introduction of the Medicare Compare website in late 1997, beneficiaries and researchers were for the first time provided with more detailed information on copayment requirements and limits on specific benefits.

The Medicare Compare Internet database (www.medicare.gov) was set up in late 1997 and has subsequently been revised for 1998 and 1999.⁴ The database contains information on 24 categories of services offered by each Medicare+Choice plan as well as traditional fee-for-service Medicare and the various categories of Medigap insurance (A-J). These benefits include the basic Medicare coverage required by law as well as information on any supplemental benefits offered by Medicare+Choice plans. The entire database can be downloaded, or can be used interactively allowing users to make queries regarding the features of specific types of benefits for a given state, county, or zip code to compare benefits across plans. HCFA does not provide data on enrollments in each package that a plan may offer.

The paper focuses on benefits for which there is significant variation in cost-sharing requirements, and sufficient information on Medicare Compare to assess variations in benefit structures across plans. Our preliminary analysis found minimal variation in most benefits covered under the traditional Medicare program, with the exception of cost-sharing for physician services. This study thus examines cost-sharing requirements for physician care and for

³ Beginning in January 1999, all benefit information was dropped from the report, presumably because Medicare Compare exists with an explicit purpose of reporting benefits, both standard Medicare and supplemental HMO offerings.

⁴ The 1997 data in Medicare Compare were generally incomplete and inconsistently coded, though data for subsequent years have been more complete and contain information consistent with other HCFA data sets.

supplemental benefits, including prescription drugs, preventive dental services, hearing exams and hearing aids.⁵

A particular focus of this study is detailed examination of the prescription drug benefits offered by Medicare HMOs to beneficiaries. Prescription drug benefits are often used in Medicare HMO marketing materials to attract new enrollees, and are cited by beneficiaries as a major reason for joining a Medicare HMO.⁶ Prescription drug costs have been rising rapidly in recent years, in part because of the introduction of new and more effective products. Because outpatient prescription drug benefits are not offered by Medicare the availability of drug coverage through Medicare HMOs is one of the attractive features of joining these plans.⁷ However, it is possible that the changes in Medicare payments to HMOs, combined with the rising costs of prescription drugs, may cause HMOs to reduce or eliminate these benefits in future years. The analysis in this paper is intended to describe current prescription drug coverage through HMOs in order to assess the range in the generosity of benefits and the effects of different drug limits on out-of-pocket spending.

The analysis of the features of benefits and premiums reported in this paper is based on the "basic plan" offered by Medicare managed care plans. Medicare HMOs may offer "high option" benefit plans, as well as the "basic plan." HCFA data sets report do not provide information on the number of a plan's members who are enrolled in the "basic" plan versus "high option" benefit plans. Thus, the analysis reported here should be interpreted as indicating the number of Medicare beneficiaries who are enrolled in Medicare managed care plans that offer the benefits described in their "basic" plan. Some of these enrollees may have chosen a "high option" plan and are paying a higher supplemental premium for a more generous set of benefits.

In presenting data on premiums and the characteristics of benefits, we have computed the share of enrollees in health plans that offered a benefit with a certain characteristic (e.g., a \$5 copayment for prescription drugs) under their "basic package." This allows us to account for the possibility that characteristics of benefits may differ across HMOs of different size. By accounting for the variation in plan enrollment, these weighted figures provide a better indication of the distribution of benefits with different characteristics among those beneficiaries who were enrolled in Medicare HMOs in 1999.

⁵ While vision care services and eyeglasses were also of interest, the Medicare Compare data base does not provide detail on these benefits.

⁶ Neuman, P. E. Maibach, K. Dusenbury, M. Kitchman, and P. Zupp, "Marketing HMOs to Medicare Beneficiaries," *Health Affairs* (July/August 1998): 132-139.

⁷ The Administration has proposed the addition of a prescription drug benefit to Medicare which, when fully phased in by 2008, would pay a maximum of \$2500 – 50 percent of an individual beneficiary's prescription drug costs up to \$5000.)

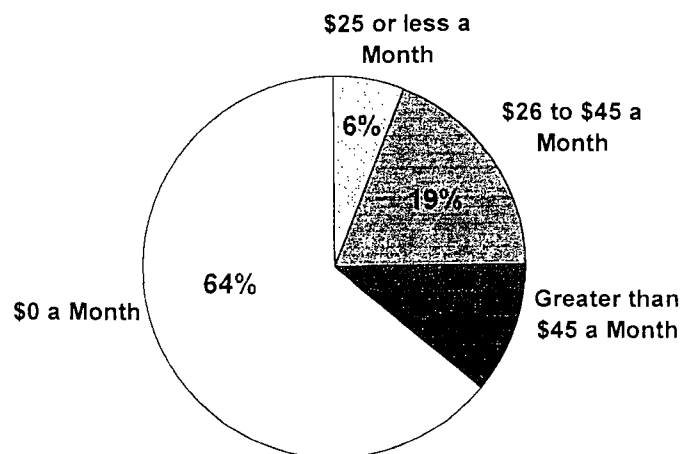
DESCRIPTION OF PREMIUMS AND BENEFITS AVAILABLE TO MEDICARE BENEFICIARIES ENROLLED IN MEDICARE HMOs

The analysis of benefits offered by Medicare HMOs in 1999 shows wide variation in the premiums charged to beneficiaries, and the generosity of many supplemental benefits, especially potentially high-cost benefits, such as prescription drugs and hearing aids.

Supplemental Plan Premiums

The range of monthly "basic plan" premiums (above the Part B premium) charged by plans to beneficiaries is presented in Exhibit 1. Nearly two-thirds (64 percent) of Medicare HMO enrollees are in HMOs that provide reduced cost-sharing and supplemental benefits to their enrollees at no additional premium, and 89 percent of beneficiaries are enrolled in plans that charge less than \$45 a month. However, the range of premiums charged, for plans charging a supplemental premium for their "basic plan," is quite large, from \$9 in some plans to \$250 a month in others. In addition to examining the share of risk enrollees charged a premium, it is also of interest to describe the premium *amounts* that beneficiaries pay. There are two ways to measure this amount. The first measure is the average premium paid by beneficiaries, excluding those who do not pay a premium, yielding a monthly premium of \$41.37 a month. Alternatively, the average for beneficiaries across *all* plans, including those who are enrolled in plans that charge no premium for their "basic" package, is \$15.50 a month.

**Exhibit 1: Supplemental Premium Requirements for
Medicare Managed Care Enrollees in "Basic Plan," 1999**



Note: Mean Premium for all beneficiaries: \$15.50; Mean premium for only beneficiaries charged a premium: \$41.37; 5.95 million Medicare beneficiaries enrolled in 279 plans.
SOURCE: Barents Group LLC analysis of HCFA, *Medicare Compare 1999 and Monthly Report of Prepaid Health Plans*, May 1999.

Copayments for Physician Office Services

Most (81 percent) of all Medicare beneficiaries are enrolled in HMOs that require their enrollees to make a copayment for primary care physician office visits in 1999 under their “basic plan” package. Two-thirds of enrollees paid between \$5 and \$10 for each primary care office visit (Exhibit 2). There was wide variation in copayment requirements, however, with per-visit copayments ranging from \$2 to \$20 across plans and an average copayment of \$5.94 per visit.

In general, copayment requirements for specialist visits are similar to those for visits to primary care physicians. The average copayment for specialist visits is \$6.37. Copayments for specialist visits varied from \$3 per visit to \$25 per visit, under HMO “basic plans.”

Exhibit 2: Percent of Enrollees in HMOs, by Copayment Charged Per Visit Under the “Basic Plan,” 1999

	Required Copayment Per Visit					Total
	\$0	Up to \$5	\$5	\$6 to \$10	Greater than \$10	
Percent of HMO Enrollees by Primary Care Physician Copayment Charged	19%	7%	35%	32%	7%	100%
Mean Copayment	\$5.94					
Minimum Copayment	\$0					
Maximum Copayment	\$20.00					
Percent of HMO Enrollees by Specialist Physician Copayment Charged	24%	4%	33%	27%	13%	100%
Mean Copayment	\$6.37					
Minimum Copayment	\$0					
Maximum Copayment	\$25.00					

Source: Barents Group LLC analysis of HCFA, *Medicare Compare 1999* and *Monthly Report of Prepaid Health Plans*, May 1999, 6,126,199 Medicare beneficiaries enrolled in 285 plans.

Prescription Drugs

Outpatient prescription drugs are generally not a covered Medicare benefit, and Medicare HMOs often feature the availability of this benefit prominently in their marketing materials. The availability of outpatient prescription drug benefits offered by Medicare HMOs is particularly of interest, since prescription drug costs are rising much faster than overall medical care costs. Medicare does not cover the cost of outpatient prescription drugs, although there have been a number of initiatives that would modify Medicare to cover some outpatient prescription drug costs. However, at present, Medicare beneficiaries who wish to purchase outpatient prescription drug coverage have limited options for coverage under relatively expensive ‘high option’ Medigap plans or they may join a Medicare HMO that offers a prescription drug benefit.

Currently 83 percent of plans in the Medicare Compare database offer some type of prescription drug benefit. These benefits have a number of features, including copayments, maximum annual limits, and drug formulary restrictions, all of which have implications for out-of-pocket costs.

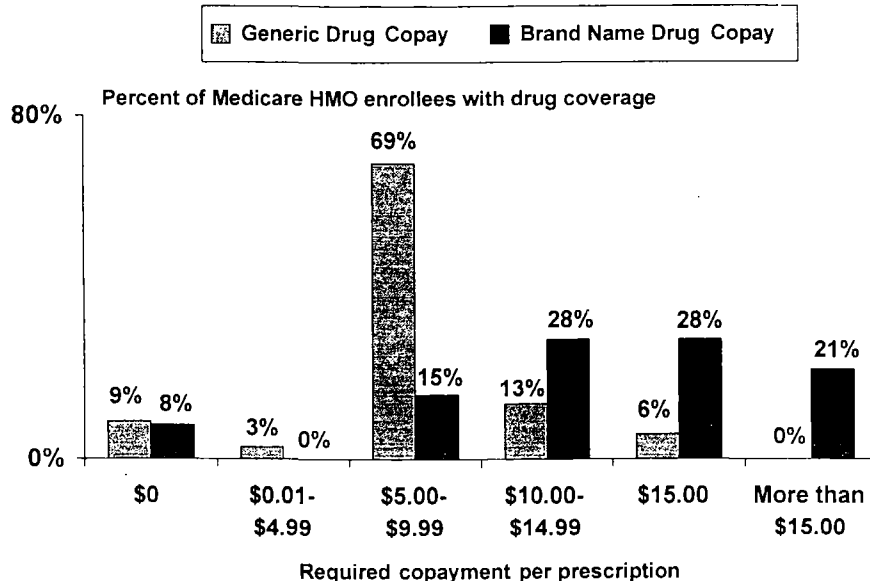
Copayments

Plans that offer prescription drug benefits in their "basic plan" typically require a fixed copayment per prescription filled (usually for a 30-day period) and the level of that payment differs by whether the drug is a generic or a brand name.

Nine out of ten enrollees offered a prescription drug benefit are in HMOs requiring some copayment for each generic prescription filled in 1999. Most (69 percent of enrollees) are enrolled in HMOs charging between \$5 and \$10 per generic prescription. The average copayment requirement in "basic plans" is \$6.42 per generic prescription (Exhibit 3)

Medicare HMOs tend to charge higher copayments for brand name prescription drugs than for generic drugs. The majority (56 percent) of beneficiaries are in plans charging between \$10 and \$15 for brand name prescription drugs under their "basic" package. An additional 21 percent are charged more than \$15 per brand name prescription. On average, beneficiaries are charged a \$13.15 copayment per brand name prescription, more than twice the average copayment for generics. While 23 percent of HMO enrollees pay less than \$10 per prescription for brand name drugs, 81 percent are charged less than \$10 per prescription for generic drugs as part of the "basic" benefits package.

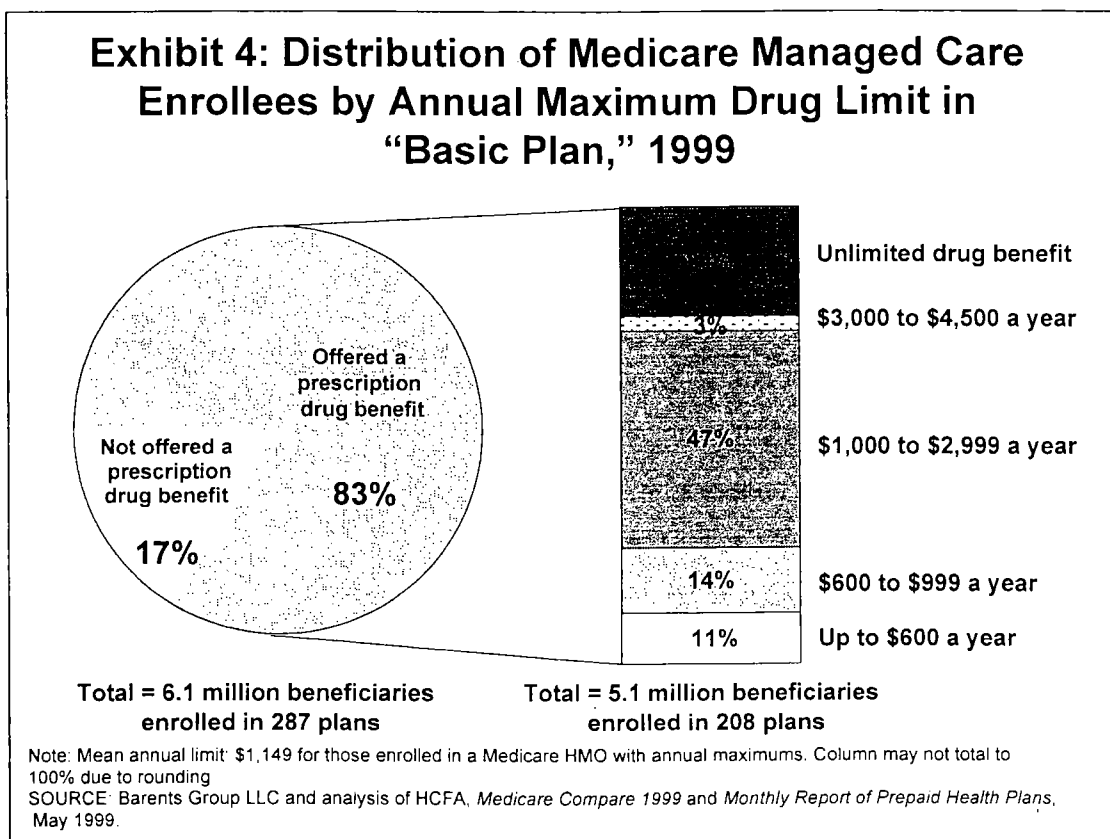
Exhibit 3: Comparison of Prescription Drug Copayments Required for Generic and Brand Name Drugs, 1999



Source: Barents Group LLC analysis of HCFA, *Medicare Compare 1999* and *Monthly Report of Prepaid Health Plans* May 1999. Among HMOs that offer a drug benefit in their "basic plan," mean generic copayment \$6.42 (4.97 million beneficiaries enrolled in 198 plans); mean brand copayment \$13.15 (4.80 million beneficiaries in 192 plans); 5.95 million Medicare beneficiaries enrolled in 279 plans.

Maximum Limits

In addition to copayment requirements, HMOs typically impose maximum quarterly or annual limits on payments for drugs, above the beneficiary copayments. Exhibit 4 shows that 24 percent of enrollees in HMOs offering a drug benefit have unlimited prescription drug benefits. About 11 percent of beneficiaries with drug coverage are enrolled in HMOs that limit payment for drugs to under \$600 a year, in their "basic plan." Fourteen percent face a limit between \$600 and \$999 annually. Forty-seven percent of enrollees with drug coverage face a limit of \$1,000 to \$2,999 for their medications. On average, beneficiaries with drug benefits are limited to about \$1,149 of drugs paid by the plan, above any copayment that a beneficiary may be required to pay in 1999. Three percent of enrollees with prescription drug coverage are in HMOs that impose annual limits between \$3,000 and \$4,500 a year.



Copayment for Dental Exams

Sixty-three percent of enrollees in Medicare HMOs for which data are reported are offered preventive dental benefits. Copayment requirements for dental exams, in HMOs offering dental benefits under their "basic plan," appear to be similar to the physician copayments discussed above. Three of four beneficiaries with preventive dental benefits are enrolled in managed care plans that require enrollees to pay some level of copayment, under the "basic plan," for routine (i.e., preventive) dental exams, with most charged between \$5 and \$10. The mean payment for dental exams is about \$6.38 per visit. Fewer than 15 percent of all enrollees are enrolled in plans

charging more than \$10 per routine dental exam. However, the range of dental copayments is much wider than for physician copayments - \$2 to \$50 (Exhibit 5).

Variation across plans for other dental related services may exist, but cannot be determined from the Medicare Compare database. All versions of the database through July 1999 only reported whether preventive dental services were offered, what (if any) copayments were required for preventive visits, and whether "other dental services" were offered. Beneficiaries are instructed to contact the plan for details. No information is provided in the Medicare Compare database on whether or not plans cover dentures, presumably a benefit of interest to the Medicare population.

Hearing Care Benefits

Ninety percent of Medicare HMO enrollees for which data exist in Medicare Compare are offered some kind of hearing benefit. This could range from as basic of a benefit as coverage for aural exams, to coverage for hearing aids. Thirty-five percent of Medicare HMO members enrolled in HMOs offering hearing benefits in their "basic plan" are not charged a copayment for routine hearing exams, while most who are charged pay between \$5 and \$10 – similar to the copayments for other office visits (physician and dentist). The average payment across all beneficiaries is about \$5.41. Only 12 percent of beneficiaries are charged more than \$10 for hearing exams (Exhibit 5).

Exhibit 5: Percent of Enrollees in HMOs, by Copayment Charged Per Dental and Hearing Visit Under the "Basic Plan," 1999

	Required Copayment Per Visit					Total
	\$0	Up to \$5	\$5	\$6 to \$10	Greater than \$10	
Percent of HMO Enrollees by Dental Exam Copayment Charged	26%	4%	38%	18%	13%	100%
Mean Copayment	\$6.38					
Minimum Copayment	\$0					
Maximum Copayment	\$50.00					
Number of Enrollees	3,472,566					
Number of Plans	96					
Percent of HMO Enrollees by Hearing Exam Copayment Charged	35%	5%	31%	17%	12%	100%
Mean Copayment	\$5.41					
Minimum Copayment	\$0					
Maximum Copayment	\$25.00					
Number of Enrollees	5,381,654					
Number of Plans	227					

Note: Rows may not total to 100% due to rounding.

Source: Barents Group LLC analysis of HCFA, *Medicare Compare 1999* and *Monthly Report of Prepaid Health Plans*, May 1999.

Hearing aid coverage can take many different forms. Some HMOs offer a predetermined number of hearing aids over a specified time period without limits on the value of the hearing aid (e.g., two hearing aids every two years). Others limit the value of hearing aids without limiting the number of aids (e.g., hearing aids are covered up to \$500 over two years). Some HMOs use both types of limits (e.g., two hearing aids over two years are covered up to a maximum value of \$500). Only 18 percent of Medicare HMO enrollees are offered “discounts” on hearing aids purchased (e.g., beneficiary pays 65 percent of all hearing aid costs) that may be used in addition to the other restrictions described above or independently.

Vision

The information provided in Medicare Compare on coverage for vision services is limited. Data for all years of Medicare Compare simply indicate whether there is some coverage for eyeglasses and eye exams, without any detail on the frequency of the exam or copayment requirement. It is therefore not possible to examine the depth or generosity of this benefit (i.e., whether eye exams and/or corrective lenses are covered).

VARIATIONS IN BENEFITS ACROSS MARKET AREAS AND HMOs: EFFECTS ON ENROLLEES' OUT-OF-POCKET COSTS

Medicare beneficiaries in different markets and within markets are offered different HMO benefit packages and cost-sharing requirements that can significantly affect their out-of-pocket costs. While the generosity of benefit packages are related, in part, to the level of payments that HMOs receive from Medicare, the generosity of specific benefits can also vary among HMOs within market areas. To highlight the variations in benefits and their implications for Medicare beneficiaries' out-of-pocket costs, we first construct profiles of the range of benefits offered to Medicare beneficiaries by HMOs in six market areas. Then we develop a profile of prescription drug use for a Medicare beneficiary who has multiple medical conditions, requiring high use of prescription drugs, and a profile for a Medicare beneficiary who has moderate use of prescription drugs. These profiles are then used to estimate annual out-of-pocket costs for prescription drugs for these 'hypothetical' beneficiaries if they were enrolled in typical Medicare HMOs with differing levels of prescription drug benefits and limits. In addition, we estimate potential out-of-pocket costs associated with different hearing aid benefit offerings of Medicare HMOs. Results of these analyses illustrate the wide range of differences in benefits offered by Medicare HMOs and the range of out-of-pocket liabilities that Medicare beneficiaries face in choosing among HMOs that offer different benefit packages.

Variations in Premiums and Benefits Offered by Medicare HMOs Within Specific Market Areas

Most (71 percent) Medicare beneficiaries have access to at least one Medicare HMO, and the majority of Medicare beneficiaries have access to two or more HMOs. Twenty-five percent of Medicare beneficiaries had access to six or more HMOs (Exhibit 6). Thus, for most Medicare beneficiaries, choosing an HMO can require obtaining information from several HMOs and comparing their various benefit offerings.

Exhibit 6: Availability of Medicare HMOs for Medicare Beneficiaries, 1998

Number of HMOs Serving County	Number of Counties	Number of Medicare Beneficiaries in County (millions)	Share of Total Medicare Beneficiaries
No plans	2,305	11.6	29%
1 plan	379	4.1	10%
2 - 5 plans	445	14.1	36%
6 - 9 plans	70	7.1	18%
10 or more plans	10	2.8	7%
Total	3,209	39.7	100%

Source: HCFA, *Market Penetration Report*, March 1999 and HCFA, *Medicare Managed Care Contract Service Areas*, April 1999

To illustrate variations in "basic plan" benefits offered to Medicare beneficiaries, we have used the Medicare Compare data to present the ranges in premiums and copayment amounts that exist within five counties from around the nation that (as of March 1999) have a large number of Medicare beneficiaries and high levels of Medicare HMO enrollment (Exhibit 7). There is substantial variation in "basic plan" benefits offered in these counties for most of the benefits considered. In addition, some HMOs offer "high option" packages, as well as the "basic plan," increasing the number of choices and comparisons necessary.

In Los Angeles County, California, 12 Medicare HMOs were serving Medicare beneficiaries in 1999. While all of these HMOs offered supplemental benefits without charging their enrollees a supplemental premium, there were significant variations in enrollees' potential out-of-pocket costs depending on which Medicare HMO they joined. Physician office visit copayments ranged from \$0 to \$5 in these plans and dental examination copayments ranged from \$0 to \$30. The greatest variation and complexity in benefit structure is observed for prescription drug coverage and for hearing aid limits. Copayments for generic drugs in these 12 HMOs ranged from \$0 to \$7 for a 30 day prescription. For brand name drugs, the copayments ranged from \$5 to \$20. Limits on maximum prescription drug payments by the HMOs ranged from 'unlimited' to a maximum of \$2000 annually. The hearing aid benefit was comparably complicated, with one plan covering 65 percent of the costs of all hearing aids purchased by enrollees and other plans limiting the benefit to a maximum of \$250 every three years.

By comparison, in Cook County, Illinois, Medicare beneficiaries are offered less generous benefit packages and may need to pay a supplemental premium to the HMO to obtain these supplemental benefits. The range of copayment requirements for physician office visits is higher in Cook County than in Los Angeles County -- up to \$10 for primary care physician visits and \$15 for specialist physician visits. Similarly, the copayment for generic and brand name prescription drugs is higher in Cook County and one Medicare HMO does not offer any prescription drug benefit. Maximum limits for HMO payments for prescription drugs range from 'unlimited' to a maximum of only \$600 annually. The hearing aid benefit offered by Cook County HMOs is more comparable across HMOs, ranging from a copayment requirement of between 70 and 80 percent of hearing aid costs.

The comparisons in Exhibit 7, within market area and across market areas, illustrate the complexity of choices available to Medicare beneficiaries and the potential for significant differences in out-of-pocket liabilities that beneficiaries face depending on where they live and the specific Medicare HMO that they choose. In the next section, we provide some illustrative examples of out-of-pocket costs that would be incurred by a 'typical' Medicare beneficiary with specific needs for prescription drugs and for hearing aids, depending on the benefit structure offered by her HMO. We limit this illustration to examples of prescription drugs and hearing aids because of the wide range of differences observed among HMOs in the structure of these specific benefit offerings.

Exhibit 7: Comparison of HMO Premiums and Benefit Copayment Amounts for Basic Benefit Package, Selected Counties, 1999

	Los Angeles, CA	Dade, FL	Maricopa, AZ	Cook, IL	Allegheny, PA	King, WA
Number of active HMOs	12	10	9	6	5	7 ^a
Monthly supplemental premiums	\$0	\$0	\$0	\$0 - \$63	\$0 - \$13	\$0 - \$29
Physician Copays						
Primary care physician copay per visit	\$0 - \$5	\$0	\$3 - \$7	\$0 - \$10	\$5 - \$10	\$0 - \$5
Specialist copay per visit	\$0 - \$5	\$0	\$5 - \$7	\$0 - \$15	\$0 - \$10	\$0 - \$5
Dental exam copay	\$0 - \$30	\$0 - \$15	\$0 - \$5	\$0 - \$18	Benefit not offered for all but one plan charging \$5	Benefit not offered
Drug Benefit						
Generic drug copay per prescription	\$0 - \$7	\$0	\$3 - \$7	\$5 - \$10 for all plans except one plan not offering benefit.	\$5 - \$12 for all plans except one plan not offering benefit.	Benefit not offered
Brand name drug copay per prescription	\$5 - \$20	\$0	\$5 - \$15	\$10 - \$15 for all plans except one plan not offering benefit.	\$10 - \$12 for all plans except one plan not offering benefit.	Benefit not offered
Drug benefit limits	Unlimited or \$2,000 - \$4,500 for those imposing limit	\$2,400 for one plan, no limits on all other plans	Unlimited or \$1,500 - \$3,000 for those imposing limit	Unlimited or \$600 - \$1,000 for those imposing limit. One plan does not offer.	\$1,000 - \$1,500 for all plans except one plan not offering benefit.	Benefit not offered
Hearing Benefit						
Hearing exam copay	\$0 - \$5	\$0 - \$25	\$0	\$0 - \$15	\$0 - \$10	\$0 - \$5
Hearing aid limit	\$250/3yrs - \$600/3yrs except one plan charging 65% of all hearing aids	\$100/yr - \$120/yr except on plan not offering benefit	\$600/3yrs - \$700/3yrs	70% - 80% copay, no limit	\$500/2yrs - \$500/3yrs	\$250/2yrs

Source: Barents Group LLC analysis of HCFA, *Medicare Compare 1999*.

a. Eight HMOs operate in King County Washington, however one HMO is open to military retirees only.

Illustrative Examples of the Effect of Variations in Generosity of HMO Benefits on Enrollees' Out-of-Pocket Costs for Prescription Drugs and Hearing Aids

In this section, we develop hypothetical examples of Medicare beneficiaries' use of prescription drugs and of hearing aids and evaluate the out-of-pocket costs associated with coverage that would be offered by 'typical' HMO packages of benefits.

Illustrative Examples for Prescription Drug Coverage

To illustrate how the variation in drug benefits may affect enrollees, we have constructed profiles of Medicare beneficiary drug use and estimated out-of-pocket liability under "typical" plans that vary in generosity of their prescription drug benefits. In the first example, we profile a "high" user patient who is prescribed drugs to treat diabetes, hypertension, stomach ulcers, high cholesterol, and anxiety/depression. The profile below presents the drugs used to treat these conditions, their therapeutic categories, the actual retail price in a non-metropolitan Midwest community, and whether or not they are brand name drugs (Exhibit 8).

Exhibit 8: Prescription Profile for Beneficiary with High Prescription Drug Use, 1999

Drug	Therapeutic Category	Retail Price per Month	Brand or Generic
Relafen	NSAID arthritic drug	\$71.99	Brand
Axid	Stomach acid blocker	\$25.79	Brand
Paxil	Antidepressant	\$67.49	Brand
Prilosec	Antiulcerant	\$53.69	Brand
Vaseteric	High blood pressure/diuretic	\$70.00	Brand
Rezulin	Antidiabetic	\$79.59	Brand
Verapamil	High blood pressure	\$16.99	Generic
Baycol	Cholesterol reducer	\$39.99	Brand
Cardura	High blood pressure	\$71.00	Brand
Total Drug Costs:			
	Monthly	\$496.53	
	Annually	\$5,958.36	

Source: Barents Group LLC

Below are four actual plans available to Medicare beneficiaries (Exhibit 9). They were chosen because their features (copayments and maximum limits) are typical of Medicare HMOs throughout the country, illustrating different degrees of generosity for drug benefits. Generosity is defined in terms of the maximum amount that the plan will pay annually for prescription drugs per beneficiary, and the copayments required for each generic and brand prescription.

Exhibit 9: HMO Prescription Drug Coverage, by Level of Generosity, 1999

HMO	Level of Generosity	Drug Maximum	Generic Copay	Brand Copay
HMO A	Least generous	\$600	\$7	\$12
HMO B	Less generous	\$1,000	\$5	\$15
HMO C	More generous	\$3,000	\$5	\$10
HMO D	Most generous	None (unlimited benefit)	\$5	\$10

Source: Barents Group LLC analysis of HCFA, Medicare Compare 1999

Monthly and annual estimates of both HMO and beneficiary payments for the specified drugs are presented in Exhibit 10, as well as the number of months it would take for the beneficiary to "max out" on their drug benefits, after which the beneficiary is liable for 100 percent of drug costs.

Neither the results below nor in the next example include information on whether the HMO maintains a drug formulary. Under some formularies, it would be possible that the beneficiary might not have coverage for one or more of the prescribed medications and would be required to use other, potentially less effective medications, or to pay for the non-formulary medication out-of-pocket.

Exhibit 10: Comparison of HMO and Beneficiary Costs Under Each Plan for High Prescription Drug Utilization, 1999

HMO	Level of Generosity	HMO Share		Beneficiary Copay		Month in which Maximum is Reached (100% Beneficiary Cost Sharing)
		Monthly	Annually	Monthly	Annually	
HMO A	Least generous	\$389	\$600	\$108	\$5,358	2
HMO B	Less generous	\$319	\$1,000	\$125	\$4,325	4
HMO C	More generous	\$407	\$3,000	\$90	\$2,958	8
HMO D	Most generous	\$407	\$4,878	\$90	\$1,080	No Maximum

Source: Barents Group LLC

In the 'least generous' HMO, with a \$600 maximum, this Medicare beneficiary with high prescription drug use would 'max out' of prescription drug benefits in the second month and would pay \$5,358 out-of-pocket of the total costs of \$5,958. In the "more generous" HMO, that imposes a \$3,000 annual maximum, the beneficiary's out-of-pocket liability would be \$2,958 and coverage would be exhausted in the eighth month. A 'most generous' HMO – with no

maximum limits' - would pay \$4,878 of the total prescription drug costs, leaving the beneficiary with an out-of-pocket liability of \$1,080 entirely comprised of copayments. There is a \$4,300 difference in beneficiary out-of-pocket liability between the "most generous" HMO (HMO D) and the "least generous" (HMO A).

As a second example, we present information for a hypothetical beneficiary with more moderate drug needs for treatment of high blood pressure, Type II diabetes, and high cholesterol (Exhibit 11).

Exhibit 11: Prescription Profile for a Beneficiary with Moderate Prescription Drug Use, 1999

Drug	Therapeutic Category	Retail Price per Month	Brand or Generic
Vaseteric	High blood pressure/diuretic	\$70.00	Brand
Rezulin	Antidiabetic	\$79.59	Brand
Verapamil	High blood pressure	\$16.99	Generic
Baycol	Cholesterol reducer	\$39.99	Brand
Cardura	High blood pressure	\$71.00	Brand
Total Drug Costs			
	Monthly	\$277.57	
	Annual	\$3,330.84	

Source: Barents Group LLC

Under the 'least generous' HMO, this hypothetical beneficiary would exhaust their prescription drug coverage in the third month and would incur \$2,731 in out-of-pocket costs annually (Exhibit 12). Under the 'more generous' and the 'most generous' HMOs, the beneficiary would have coverage for prescription drugs for the full year and would pay only \$600 in out-of-pocket costs annually - a \$2,131 difference in out-of-pocket liability between the "least" and "most generous" HMO.⁸

⁸ It is interesting, also, to examine the findings in the context of the Administration's recent proposal to add a prescription drug benefit to Medicare. In the first year of implementation, the Administration's plan would pay a maximum of \$1,000 -- 50 percent of an individual beneficiary's prescription drug costs up to \$2,000, with the beneficiary responsible for \$1,000 in co-payments and for all prescription drug costs that exceeded \$2,000. For the hypothetical "moderate use" Medicare beneficiary in our illustration, with over \$3,000 in annual prescription drug costs, HMO package A would be less generous than the Administration's proposal and HMO packages B, C, and D would be more generous.

Exhibit 12: Comparison of HMO and Beneficiary Costs Under Each Plan for Moderate Prescription Drug Utilization, 1999

HMO	Level of Generosity	HMO Share		Beneficiary Copay		Months in which Maximum is Reached (100% Beneficiary Cost Sharing)
		Monthly	Annually	Monthly	Annually	
HMO A	Least generous	\$218	\$600	\$60	\$2,731	3
HMO B	Less generous	\$198	\$1,000	\$80	\$2,341	6
HMO C	More generous	\$228	\$2,731	\$50	\$600	Not Reached
HMO D	Most generous	\$228	\$2,731	\$50	\$600	No Maximum

Source: Barents Group LLC analysis

Illustrative Example of Hearing Aid Coverage

An illustration of variations in out-of-pocket liability under different HMO hearing aid benefit structures for a beneficiary wishing to purchase two hearing aids valued at \$1,100 a piece, a typical hearing aid purchase, is provided in Exhibit 13.⁹

Exhibit 13: Example Cost Sharing Arrangements for a Hypothetical Beneficiary Purchase of Two Hearing Aids for \$1,100 Each

HMO	HMO Limit	HMO Coverage	Beneficiary Liability
HMO A	No	\$0	\$2,200
HMO B	Beneficiary pay for hearing aids up to \$750	\$750	\$1,450
HMO C	HMO will pay 35 percent of all hearing aid costs	\$770	\$1,430
HMO D	Limited to one hearing aid a year	\$1,100	\$1,100

Source: Barents Group LLC analysis of HCFA, Medicare Compare 1999

As is the case for prescription drugs, there is variation in beneficiary liability for the same hearing aid needs across different HMOs. In this hypothetical example, a beneficiary requiring two hearing aids valued at \$2,200 total would be best served under HMO D, which would pay the full amount for one hearing aid per year.

⁹ See Kochkin, Sergei. "Baby Boomers Spur Growth in Potential Market, but Penetration Rate Declines." *The Hearing Journal*, January 1999; Vol. 52:1, for further discussion.

DISCUSSION

By law, all Medicare HMOs must offer basic Medicare benefits. Most offer a complex package of supplemental benefits, in addition to required Medicare benefits. These supplemental benefits are attractive to Medicare beneficiaries who often face significant out-of-pocket liability for these services. The analysis of selected benefits offered by Medicare HMOs in 1999 indicates that there are wide variations in the coverage for supplemental benefits that are offered. Medicare beneficiaries who must choose among HMOs and between HMOs and other supplemental insurance policies are faced with a complicated task in evaluating their choices.

The level of Medicare HMO prescription drug benefits ranges from very limited coverage to quite generous coverage. At a time when prescription drug costs are rising rapidly, the more generous Medicare HMOs may be the best alternative available to many Medicare beneficiaries facing high out-of-pocket costs for these products. The rapid increases in prescription drug costs, coupled with reductions in the growth of Medicare payments to plans, may place increasing financial pressures on Medicare HMOs, potentially jeopardizing the availability of relatively generous, affordable drug coverage under Medicare HMOs in the future.

Results of the study provide useful information for the current policy discussions about the complexities of choices available to Medicare beneficiaries and the information they need to make appropriate choices. In addition, it highlights the uneven availability of highly desired benefits under Medicare HMOs throughout the nation.

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MEDICARE+CHOICE PROGRAM TRENDS

Executive Summary

The Medicare+Choice program continues to grow despite challenges that parallel changes in the larger managed care market in the United States. Each month in 1999, about 45,000 Medicare beneficiaries have been choosing to join Medicare+Choice plans. As of August 1999, there were 6.2 million Medicare+Choice enrollees, representing about 16 percent of all Medicare beneficiaries. Beneficiary enrollment in Medicare risk and Medicare+Choice plans has increased every year since the inception of the program, even through periods of great volatility and instability in participation by private health plans.

Recently in both Medicare and in the private sector health plan enrollees are finding that many plans are

- raising premiums,
- restructuring benefits and increasing costs to enrollees, and
- withdrawing from selected markets for a variety of business reasons.

Analysis of Medicare+Choice plan business decisions to remain in or leave the program reveals that plans facing similar situations make different decisions depending on individual corporate strategies.

This report highlights emerging trends in Medicare+Choice, based on proposed premium and benefit structures for the year 2000. Based on these data, some noteworthy trends have emerged:

- **Premium Increases.** The national monthly average premium, weighted by population, will double, rising from \$17 in 1999 to \$35 in 2000. The number of plans charging no premium is dropping from 49 percent to 31 percent. While in 1999 about half of plans that included a drug benefit in the basic package charged no premium, in 2000 only about 30 percent of plans will offer a basic package with drug coverage and no premium.
- **Benefit Reductions.** Plans appear to be reducing and restructuring drug benefits in ways that increase enrollee out-of-pocket costs and limit choice of drugs, with 86% of plans having annual dollar caps on brand and/or generic drugs. The annual caps are being reduced: while in 1999 only 21% of plans had a cap of \$500 or less on either brand or generic drugs, in 2000 the \$500 or less cap will be a feature of 32% of plans. Copayments for drugs will also rise between 1999 and 2000, at the rate of 24% for brand-name drugs and 15% for generic drugs.
- **Plan Withdrawals.** As the General Accounting Office found to be the case for Medicare+Choice withdrawals at the end of 1998, causes other than payment rates play a large role in business decisions to participate in Medicare+Choice. Causative factors include size of Medicare+Choice enrollment, market share, and an inability to sustain adequate provider networks.

- ***Plan Withdrawals and Payment Levels.*** Withdrawals from Medicare+Choice at the end of 1999 are not primarily occurring in the lowest payment areas. Only four percent of Medicare+Choice enrollees in counties with the year 2000 floor payment rate of \$401 per month were affected by withdrawals, versus 12 percent in counties where the payment rate was in the \$451 to \$500 range. Plan withdrawals are affecting 7.2% of enrollees in counties where rates are rising by 10% or more but affecting only 2.4% of enrollees where rates are rising by the 2% minimum.

Some of the most troubling trends reflect the disproportionate impact of plan withdrawals on rural areas. The decline in rural access is occurring despite the fact that rural counties are receiving far greater payment increases than average counties, as provided for in the Balanced Budget Act of 1997. As a result of 1999 withdrawals, there will be a ten percent reduction (from 23 percent of rural beneficiaries to 21 percent) in the percent of beneficiaries with access to a Medicare+Choice option. There are already significant disparities between the availability of Medicare+Choice plans and their premiums and benefits as compared to urban areas. In rural areas, Medicare+Choice premiums are on average about 20 percent higher than in urban areas, and drug coverage is less common among Medicare+Choice enrollees in rural areas: 23% of rural beneficiaries have access to a plan that covers drugs, compared to 86% in rural areas. However, one bright spot concerning rural areas is that there are new Medicare+Choice applicants entering rural areas: about 200,000 beneficiaries, or 2.2% of the total number of rural beneficiaries, will have a Medicare+Choice option if pending contract requests are approved.

As was in the case in 1998, there are many parallels between what is occurring in Medicare+Choice and what is occurring in the private sector, with increasing numbers of organizations exiting markets, rethinking corporate strategies, and modifying benefit offerings. However, in Medicare, private health plan decisions may have more dire consequences. Many beneficiaries turn to managed care because it is the only affordable way to gain access to benefits like prescription drugs. As such, changes in plan participation or the nature of drug coverage could affect beneficiaries' access to needed health services—especially since there are few protections for beneficiaries to access alternatives like Medigap. The experiences of 1998 and 1999 in Medicare+Choice, which parallel the history of Medicare risk contracting in the late 1980s, have taught us that we cannot look to Medicare+Choice alone to provide extra benefits not covered by Medicare—most notably, prescription drugs. Ongoing market volatility and regional disparities make it abundantly clear that access to affordable prescription drug coverage is eroding in many markets.

PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE

The President's plan to strengthen and modernize Medicare would help address the shortcomings in the current Medicare+Choice system and make managed care a fair, efficient option for beneficiaries. It would do so by, first, helping to stabilize payments to private plans by converting to a bidding system rather than a statutory pricing system. The President's reform proposal will establish a market-based payment system that uses competition, rather than administered prices set by statute, to set truly fair prices in all markets. All plans will be paid their full price through a combination of government and beneficiary payments, with savings from low-priced plans passed directly on to beneficiaries, as in the Federal Employees Health Benefits Program. Beneficiaries choosing plans that cost approximately 80 percent of traditional fee-for-service will pay no Part B premium.

The President's plan would also make traditional Medicare a more viable option by giving it private-sector tools to manage costs and improve quality. It would also improve the basic Medicare benefit package by adding an affordable prescription drug benefit for all beneficiaries, and then paying Medicare+Choice plans explicitly for providing it to the beneficiaries they enroll. The President's Medicare reform proposal gives all beneficiaries the option to pay a modest premium for a benefit that covers half of all prescription costs up to \$5,000 annually when fully phased-in in 2008, with no deductible and for less than half the price of the average Medigap policy with drug benefits. This will allow plans to provide additional benefits to their enrollees and help bring even more choices to Medicare beneficiaries.

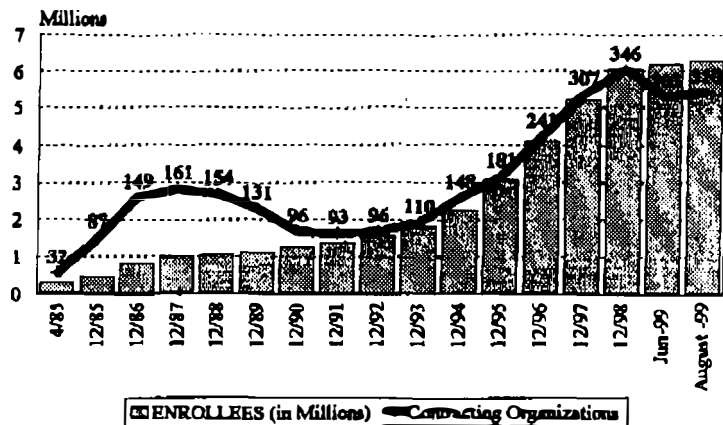
Market volatility also makes clear that stronger protections are needed for beneficiaries affected by health plan corporate business decisions. The President's proposal will give enrollees in departing plans access to all Medigap policies regardless of health status; expand Medigap open enrollment to newly disabled beneficiaries and those with end stage renal disease, and allow those with end stage renal disease to enroll in another plan; mandate a special Medigap open enrollment period for beneficiaries affected by a plan termination in January 1999; and increase penalties for violation of the Medigap open enrollment requirements. The wide variation in what plans offer makes clear that payment and benefit reforms are needed to ensure that all Americans get a fair and equitable deal for their tax and Medicare premium dollars, regardless of where they live.

MEDICARE+CHOICE PROGRAM TRENDS

Beneficiary Enrollment and Managed Care Organization Participation

Despite recent volatility in the market, an ever-increasing percentage of Medicare beneficiaries continues to enroll in Medicare+Choice (M+C) organizations.¹ Total enrollment is rising, with about 45,000 new enrollees on average each month so far in 1999. Total Medicare managed care enrollment more than doubled in the past four years, from 2.7 million in 1995 to 6.2 million in 1999. About

Medicare Risk HMO/M+C Enrollment and HMO Participation, 1985-1999



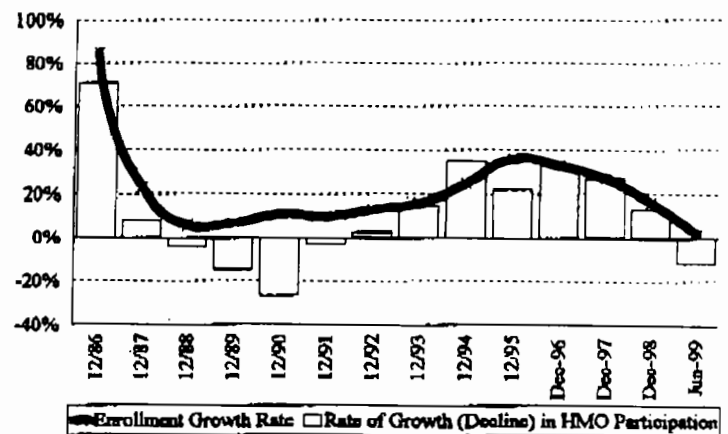
one in every six beneficiaries is now enrolled in an M+C organization, and the “penetration” rate of M+C plans among those Medicare beneficiaries who live in an area served by one or more M+C

¹As a result of provisions of the Balanced Budget Act of 1997 (BBA), the terms *organization* and *plan* have specific meanings in the context of the Medicare+Choice program. The BBA gives an organization that has an M+C contract the ability to offer more than one “plan” under a single contract. The “plans” offered by an organization may have different service areas under the contract. For example, an organization may offer a “plan” structured as a PPO under its M+C contract while at the same time offering a “plan” structured as a closed-panel HMO in the same service area, under the single contract. However, each “plan” offered by a contracting organization must have a uniform benefit and premium structure throughout the approved service area of the “plan.” An M+C organization may, under a single contract, offer different “plans” in different, non-overlapping, non-contiguous service areas, with each plan having a separate premium and benefit structure (even though the “plans” might otherwise be the same in their structure—e.g., both are HMOs). Another way in which an M+C organization may offer more than one plan under one contract is through “segmented service areas.” The segmented service area provision is the successor to the pre-BBA “flexible benefits” policy under which an organization could vary premiums and benefits under one contract on a county-by-county basis. The segmented service area policy allows organizations to essentially set up multiple service areas under a single contract in such a way that each sub-service area has a different “plan” (enabling the organization to comply with the BBA requirement of uniform premiums and benefits within a service area—a requirement that applies at the plan level not at the organization level). The term *organization* is generally used in this paper in the meaning that the term *plan* had been used prior to the BBA. The term *plan* refers to particular options available to beneficiaries.

organizations is about 23% (i.e., nearly one in four Medicare beneficiaries chooses an M+C plan where one is available). Enrollment losses resulting from reductions in plan participation last year were recouped within just two months. Program growth will likely continue despite decisions by some organizations this year to discontinue participation in the M+C program.

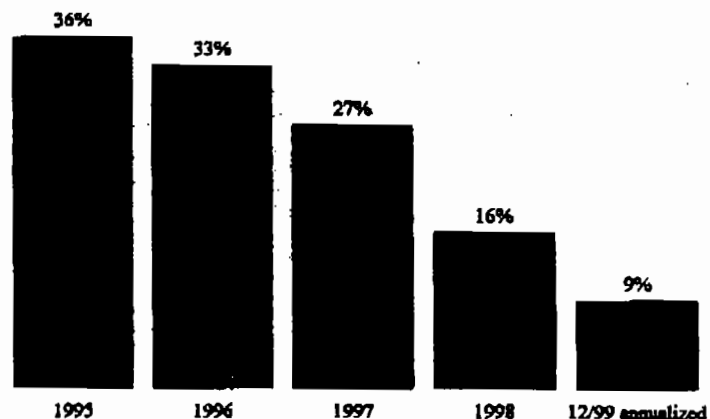
Enrollment in Medicare risk organizations (today's M+C organizations) has grown every year since the inception of the program in 1985. Enrollment has increased consistently year after year even though HMO participation in the program has been volatile over the years and declined in certain time periods. Enrollment reached the one million mark in 1987, and grew relatively modestly—at the rate of 12% per year—between 1988 and 1992. Enrollment growth increased dramatically in subsequent years. Between 1993 and the end of 1998, enrollment in Medicare risk organizations increased an average of 26% each year.

Yearly Medicare Risk Enrollment Growth Rates and Rates of Change in HMO Participation Levels, 1986-1999



Levelling Off of Enrollment Increases. While enrollment is increasing at the rate of 45,000 per month currently, that rate of monthly enrollment growth is about two-thirds of the 1995 average of 68,000 beneficiaries per month. Even though the level of access to M+C plans has remained relatively

Rate of Increase in Risk HMO Enrollment Year-to-Year, December to December
December 99 Annualized Based on New Enrollment of 45,000 Per Month and Ignores 12/31/98 Disenrollments



stable in the last few years (as discussed below), the rate of increase in enrollment among Medicare beneficiaries has declined. After 1986, the highest rate of increase in enrollment from one year to the next occurred between 1994 and 1995, when the program saw a 36% jump in enrollment. Since that time, enrollment increases have been declining. At the current rate of monthly enrollment growth in the M+C program, the enrollment increase at the end of 1999 will be substantially smaller than in recent years.²

There may be some evidence that the decisions that organizations have made to discontinue their participation in the M+C program have influenced beneficiaries' perceptions of whether to choose the M+C option. Among beneficiaries affected by contract terminations or service area reductions in 1998, half of those who could have chosen another managed care plan instead chose to return to the original fee-for-service Medicare program. Weiss Ratings, Inc., which rates the financial health of insurance companies and HMOs advised beneficiaries affected by non-renewals and service area reductions, at the end of 1998, to "Seriously consider leaving HMOs entirely and using traditional Medicare plus a supplemental policy....Approach HMOs with caution."

The Medicare+Choice Program in the Year 2000

The majority of Medicare+Choice organizations are remaining in the program. Organizations remaining in the program will be raising premiums and reducing and restructuring benefits in ways that increase enrollee out-of-pocket costs. This is especially true for coverage of prescription drugs, which is one of the features of Medicare+Choice that is most attractive to Medicare beneficiaries.

Changes in Premiums and Benefits. Most Medicare+Choice plans will continue to offer extra benefits beyond the basic Medicare package, such as coverage for prescription drugs. For the year

²Note that the 9 percent number in the accompanying graph is the rate of increase ignoring the 407,000 enrollees affected by non-renewals and service area reductions at the end of 1998, for purposes of comparability to other years included in the chart. Including the people affected by non-renewals (those with no plan available in 1999, and those who chose not to join another available managed care organization) would result in an annualized net enrollment increase of 7 percent for 1999.)

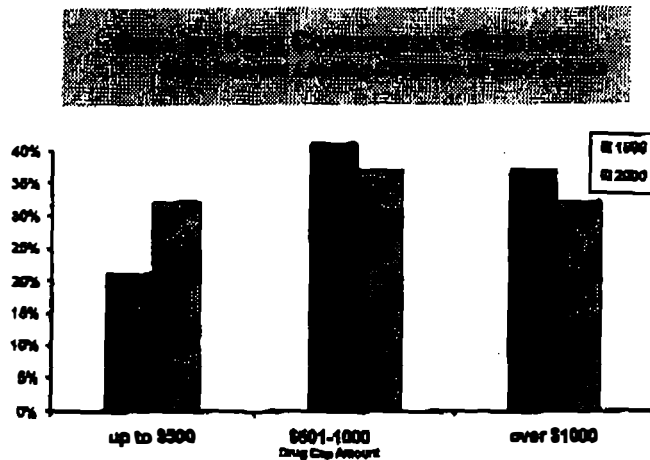
2000, organizations are increasing what beneficiaries must pay for these extras. As is discussed further below, the average monthly premium is expected to double in 2000, from \$21 a month in 1999 to \$42 a month in 2000 (with the population-weighted premium rising from \$17 to \$35).³ The plan-level average actuarial value of copayments for various benefits is rising about 10%, from \$29 to \$32 per month. But, more importantly, the structure of these benefits, particularly prescription drug coverage, is changing in ways that limit plans costs, increase enrollee out-of-pocket expenditures, and ultimately may discourage enrollment by beneficiaries with greater health care needs.

Drug Coverage. The number of beneficiaries with access to a Medicare+Choice plan offering some drug coverage remains virtually unchanged, dropping from 65 percent to 63 percent between 1999 and 2000. However, the total value of prescription drug benefits to beneficiaries is declining. Organizations are decreasing the total dollar amount of drugs they will pay for in a given year or quarter and are increasing the amount that beneficiaries must pay each time they receive a prescription—particularly for brand name drugs. Organizations are also increasing the use of formularies designed to limit choices available to physicians and beneficiaries.

Organizations have changed the structure of the prescription drug benefits included in M+C plans. Although a few more plans are offering unlimited prescription drug benefits for both generic and brand name drugs, the majority of plans (86 percent) will continue limiting drug benefits next year. Of those that have annual limits, there is now a major emphasis on limiting coverage of brand name drugs and encouraging the use of (less expensive) generic drugs: in 1999, 74 percent of plans had limits on both brand and generic drugs, but in the year 2000, only 45 percent of plans will impose dollar limits, or caps, on generic drug coverage (with 14% of the remaining 55% of plans offering unlimited generic and brand coverage, though formularies may also be used).

³These averages are plan averages, not organization-level averages. In the year 2000 many more organizations will be segmenting their service areas within contracts. Although the number of contracts between 1999 and 2000 will decline (going from 303 to 262), the number of plans will increase from 622 to 793. Therefore, unweighted average premium levels are not strictly comparable between 1999 and 2000, and such numbers are not comparable to pre-1999 figures appearing in HCFA's monthly managed care reports.

When organizations do impose limits, the annual limits are smaller for the year 2000. For example,

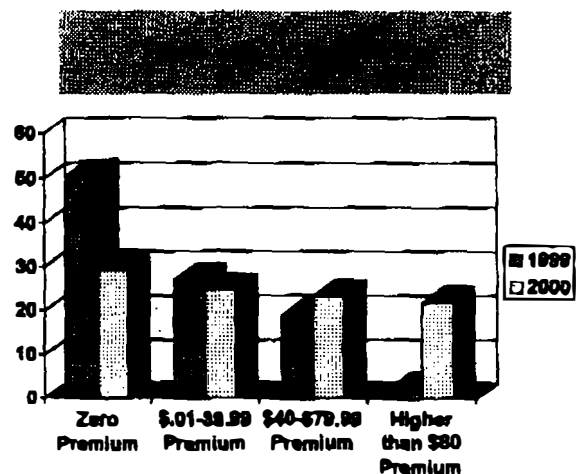


the proportion of plans with annual benefit limits of \$500 or less is increasing from 21 percent in 1999 to 32 percent in 2000, and more than half of plans offering drug coverage will have annual limits of \$1,000 or less. In fact, 82 percent of plans in 2000 will cap drug coverage below the \$2000 level that is provided at the start of the President's Medicare reform plan. More organizations are also putting special caps on brand

name drugs vs generics. The number with such arrangements is increasing from 24 percent in 1999 to 47 percent in 2000. [NOTE THAT THESE NUMBERS AND ALL OTHER PLAN-SPECIFIC NUMBERS NEED TO BE CONVERTED TO ENROLLMENT OR POPULATION-WEIGHTED NUMBERS IF POSSIBLE.]

Premiums for Plans with Drug Coverage.

About 30 percent of plans with a drug benefit do not have a premium, down from 51 percent in 1999. The number that offer drug coverage with premiums above \$40 is increasing from 22 percent in 1999 to 46 percent in 2000.



Premiums for Drug Coverage in Rural Areas. The number of rural counties and rural beneficiaries with access to drugs is

smaller in 2000 than in 1999, with higher premiums. In 2000, over one-third of rural plans with drug coverage will have a premium of \$80 or more, up from fewer than 10 percent in 1999.

Drug Formularies. Organizations are making greater use of drug formularies, meaning they encourage enrollees to use specific drugs, often because the organization obtains discounted prices from manufacturers. In 2000, 85 percent of plans with a drug benefit will have an established formulary, up from 78 percent in 1999. Of these, 57 percent may charge enrollees more for drugs that are not on the plan formulary, up from only 14 percent in 1999.

Drug Copayments. Organizations are maintaining high copayments for brand name drugs, and raising copayments for generics. On average, Medicare beneficiaries will pay 24% more in 2000 in copayments for brand name drugs, compared to 1999. Nine out of ten plans with copayments continue to charge \$15 or more for brand name drugs, with one in four charging \$25 or more, as in 1999. Medicare beneficiaries will pay an average of 15% more in copayments for generic drugs. For generics, however, the share of plans with copayments charging \$10 or more is rising from 28 percent to 44 percent.

In 2000, the number of plans that require Medicare beneficiaries to pay a percentage of the actual costs for prescription drugs, rather than a fixed surcharge, will double. However the majority of plans continue to require copayments. At least one plans in one in every eight counties where there is Medicare+Choice access requires beneficiaries to pay coinsurance for drugs.

Other Benefits. There are also moderate decreases in levels of coverage for other extra benefits not covered by Medicare, such as dental vision and hearing aid coverage.

- ▶ The number of plans offering dental benefits is dropping from 52 percent to 48 percent.
- ▶ The number of plans offering vision benefits is dropping from 95 percent to 91 percent.
- ▶ The number offering hearing aid coverage is dropping from 59 percent to 56 percent.

As with drug coverage, copayments and coinsurance are rising for office visits as well. The average copayment for a primary care office visit is rising by 20%, from \$6.90 to \$8.33, and the average

copayment for seeing a specialist is rising by 37%, from \$7.67 to \$10.52.

Changes in Premiums. As in the commercial and other managed care markets, premiums are going up in Medicare+Choice, as noted above. The number of plans charging no premium is dropping from 49 percent to 31 percent, and the proportion of plans charging premiums of more than \$80 per month for the basic package is rising from 2.9 percent to 18.4 percent. The highest premium rate is rising from \$250 to \$300 per month.

Premium increases are most dramatic in urban areas, including many areas with large Medicare populations. For example, in New Jersey urban markets, premiums, weighted by eligibles, are more than tripling from an average of \$22 to \$80 per month. And in Florida urban markets, they are quadrupling from an average of \$6 to \$25.

Yet premiums remain much higher in rural areas, where substantial increases are also occurring, and extras like prescription drug coverage are less common and less generous. In 1999, over half of plans in rural areas had premiums of \$40 or less per month, compared to only 35% in 2000. Rural premiums, weighted by eligibles, will be about 20% higher than urban premiums for basic benefit plans (\$42 versus \$35). In rural areas of Illinois, for example, average monthly premiums, weighted by eligibles, will increase from \$3 to \$12, while in rural Wisconsin, premiums, weighted by eligibles, will increase from \$15 to \$52.

Organizations Leaving M+C or Reducing Service Areas at the End of 1999

This year and last year, a number of organizations decided to end or reduce their participation in the M+C program. For the year 2000, 99 Medicare+Choice contracting organizations have decided to reduce or drop participation in the program. This includes withdrawals from the program by 41 contractors—i.e., termination of the contracting arrangement between HCFA and the organization—and cuts in the geographic areas served by another 58 contractors (i.e., organizations retaining contracts with HCFA but dropping portions of their service area from the Medicare

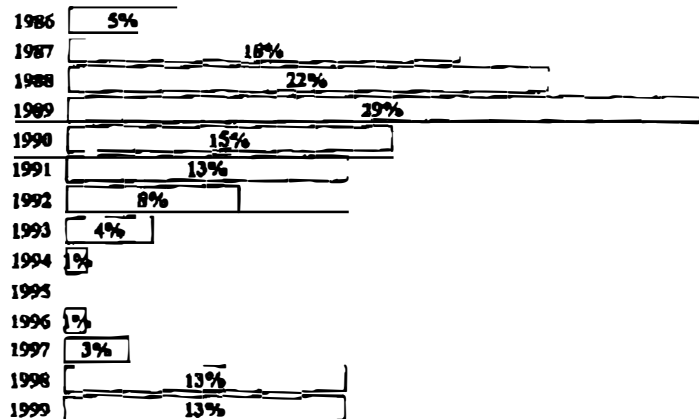
contract). These changes affect about 327,000 beneficiaries in 329 counties in 33 States, or about 5% of all Medicare+Choice enrollees. Of the 327,000 affected, 79,000 (1.3% of all Medicare+Choice enrollees), will have to return to traditional Medicare because they do not have any Medicare+Choice plan available in their county. In 1998, decisions to terminate or reduce participation by M+C organizations affected 407,000 beneficiaries in 407 counties in 29 States; and 51,000 enrollees were left without access to another M+C plan in 1998.

Terminations of contracts by managed care organizations are still well below the rate seen a decade ago. In 1988, 22 percent of Medicare managed care organizations withdrew from the program (terminating their contracts), with 8.2 percent of enrollees affected.⁴

In 1989, 29 percent of organizations terminated their contracts, affecting 6.6

percent of enrollees. That compares to 13 percent of organizations terminating contracts in 1998 and again in 1999, with 3.7 percent and 2.7 percent of beneficiaries affected each year respectively (exclusive of service area reductions).

**Risk Contract Non-Renewals by Percent of Plans, 1986-1999
(Excludes Service Area Reductions)**



Refers only to risk non-renewals (including conversion to cost plans), not service area reductions. The 1989 figure includes 29 plans that had no enrollees. The percent for 1995 was less than one. 1999 data are based on the number of plans as of August 1999.

Access to M+C Organizations. Overall access to M+C options will decline slightly in the year 2000, as it did in 1999 as a result of terminations and service area reductions. In 1998, 72% of beneficiaries had access to one or more M+C organizations; in 1999 the percentage declined to 71%, and for 2000 the percentage will decline to 69% (a figure based on currently approved plans and which will increase as new applicants enter the program). In 2000, the total number of counties with plans is declining from 27 percent to 25 percent.

⁴The data in this paragraph pertain only to contract terminations, not to service area reductions because we do not have complete historical data on the number of beneficiaries affected by service area reductions.

Despite volatility in the marketplace, new organizations continue to come into the program. Since July 1998, 42 organizations have been approved for participation or expansion in the program. As of August 1999, there are 13 pending applications from organizations seeking new Medicare+Choice contracts and nine requests for service areas expansions. Over 50% of the counties included in these applications now have no Medicare+Choice plans. If approved, these applications would bring Medicare+Choice access to an additional 1.5 percent of beneficiaries. For 2000, 262 organizations will continue their M+C contracts with Medicare. With the additional 13 new applications, the number of contractors operating in 2000 would be at least 275, resulting in a net decrease of 10% in the number of contractors between 1999 and 2000—a lower rate of net decline than occurred in the years 1987 to 1991.

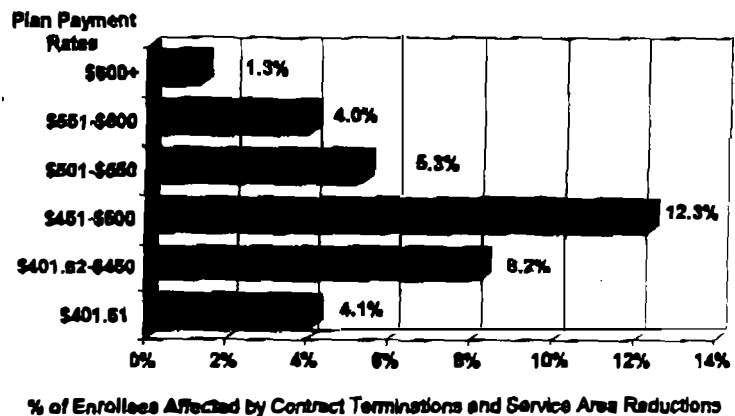
Access Differences in Rural Areas. The decisions that M+C organizations have made in 1999 to reduce their participation in the Medicare program have had different effects in rural versus urban areas. While 83 percent of urban beneficiaries will have access to Medicare+Choice plans in 2000 (versus 86 percent of urban beneficiaries in 1999), in rural areas only 21 percent of rural beneficiaries will have access to an M+C plan, down from 23 percent in 1999. That is, while in urban areas access will decline by about 4 percent, in rural areas access will decline about 10 percent.

However, it is also the case that the most recent new applicants and organizations requesting service area expansions are expanding predominately into rural areas. Focusing exclusively on expansions into counties in which there were no M+C plans in March of 1999, about 400,000 beneficiaries, and 87 counties, are gaining new M+C plans. Of the 400,000 beneficiaries, 47% were residents of rural areas; and 84% of the counties in which expansions are occurring are rural counties. Only three of the 87 counties will have an M+C payment over \$450 in the year 2000 (with 2,200 enrollees in the three counties). The 400,000 beneficiaries represent only one percent of the total number of beneficiaries, but the 200,000 rural beneficiaries who will have an M+C plan represent 2.2% of rural beneficiaries. Looking at all counties for which this at least one pending request for inclusion in an M+C service area, including those counties in which there are already operating organizations, 51% of the applications are for rural counties. The average payment rate for all counties (unduplicated)

with a pending request for inclusion in the service area of a new or existing organization is \$466 for the year 2000.

Medicare Revenue and Its Relation to Non-Renewal Decisions. Contrary to assertions by some industry sources, the level of M+C payment to organizations does not explain decisions to discontinue participation in the program.

Organizations are primarily leaving counties where year 2000 payment rates are between \$451 and \$500, and not primarily counties with the lowest payment rates. Only 4 percent of enrollees in counties with the Year 2000 floor payment rate of \$401 were affected, vs 12 percent in counties with payments ranging from \$451 to \$500. That is to say, among Medicare beneficiaries enrolled in M+C organizations operating



in "floor" counties, 96% can retain their current M+C plan in the year 2000. Enrollees in counties with the highest payment rates, where organizations are paid far more than the cost of providing Medicare benefits, were less likely to be affected. Only 1.3 percent of organizations are leaving counties where payments are \$600 or higher.

Payment is rising in all counties this coming year by an average of 5% (the average weighted by county Medicare beneficiary populations), by at least 2 percent, and by as much as 18% (an Alaska county). These increases result from Balanced Budget Act reforms designed to bring more plan choices to beneficiaries and level the playing field by increasing payment in counties that had the lowest rates. Yet counties receiving some of the largest increases under the BBA payment system are experiencing the most disruption. Organization withdrawals are affecting 7.2% of enrollees in counties where rates are rising by 10% or more, but only 2.4% of enrollees where rates are rising by

2%.

In addition to M+C payments from HCFA, another source of revenue for M+C organizations is the collection of premiums and other cost sharing from Medicare enrollees. The relation between the availability of a zero premium plan and the level of payment in a given county remains virtually unchanged between 1999 and 2000. If Medicare payments were insufficient for the revenue needs of organizations, one would expect to see a rise in the average payment level among organizations charging no premium; that is, counties with lower payment levels should have a decrease in the number of zero premium plans between 1999 and 2000. The data do not show such a change. In fact, there has been a slight decrease in the average payment level for counties with zero premium plans for both urban and rural areas, as shown in the table below.

**Average HCFA M+C Payment
for Counties with at Least One \$0 Premium Plan**

	1999			2000		
Simple Average	\$500.36	\$450.49	\$483.88	\$499.08	\$445.02	\$483.39
Weighted Average	\$539.47	\$455.72	\$534.41	\$535.05	\$449.88	\$531.57

Other Factors Leading to Non-Renewal Decisions. In its analysis of the M+C terminations and service area reductions occurring at the end of 1998, the General Accounting Office concluded that a variety of factors other than payment rates played a role in the decisions organizations make regarding continued participation in the M+C program. Given that payment cannot be directly correlated with such decisions regarding M+C contracts for the year 2000, other factors must have played a large role in the decisions made by M+C organizations. Among the factors that appear to have influenced organization decisions in both 1998 and 1999 are M+C enrollment levels in each contract, share of the local M+C market, and the ability to maintain provider contracts and assure accessibility of care, as well as strategic business decisions by particular organizations.

The case of CIGNA illustrates many of the factors that enter into a decision to leave a health care

market, in particular the effect of enrollment numbers and market share. CIGNA terminated six M+C contracts and reduced services areas for four other contracts. The terminated contracts served 43 counties with average payments of \$533 for 2000. The enrollment-weighted average payments for the 43 counties (weighted by current CIGNA enrollment) would have been \$500 in 2000. The 43 counties included three counties with payments over \$600, but in those three counties CIGNA never enrolled any Medicare members. The 43 counties also included 24 counties in which CIGNA had fewer than 100 Medicare enrollees in each of the 24 counties. CIGNA's average share of the M+C market (percent of M+C enrollees within a county who were CIGNA enrollees) in the 43 counties was 6 percent. CIGNA's M+C market share exceeded 10% in only four of the 43 counties, and in those four counties CIGNA's average county enrollment was only 845 beneficiaries. Thus, in the case of CIGNA, the decision to terminate Medicare contracts primarily reflects a limited market presence in M+C. The same appears to be true of the counties that have been dropped from M+C contracts that CIGNA will retain (service area reductions). CIGNA had an M+C market greater than 7% in only one of the 14 service area reduction counties. CIGNA's termination and service area reduction decisions affected 12% of CIGNA's M+C enrollees, leaving CIGNA with about 134,000 enrollees as of January, 2000 (ignoring any enrollment increases between now and 1/1/2000).

Different factors appear to have been involved in the business decisions of the largest Medicare contractor, PacifiCare. PacifiCare had fewer than 1% of its M+C enrollees affected by terminations or service area reductions. The PacifiCare termination involved a contract that included only one county, in which PacifiCare had a 24% M+C market share, but the county is a floor payment county (\$401.61 payment in 2000). PacifiCare's service area reductions involved counties in which the organization had an average market share of 23%. However, small numbers were involved. The average number of enrollees in the affected counties is under 1500 (and the average payment level is \$494).

Kaiser is withdrawing from markets in eastern and southern States for both M+C and other lines of business. The organization is terminating the M+C contract of its Capital Area Community Health Plan in upstate New York. A comparison between that contract and Kaiser's M+C contract in

Oregon shows that the M+C characteristics are very similar: each has small enrollment, relatively low payment rates, modest benefit packages, and substantial market share (particularly Capital Area), yet one of the contracts is not being renewed. That is to say, although the HMOs' revenues and benefit structure are similar in each location, other factors appear to have led to a decision not to renew one of the contracts.

	Enrollment (mid-1999)	M+C Market Share	Weighted Monthly Average M+C Payment, 1999	Weighted Monthly Rate Premium for Service Area	Pattern of Benefit Growth (1990)
Kaiser of the Northwest	35,000	26%	\$394	\$75	unlimited but 70% coinsurance
Capital Area	17,000	73%	\$419	\$25	annual limit of \$500, \$1000 varying by county

The role of provider contracting and sustaining viable networks is more difficult to quantify. However, a number of organizations have made reference to their inability to maintain viable networks in their public statements regarding termination decisions. For example, the Group Health Cooperative in Washington State announced that it was discontinuing operations (for all lines of business, Medicare and others) in eleven rural counties in the State—the first time in the 52-year history of the organization that it has taken such an action. The organization's press release cited its inability to maintain a viable provider network as a contributing factor.

Parallels in the Private Sector. Program withdrawals, reduced benefits and premium increases are not unique to Medicare. They reflect the industry-wide difficulty organizations have faced in the last few years in controlling costs while attempting to maintain profit levels or margins. The downturn in the fortunes of managed care organizations have been widely reported in the financial and trade press, and are clearly evident in the steep rises in premiums and in the business decisions that health

plans are making.

Volatility in the marketplace is not confined to Medicare. There are many examples of health plans withdrawing from markets other than Medicare. Pacificare is withdrawing both Medicare and commercial service in several Washington State counties. As noted above, Group Health Cooperative is pulling out of both Medicare and non-Medicare markets in 14 counties in eastern Washington and northern Idaho, citing a variety of reasons for their decision. And in the east, Kaiser Permanente is withdrawing from Medicare, Medicaid, and its commercial business, affecting about 500,000 enrollees. Kaiser has specifically said that its withdrawal from these market cannot be attributed to changes in Medicare payments.

Over the last two years, the Federal Employees Health Benefits Program, which covers 9 million people, has seen the same kinds of changes that the M+C program has experienced. At the end of 1998, about 20 percent of participating HMOs withdrew from the FEHBP program. At the end of 1999, it is expected that about 13 percent of plans will withdraw from FEHBP. Premiums in FEHBP increased by slightly over 10 percent for 1999 and by 8.5 percent for 1998, and increases for 2000 will average 10%.

There also are many examples of health plans raising premiums and reducing benefits in other markets. The California Public Employees Retirement System (CalPERS), which covers over 1 million people, agreed to an average premium increases of 7.3 percent for 1999 and more than 9.7 percent for 2000—the largest premium increases in CalPERS since 1991.

HCFA actuaries are predicting increases of nine percent in private health plan premiums for the year 2000. According to Towers-Perrin, large employers experienced a 7 percent increase in average health insurance premiums for active workers in 1999, owing to “unusually sharp increases in prescription drug costs and a health care market that continues to experience rising demand for services from an aging population.” One finding in the survey was that rate increases for HMO products in 1999 equaled or exceeded the increases for traditional indemnity plans.

It is essential to note that the large increases now common in the private sector follow several years when private sector increases were quite small--the so-called "underwriting" cycle. In those same years Medicare increases were two to three times higher than private sector increases, and in fact some financial analysts have pointed out that Medicare revenues subsidized premiums of other payers. Those years of excessive Medicare payment increases greatly contributed to the ability of organizations to provide generous extra benefit packages.

PRESIDENT'S PLAN WILL IMPROVE MEDICARE+CHOICE

Volatility in the Medicare+Choice market underscores the importance to enact the President's Medicare reform plan. It will increase protections for beneficiaries when plans withdraw from the program, ensure that plans receive full payment of market-based rates, and guarantee that all beneficiaries have access to affordable prescription drug coverage.

Clearly all beneficiaries need a more stable and reliable source of prescription drug coverage. And, if plans' primary problem is paying for benefits beyond the Medicare benefit package, the best solution is to improve the benefit package by providing all beneficiaries with access to an affordable prescription drug benefit, and paying plans explicitly for what most now offer only in areas where payments are excessive.

The President's plan gives all beneficiaries the option to pay a modest premium for a drug benefit. This benefit will cover half of all prescription costs up to \$5,000 when fully phased in, with no deductible -- all for a premium that will be less than half the price of the average Medigap policy.

Medicare+Choice plans would be explicitly paid for providing a drug benefit under the President's plan. They would no longer have to depend on what the rate is in a given area to determine whether they can offer to do so. Thus, plans would continue to be able to expand the standard Medicare drug benefit if they choose to do so.

The President's plan also will modernize the way Medicare pays managed care plans. Rates would be set through competition among plans rather than through a complicated statutory formula, as they are today. All plans would be paid their full price through a combination of government and beneficiary payments. The lower the price, the less beneficiaries pay since the beneficiary contribution rate declines relative to the price of the plan, as in the Federal Employees' Health Benefits Program. Beneficiaries choosing plans that cost approximately 80% of traditional fee-for-service will pay no Part B premium.

The President's plan will preserve beneficiary options and strengthen protections when plans withdraw from Medicare by:

- giving beneficiaries access to all Medigap plans regardless of preexisting conditions, including those with prescription drug coverage;
- expanding the Medigap 6-month open enrollment period to newly disabled beneficiaries and those with end stage renal disease;
- allowing beneficiaries with end stage renal disease to enroll in another plan;
- mandating a special one-time additional Medigap open enrollment period for beneficiaries who were affected by a plan termination last fall; and
- increasing civil monetary penalties of up to \$50,000 per violation plus \$5,000 per day per violation of the Medigap open enrollment requirements.

All these changes will strengthen and stabilize the Medicare managed care market.

The President's plan also dedicates 15 percent of the budget surplus to Medicare for the next 15 years. This will assure the financial health of the Medicare Trust Fund through at least 2027, and help ensure that Medicare+Choice plan payment rates will be adequate well into the future.