The Landscape of Private Firms Offering Medicare Prescription Drug Coverage in 2006

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EXECUTIVE SUMMARY

As Medicare's new prescription drug benefit rolls out this year, beneficiaries who want to take advantage of it must enroll in a private plan. Options include stand-alone prescription drug plans (PDPs) for beneficiaries covered under the traditional Medicare program or Medicare Advantage (MA) plans that integrate prescription drug coverage with other Medicare benefits. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) authorized new types of MA plans and modified plan payment rates to provide incentives for firms to offer such products. The MMA also modified federal requirements for Medigap plans, prohibiting the sale of any new policies that include prescription drug benefits starting in 2006.

This issue brief describes the characteristics and features of organizations offering the Medicare drug benefit including stand-alone PDPs as well as MA plans, analyzes selected features of the current market, and discusses implications for understanding strategies and marketing approaches used by firms contracting with Medicare. The analysis is based on public data available from the Centers for Medicare and Medicaid Services (CMS) for 2006 and over time, and narrative information posted by firms on their company websites.

KEY FINDINGS:

- Though public attention has focused on the large number of PDPs available in 2006, the number of organizations sponsoring PDPs is relatively small. Only ten organizations are sponsoring national PDPs, and these account for 62 percent of all PDPs nationwide. Most of the rest are affiliated with four near-national organizations that operate plans in 30 or more regions.

- Of the ten organizations sponsoring national PDPs, seven are based in commercial insurance firms that have substantial MA experience. The other three national sponsors are firms in the pharmacy benefits management (PBM) and services sector. Nine of the ten firms offering national PDPs (all but Wellcare), either offered a prescription drug discount card in 2004-2005 or partnered with a firm that did. Thus, the discount card program appears to have helped to position organizations for 2006.

- Most of the major firms that historically have dominated the MA program expanded their offerings substantially in anticipation of 2006. Humana, UnitedHealthcare, PacifiCare (which recently merged with UnitedHealthcare) and Blues' affiliates seem poised to compete most aggressively on a national scale for new Medicare business in 2006. Each is offering PDP and MA plans designed to appeal to a range of beneficiaries.

- The diversity of firms sponsoring PDPs and MA plans in 2006 is consistent with the complexity of the existing Medicare supplemental market, which includes products for the individual private market (Medigap, MA), group market (retiree health benefits), and Medicaid. Each of these sectors is affected by provisions of the MMA, creating both new opportunities for growth and risks to current lines of business.

Firms sponsoring PDPs and MA plans likely are doing so for a combination of proactive and defensive reasons.

- Marketing strategies used by firms to gain PDP enrollment are likely to vary with the market segment their plans target. For example, advertising and direct marketing may be virtually irrelevant to a firm whose main goal is keeping its current membership base. In addition to direct-to-consumer advertising—the traditional way to gain new MA enrollment—firms also are developing exclusive and nonexclusive relationships with insurance agents and brokers and are leveraging relationships with pharmacies in 2006.

The diverse characteristics of PDP and MA sponsors are important factors in understanding the Medicare private plan market and the forces that are shaping it. Each of the firms sponsoring PDPs and MA plans has its own unique organizational features, product lines, and market objectives. They also have different historical roles in the Medicare supplemental market. These organization-specific attributes and the interests they generate influence the goals each firm has for its PDP and MA offerings and the metrics each uses to gauge success. Current plan offerings also represent a mixture of short-term defensive actions and potentially more stable strategies. In some cases, for example, firms may be hedging their bets in 2006 to provide flexibility so that their business will be protected if the new drug benefit reconfigures the market for Medicare supplemental products.

Understanding these dynamics is important not only for predicting future behavior of firms, but also for assessing the implications for public policy and for beneficiaries. The decision of the relatively small number of organizations sponsoring most PDP and MA plans, are likely to drive the market, affecting the number and scope of choices available to beneficiaries in the future.

INTRODUCTION

When Congress gave authority for Medicare's new prescription drug program through private prescription drug plans (PDPs), few anticipated a high level of private-sector response. Indeed, the legislation itself included a fall-back option where the government would directly contract to administer the program on its behalf if there were not at least two eligible private plan sponsors available to beneficiaries in each region of the country. This fall-back option has proved irrelevant in 2006, with beneficiaries having more than sufficient choice to meet the statutory test (KFF, 2005a).

This issue brief analyzes the characteristics and features of private organizations that are participating in Medicare's new prescription drug program in context of their overall business. It also highlights selected features of the current market. Our analysis is based primarily on publicly available plan information from the Centers for Medicare and Medicaid Services (CMS) and on information firms post on their websites.[1] The brief also draws on our historical experience analyzing private firms involved in the Medicare Advantage (MA) program.

The issue brief is organized with background on the Medicare prescription drug program first, followed by analysis of PDP sponsors and how they compare to sponsors in the MA program. The paper then discusses selected characteristics of the emerging market and its implications for understanding firm strategies and marketing approaches. It concludes with a discussion of the implications of the emerging private marketplace in Medicare for beneficiaries and for policy.

[1] Sponsors' websites were reviewed in the Fall of 2005 when firms were beginning to market their products. Since then, firms have likely further refined their collaborations with other organizations and potentially modified earlier reported arrangements. Hence, the examples cited in this brief are illustrative and do not necessarily reflect a complete account of sponsors' current strategies and positioning.

PROGRAM BACKGROUND

Medicare's new drug benefit is the cornerstone of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (U.S. Congress, 2003). Effective January 1, 2006, the benefit represents a major expansion of Medicare, which previously provided limited drug coverage in selected circumstances (KFF, 2005a). Beneficiaries who wish to take advantage of the benefit must enroll in a private plan. The MMA authorizes new private stand-alone PDPs for beneficiaries who get their other Medicare covered benefits through the traditional Medicare program. Beneficiaries also can get drug coverage through private MA plans that integrate prescription drug benefits with other Medicare-covered benefits, and sometimes supplemental services. Multiple types of MA plans are authorized including local health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, regional PPOs, and special needs plans (SNPs). Service areas for each of these, except regional PPOs, are defined on a county-by-county basis, which is why they are often called local plans.

Because almost nine in ten Medicare beneficiaries are in the traditional program, most are likely to select a PDP—at least initially—if they choose to enroll in the prescription drug program. To encourage entry of PDPs, the MMA authorizes the federal government to share risk with PDP sponsors for catastrophic coverage and to limit private firms' risk for the basic benefit. CMS requires PDP sponsors offer drug coverage to all beneficiaries in one or more of the 34 regions CMS defined based on aggregations of states.[2,3] Ten insurers offering PDPs were

[2] In addition, Puerto Rico and the territories were each defined as separate regions. This issue brief focuses primarily on choices within the 50 states and the District of Columbia that comprise the 34 PDP regions.

[3] A smaller number of MA regions (26) were defined; these are identical to PDP regions or involve aggregations of them. (Regional PPO plans' service area are defined by these regions.) All organizations wishing to sponsor either a PDP or an MA plan with prescription drug coverage had to file a notice of intent by March 23, 2005 and provide bid information by June 6, 2005 (Kaiser Family Foundation, 2005b).

approved by CMS as national plans serving all 34 regions while others were approved to serve fewer or only one region. The lowest number of organizations sponsoring PDPs in a region is 11 in Alaska and 12 in Hawaii. The rest of the country is served by 15 to 21 PDPs. In most locations, beneficiaries also have MA choices (Gold, 2006). Regional PPOs must include prescription drugs in all their plans, and local HMOs and PPOs must cover them in at least one plan. Such coverage is optional in MA's PFFS plans, so beneficiaries who choose to join such a plan will be allowed to get it in a free-standing PDP**.**

All sponsors of prescription drug plans must provide at least the standard Medicare drug benefit or an actuarially equivalent plan. Most sponsors also provide enhanced benefits. MA plans that cover prescription drugs may offset the cost of the benefit with savings from their capitation rates for traditional Medicare benefits.[4]

Implementation Timeframe

Organizations began marketing their PDPs and MA plans October 1, 2005, and beneficiaries began enrolling November 15, 2005. The enrollment period for current beneficiaries ends May 15, 2006.[5] The MMA also transfers responsibility for prescription drug coverage for those dually eligible for Medicare and Medicaid to Medicare effective January 1, 2006 and establishes a subsidy program to offset Medicare premiums and cost-sharing requirements. Dual eligibles and some beneficiaries with low incomes and limited assets are eligible for additional subsidies. The Low-Income Subsidy (LIS) Program limits premium coverage to a subset of PDPs that

[4] The MMA increased payments for MA plans effective 2004 to encourage firms to participate in the program. As a result, firms typically are receiving more, sometimes substantially more, than Medicare pays for similar beneficiaries in the traditional Medicare program (Berenson, 2004; Biles et al., 2004; Gold, 2005). These policies have influenced MA participation in 2006 and any changes will likely affect firms' future participation (Biles, Dallek and Nicholas, 2004).

[5] Those enrolling after May 15, 2006 will have to wait until 2007 and may incur a penalty for late enrollment that will continue throughout their time in the program. Those with drug coverage at least as good as Medicare's, such as through a retiree's former employer, will not be subject to a penalty.

qualify because their premiums are below the low-income subsidy benchmark for the region.[6] LIS-eligible beneficiaries who do not select a plan on their own will be assigned by June 2006 to a qualifying plan. Dually eligible individuals were assigned to PDPs before the start of the program to avoid a lapse in benefits. Though MA plans are available to LIS-eligible beneficiaries, they, like other beneficiaries, must choose them on their own; they are not assigned.[7] Because of the uncertainty surrounding the level of voluntary enrollment in the new Medicare drug benefit, eligibility for LIS assignments may have a major effect on enrollment levels across PDP sponsors. Higher enrollment can offset fixed costs of developing and operating a PDP. Some firms, however, may wish to avoid this market segment for a variety of reasons including concerns over risk adjustment or administrative complexity.

MMA's Effect on Choice

The new prescription drug benefit includes requirements that define the choices available to beneficiaries. For example, MA enrollees who wish to take advantage of Medicare's prescription drug coverage must do so through their MA plan. They cannot enroll in both an MA plan and a PDP. PFFS plan enrollees are the exception to this rule because PFFS plans are not required to cover prescription drugs. Sponsors of all other MA plan types are required to offer at least one plan that covers prescription drugs.

[6] The benchmark takes into account both PDP and MA premiums for drug benefits, with the latter weighted by their share of enrollment. Beneficiaries can enroll in plans with premiums above the benchmark, but they must pay the difference between the benchmark and the higher premium.

[7] A limited exception occurs when a dually eligible beneficiary already is enrolled in a Medicaid managed care plan that participates as a SNP in Medicare. These dually eligible individuals may be passively enrolled in their current plan but they can switch. According to the *Pittsburgh Gazette*, about 200,000 beneficiaries are in this situation nationwide, 110,000 of them in Pennsylvania where a suit is pending on this issue (Fahy, 2005). CMS indicates that a total of 626,214 of the 6.1 million dual eligibles they have identified will receive coverage either through an MA plan, their existing cost plan, a Program of All-Inclusive Care for the Elderly (PACE) organization, or a Medicare demonstration project (CMS, 2005).

The MMA also limits prescription drug coverage in Medigap plans. Starting in 2006, Medigap sponsors may not enroll beneficiaries in Medigap plans with prescription drug coverage (standardized Medigap options H, I, J). Beneficiaries currently enrolled in such plans may continue and renew, but they cannot enroll in the new Medicare drug benefit and remain in their current Medigap plan. If beneficiaries want to switch later from Medigap drug coverage to the Medicare benefit, they likely will have to pay the late enrollment penalty because most Medigap plans with drugs do not have benefits that equal or exceed the value of the standard Medicare drug benefit (i.e., they do not provide "creditable coverage"). The MMA also authorizes two new Medigap plans that modify current options for filling in Medicare's cost sharing. Because these changes affect the Medigap market, they likely have influenced how Medigap insurers respond to the new PDP and MA options.

PDP SPONSORS

Number of Organizational Sponsors

Though considerable press and other attention have focused on the large number of PDP plans (1,429), the number of organizations sponsoring PDP plans is actually much smaller (Table 1). Ten organizations sponsor national drug plans that operate in each of the 34 regions. All but one of these organizations offers at least two PDP plans per region; most offer three. These ten firms account for about 62 percent of all PDPs nationwide. Most of the rest of the plans are sponsored by a few additional organizations that offer plans in many regions. Six organizations are associated with plans that serve 30 or more regions and can be considered "near national."[8] An additional ten organizations serve more than one region but less than 30. Two of the three largest of these are firms that also sponsor national PDPs. The remaining single region

[8] There are four such PDP options but a total of six organizations are involved because the Prescription Pathways plan is sponsored by three insurance companies offering plans under their own brands.

organizations account for 61 plans and are a mix of state Blue Cross-Blue Shield (BCBS) organizations and other firms. This suggests that the large number of PDP choices available to most beneficiaries really reflect the decisions of a far more limited set of firms that are likely to have a disproportionate influence on the stability of the program.

TABLE 1

PDP PLAN SPONSORS BY GEOGRAPHIC SCOPE OF PLANS OFFERED, 2006

Sponsor	Number of Regions with Any PDP	Number of Regions with LIS-Eligible Plan	Number of Plans	Mean Plans/ Region	Percent of Beneficiaries with Available Plan
National	34	34	886	2.6	100
Aetna	34	6	102	3	100
Cigna	34	7	102	3	100
Coventry (Advantra)[a]	34	10	102	3	100
Medco	34	19	34	1	100
MemberHealth	34	23	102	3	100
PacifiCare	34	31	102	3	100
Silver Script	34	27	68	2	100
UnitedHealthcare	34	33	68	2	100
Well Care	34	33	102	3	100
Wellpoint UniCare[b]	34	34	102	3	100
Multi-Regional, Near-National (30+ Regions)					
Humana	31	31	93	3	99
Sterling	32	0	32	1	89
United American	31	3	31	1	96
Prescription Pathway Affiliates					
Pennsylvania Life[c]	31	25	102	3	96
Marquette[c]	22	0	66	3	75
Progressive Life[c]	8	1	23	3	21
Other Multi-Regionals					
Ameri-Health	8	8	11	1.4	50
Fox Insurance	4	0	4	1	8
Health Net	6	6	12	2	20
Health Spring	4	4	4	1	12
Rx America	20	13	40	2	50
Sierra	8	8	8	1	19
Health Care Services Corporation[d]	3	2	9	3	9
Coventry – First Health[a]	13	13	13	1	56
Wellpoint – Anthem[b]	12	12	36	3	53
Instil[d]	2	2	4	2	3
Single Region					
BCBS Affiliated	12	7	27	2.3	21
Other	21	9	34	1.6	31

Source: MPR analyses for KFF of CMS data on PDPs in the Excel Spreadsheet released October 13, 2005. Firm coding by MPR based on various sources of information.

[a] Coventry offers a national PDP product and a separate multi-regional product. Only the latter are LIS eligible.
[b] Wellpoint offers a national PDP through its UniCare product and a multi-regional PDP through Anthem, which recently merged with it. The UniCare product is a BCBS licensed product in some states.
[c] Pennsylvania Life, Marquette and Progressive Life have collaborated to sponsor the Prescription Pathway Plan. Each firm offers it separately through its brand. The combined counts of all three firms exceed the Prescription Pathways total because some plans share common identifiers.
[d] Part of organizations that are BCBS affiliates though Instil is not being offered through a BCBS branded company.

National Sponsors

The ten firms sponsoring national PDPs are offering plans either on their own or in collaboration with partners that round out their capabilities to administer the product. Seven of the ten national PDP sponsors have a base in commercial insurance, and all have some experience in MA. Three of the seven are major participants in the MA market—Aetna, PacifiCare, and UnitedHealthcare, and the rest—Cigna, Coventry, Wellpoint, and Wellcare—have some presence in the market. Some of the firms are partnering with a pharmacy benefits management (PBM) firm for their PDP product (e.g., UnitedHealthcare is partnering with Walgreen's PBM and Cigna with Nation's Health). Others have internally affiliated companies that perform the same function (e.g., Aetna, PacifiCare). With the exception of WellCare, all of these companies either offered a Medicare prescription drug discount card or partnered with a firm that did. These actions may have been a strategy used to position their organizations for the drug benefit in 2006.[9]

Mergers have influenced the PDP sector of the market and may continue to do so. Wellpoint, for example, recently merged with Anthem, which offers separate PDP products in 12 regions in 2006.[10] Coventry offers a national PDP under its Advantra label in all regions and under its First Health Premier label in 13 regions. PacifiCare and UnitedHealthcare recently merged, which could influence their PDP offerings in 2007.

The other three national PDP sponsors are firms in the pharmacy benefits management (PMB) and services sector. Each also has prior experience with the Medicare drug discount card. Medco and Silverscript (a Caremark Company) are major PBM companies that provide

[9] The card was a temporary measure for 2004-2005 authorized by the MMA to give beneficiaries access to lower priced drugs; low-income beneficiaries also received a subsidy to offset the cost of their drugs.

[10] Because these two sets of plans are owned by the same company, Wellpoint and Anthem are treated as a single unit for the purposes of auto-assignment within each region. Under the algorithms used by CMS, beneficiaries subject to autoenrollment are first randomly assigned by firm and then within a firm, randomly across eligible PDPs.

services to group purchasers, managed care plans, and others.[11] MemberHealth is a partnership model between Community Care outreach services (a network of 20,000 licensed insurance brokers with Medigap enrollment) and the National Community Pharmacists Association with 25,000 independent retail pharmacies.

Near-National PDP Sponsors

The near-national PDP sponsors are insurance companies with varying amounts of prior experience with Medicare. Humana, which is partnering with Argus Health Systems for pharmacy benefits management in its PDP, is a major sponsor of MA plans including a range of new MA products in 2006. Sterling, the first insurance company to offer PFFS in Medicare, has a PFFS MA plan with limited total enrollment (under 30,000 nationwide) and is offering its plans more widely in 2006. Marquette, Pennsylvania Life, Progressive Life and United American are offering PDP products through affiliated insurance agents/brokers as one of several products geared toward the senior market. United American indicates on its website that data from the National Association of Insurance Commissioners shows the company among the top five firms in Medigap revenue in 2003.[12] The other three of these companies are collaborating on a single offering (Prescription Pathways) that is being offered as distinctly branded plans by each of the companies.

[11] Medco's product is called YOURx PLAN. It is being underwritten by Medco Containment Insurance Co. in New York, and by Medco Containment Life Insurance Company in other states. Based in Nashville Tennessee, Caremark started as a division of Baxter Healthcare Corporate in late 1978, was spun off as a separate company in 1992, and merged with another major PBM, Advance PCS, in 2003.

[12] According to the website, the top carrier is UnitedHealthcare (the AARP supplier) with $3.6 million in direct premiums earned in 2003, for a 20 percent market share (www.unitedamerican.com/news-naic.asp).

Other Multi-Regional PDP Sponsors

Of the other multi-regional PDP sponsors, RX America, which focuses on PBM and mail order services, has the largest scope. The company was formed through various mergers involving American Drug Stores, Integrated HealthConcepts, Long's Drug Stores, and others. It is sponsoring plans in 20 regions that include 50 percent of the Medicare population. The rest of the firms are based in the insurance sector. Health Net, HealthSpring, and Sierra have MA experience in selected regions of the country. AmeriHealth's base is in Medicaid managed care products.

Role of Blue Cross-Blue Shield Affiliates

Blue Cross and Blue Shield Association (BCBSA) affiliates share a legacy of brand identity, local roots, stability, and broad provider networks that have historically made them a prominent insurer nationwide (Cunningham and Sherlock, 2002). The Blues remain dominant today despite mergers and for-profit conversions that rearranged traditional state affiliations and weakened some local roots; total national enrollment across all products and age groups reached a high of 88.3 million in mid-2003 (Grossman and Strunk, 2004). BCBS-affiliated organizations are likely to play a major role in the prescription drug program even though the state focus of their affiliates means that the Blues overall account for a relatively small share of PDPs (Table 2). In its summary of Blue-affiliated MA and PDP plans, BCBSA (2005) indicates that PDPs are being offered by its affiliated organizations in all but nine states (Alabama, Alaska, Arizona, Hawaii, Mississippi, New York, Oregon, Tennessee, and Washington). Wellpoint, which is sponsoring a national PDP as well as multi-regional PDPs, is a Blues licensee in 27 of the 34 regions it covers under the UniCare label and all 12 of the regions under the Anthem label. Health Care Services Corporation is a Blues-affiliated organization offering plans in three regions. BCBS affiliates also are offering single region plans in 12 regions.

TABLE 2

BLUE CROSS – BLUE SHEILD AFFILIATED PLANS

All BC/BS	Number of Regions	Number of Plans
Wellpoint – UniCare	27	79
Wellpoint – Anthem	12	36
Health Care Services Corporation	3	9
Single Regional Affiliates	12	27

Source: MPR analysis of CMS data. BCBS information on firm affiliates.

BCBS-affiliated companies often have a strong market position in their localities where they also may be a dominant Medigap insurer. As such an insurer, they are likely to want to retain their Medigap business, especially beneficiaries who join a PDP and drop Medigap options that cover prescription drugs. Affiliates also, to varying degrees, sponsor MA plans. Thus, while these companies may only be of relevance individually to specific states, they could account for a sizeable share of the PDP enrollment by beneficiaries in those states. And because BCBS firms are sponsoring PDPs in most parts of the country, their combined market share could be significant.

FIRMS IN THE MEDICARE ADVANTAGE MARKET

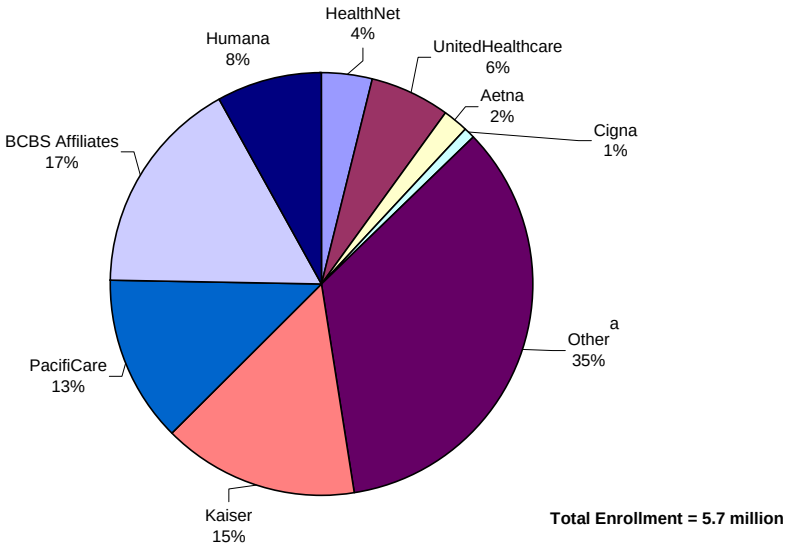
Historical Market Position

While there will be some new entrants in the MA market in 2006, most firms have a history with the program. Historically, the MA market has been relatively concentrated with a small number of firms that account for a large share of the enrollment (Draper, Gold and McCoy, 2002). About two thirds of all MA enrollees in September 2005 were either in plans from six national firms or from BCBS-affiliated organizations (Figure 1).[13] The three largest firms in

[13] These same organizations accounted for 63 percent of enrollment in 2001 (Draper, Gold and McCoy, 2002).

FIGURE 1

SHARE OF MA ENROLLMENT BY FIRM, SEPTEMBER 2005



Source: MPR analysis of CMS data from the Geographical Service Area file with MPR coded firm name.

[a]Though natioanl firms like Sierra, Sterling, and Coventry are included in this total, most of the enrollment is in local MA plans, often with a long history in particular markets.

the market are affiliated with the Blues, Kaiser, or PacifiCare, and together account for almost half of all MA enrollment. Each of the seven major organizations or affiliates, with the exception of Kaiser—which has a unique care delivery model—are offering a PDP in 2006. These MA firms account for half of the organizations sponsoring national PDPs and one near-national PDP.[14]

The same firms have dominated the MA market before and after the MMA was enacted. Enrollment levels are generally lower than in 1999, which was the height of Medicare enrollment in private plans (Table 3). Kaiser and BCBS-affiliated organizations are the exceptions and have higher enrollment in 2005 than in 1999. Aetna and Cigna have a much more limited role in the

[14] Aetna, Cigna, PacifiCare, and UnitedHealthcare are each offering a national PDP. Wellpoint, which is Blues-affiliated in most of its regions, also is offering a national PDP under its Unicare label. Humana is a near-national PDP.

TABLE 3

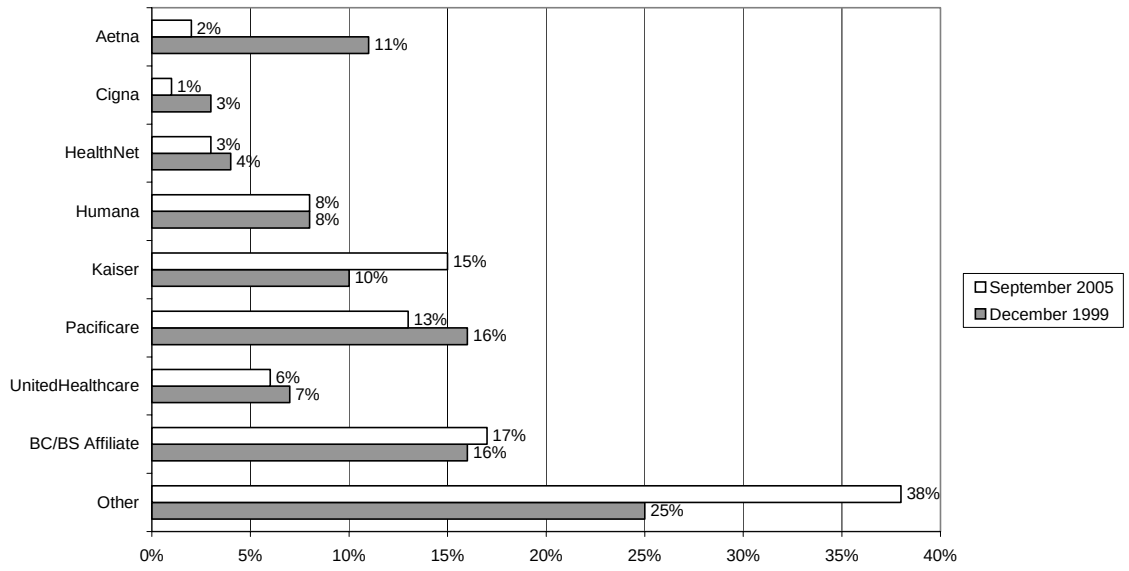
TRENDS IN MEDICARE ADVANTAGE ENROLLMENT, BY FIRM

		MA Enrollment			
	Medicare+Choice Enrollment 1999	March 2004	March 2005	September 2005	Net Change 2004 – 2005
Total Enrollment	6,190,371	5,085,161	5,426,316	5,671,480	+12%
Aetna	685,193	95,134	99,841	101,206	+6%
Cigna	189,841	60,772	57,357	56,825	-6%
HealthNet	262,795	186,410	191,127	197,495	+6%
Humana	475,560	360,826	392,195	437,254	+21%
Kaiser	644,884	832,853	859,604	873,224	+5%
PacifiCare	992,912	686,039	715,023	731,537	+7%
UnitedHealthcare	433,288	250,947	292,576	320,411	+8%
BCBS Affiliate	961,557	981,343	973,914	976,046	-1%
Other	1,544,341	1,763,136	1,994,199	2,133,909	+21%

Source: MPR analysis of CMS data; firm coding is by MPR.

MA market now than they did in 1999 (Figure 2). Though Humana's enrollment is below 1999 levels, it has increased more rapidly than other firms since the MMA was enacted (21 percent), and its market share has risen from 7.1 percent to 7.7 percent in the 18-month period measured. Each firm's dominance stems from its HMO product, which still reflects most MA enrollment (Table 4). However, UnitedHealthcare and BCBS affiliates now have substantial PPO enrollment, and Humana is active in the PFFS sector. Though national PDP sponsors Coventry and Wellcare participate in MA, their enrollment is relatively limited despite recent growth. Though national firms dominate over all enrollment, there are large local MA plans with a long history in particular markets (e.g., Harvard Pilgrim and Group Health Cooperative of Puget Sound). The decline in enrollment by many national firms in 1999 also means that these "other" plans, many local, account for a larger share of the market (38 percent) in 2005.

FIGURE 2
SHARE OF MA MARKET BY FIRM 1999-2005



Source: MPR analysis of CMS data; dirm coding is by MPR.

TABLE 4

MA FIRM ENROLLMENT BY PRODUCT, SEPTEMBER 2005

	All		HMO		PPO		PFFS	
	Number	% of Total	Number	% of Total	Number	% of Total	Number	% of Total
All Firms	5,671,480	100	4,829,296	100	166,172	100	141,921	100
National Firms								
Aetna	101,206	1.8	85,804	1.8	15,402	9.3	0	0
Cigna	56,825	1	56,825	1.2	0	0	0	0
HealthNet	197,495	3.5	180,920	3.8	16,575	10	0	0
Humana	437,254	7.7	365,346	7.6	4,703	2.8	67,205	47.4
Kaiser	873,224	15.4	802,425	16.6	0	0	0	0
PacifiCare	731,537	12.9	726,449	15.4	798	0.5	16	0
UnitedHealthcare	320,411	5.7	279,893	5.8	71,728	21.8	3,522	2.5
BCBS Affiliate	976,046	17.2	815,888	16.9	64,228	38.7	1,521	1.1
Others								
Sterling	28,606	0.5	0	0	0	0	28,606	20.2
Coventry	20,672	0.4	13,108	0.3	7,564	4.6	0	0
Sierra	54,235	1	1,742	0	0	0	0	0
Wellcare	6,275	0.1	6,275	0.1	0	0	0	0
Other	1,867,694	32.9	1,492,088	30.9	20,627	12.4	41,051	19.8

Source: MPR analysis of CMS data; firm coding by MPR.

MA Firms in 2006

Many of the major MA firms have expanded their offerings substantially for 2006. The most notable is Humana, which is offering regional PPOs in a majority of MA regions and PFFS plans that reach 69 percent of beneficiaries (Table 5). These products complement the local HMOs and local PPOs Humana offers to a smaller share of beneficiaries. PacifiCare plans of some type are available to just under half of the Medicare population. This is largely because of the substantial expansion of PacifiCare's PFFS line of business. With its four regional PPOs and other products, UnitedHealthcare's plans are available to 36 percent of beneficiaries. Affiliates of the Blues also are available to many Medicare beneficiaries. (Blues-affiliated companies offer regional PPOs in four regions, including a multiple affiliate offering a plan in the seven state MA region in the north-central region of the country).

Among MA firms, Humana and UnitedHealthcare (and PacifiCare with whom it is merging) seem poised to compete most aggressively on a national scale for new Medicare business in 2006. Each is offering a PDP and a range of MA plans that could appeal to beneficiaries (Table 6). With its branded AARP Medigap and PDP plans—and its MA offerings enhanced through the merger with PacifiCare—UnitedHealthcare appears particularly strongly positioned with a full spectrum of products.

Humana. In a September 2005 presentation to Wall Street analysts, Humana indicated that it was leveraging the PDP and MA market to attract a large number of beneficiaries enrolling in the new prescription drug program (Bertko, 2005). While their actual success remains to be seen, the company is offering multiple products in markets (as many as five in some areas) to span a spectrum of beneficiary interests and preferences. Humana offers PDPs, PFFS plans that incorporate prescription drug coverage, and regional PPOs that are available to at least two thirds

TABLE 5

SHARE OF BENEFICIARIES WITH AVAILABLE MA PRODUCT BY FIRM, 2006

Firm	Any Product[a]	Regional PPOs	Local HMO	Local PPO	PFFS
All Firms	99.5	88.0	72.0	59.6	80.3
Aetna	19.1	5.1	17.2	10.8	0.0
Cigna	1.4	0.0	1.4	0.0	0.0
HealthNet	17.6	1.9	16.1	1.9	0.0
Humana	68.8	60.6	9.2	17.9	68.8[b]
Kaiser	14.2	0.0	11.2	0.0	0.0
PacifiCare	48.0	0.0	16.2	0.0	39.2[c]
UnitedHealthcare	35.5	14.4	20.9	15.2	4.7
BCBS Affiliate[d]	69.3	22.8	35.5	26.6	7.5
Other	82.6	4.8	58.9	33.5	46.5

[a]This also includes cost contracts.
[b]This statistic increased from 7.8 percent in March 2004 to 22.2 percent in March 2005 and 67.7 percent in September 2005.
[c]This statistic increased from 0 in March 2004 and March 2005 to 23.6 percent in September 2005.
[d]Wellpoint-affiliated plans are available to 16 percent of all beneficiaries and other BCBS affiliates to 54 percent. Wellpoint's regional PPO will serve 8 percent of beneficiaries and those of other BCBS affiliates will serve 14.8 percent.

TABLE 6

NATIONAL PDP AND MA FIRM BY MEDICARE PRODUCTS, 2006

		MA Plans				
	PDP	Regional PPO	HMO	Local PPO	PFFS	SNP
Aetna	✓	✓	✓	✓		✓
Cigna	✓		✓			
HealthNet	✓	✓	✓	✓		✓
Humana	✓	✓	✓	✓	✓	✓
Kaiser			✓			
PacifiCare	✓		✓		✓	✓
UnitedHealthcare	✓	✓	✓	✓	✓	✓

Source: MPR analysis from available information.

Note: Includes firms tracked over time as national MA firms. BCBS affiliates omitted because offerings vary by affiliates.

of beneficiaries in the country. In some areas Humana complements these with local HMO and PPO products. All the Humana products use the same formulary, but the products vary in the way they structure cost sharing for the Medicare drug benefit and whether or not they provide any coverage in the gap between where Medicare basic benefits end and where the Medicare subsidized catastrophic coverage starts (KFF, 2005a). Humana products aim to cover the low and high end of the market (see Table 7 for examples in two regions). Its highest end PDPs and local HMO plans cover brand-name drugs in the gap. Humana expects each of these products to be profitable, but their long-term strategy is to move beneficiaries into higher revenue MA products (Bertko, 2005). This strategy presumably reflects the fact that MA products are broader in benefit scope and total revenue and also more fully risk-based than PDPs. Such a design provides greater potential to generate profits, particularly given MA payment policies that currently pay more for an MA enrollee than Medicare pays for beneficiaries in the traditional program (Biles et al., 2004; Berenson, 2005).

UnitedHealthcare/PacifiCare. These two firms are offering separate product lines that should complement one another in the merged entity. UnitedHealthcare is offering an AARP-affiliated national PDP. The firm's ongoing affiliation with AARP has led to its leadership position both in the Medigap market and in the Medicare prescription drug discount card market. UnitedHealthcare also is sponsoring regional PPOs in three regions (Florida, Hawaii, and New York), various local health plans, and SNPs that build on its strength in the Evercare product line offered by its Ovations (senior) line and in Medicaid (through its AmeriChoice subsidiary).

Though PacifiCare is offering a national PDP, its historical strength is in traditional MA products. In addition to its local HMO plans, PacifiCare is making a major expansion into the PFFS market with plans that are available to 39 percent of Medicare beneficiaries. In contrast

TABLE 7

HUMANA MEDICARE PLANS, SELECTED MARKETS

		Drug Coverage			
	Total Premium	Premium	Deductible	Tiered Copy	Gap
Miami, Florida (Dade Co.)					
PDP					
Standard	--	$10.35	$250	N	N
Enhanced	--	$20.15	0	Y	N
Complete	--	$61.70	0	Y	G/B
Regional PPO					
Plan 1	$0	$0	0	N	N
Plan 2	$30	$14.48	$250	Y	N
Plan 3	$39	$22.99	0	Y	N
PFFS	$104	$21.35	0	Y	N
Local HMO					
Plan 1	$0	$0	0	Y	N
Plan 2	$0	$0	0	Y	G
Plan 3	$0	$0	0	Y	G
Plan 4	$0	$0	0	Y	N
Jefferson County, Kentucky					
PDP					
Standard	--	$12.30	$250	N	N
Enhanced	--	$23.15	0	Y	N
Completed	--	$66.89	0	Y	G/B
Regional PPO					
Plan 1	$39	$0	0	N	N
Plan 2	$79	$17.56	$250	N	N
Plan 3	$89	$27.28	0	Y	N
PFFS	$64	$25.66	0	Y	N
Local PPO	$32	$9.38	0	Y	G

Source: CMS Landscape Tables, November 13, 12005
N = No
Y = Yes
G = Generic
B = Brand

to Humana, PacifiCare's PPFS plans do not include drug coverage though beneficiaries can get it from them through the national PDP the firm offers. In a presentation to Wall Street analysts, PacifiCare indicated that it was developing arrangements to offer their PDP and PFFS plans through affiliations with insurance agents (PacifiCare, 2005). The company also said it believed this strategy would prove highly beneficial in the potential merger with UnitedHealthcare because it would tap additional outlets for Medicare products beyond those available through direct marketing.

Blue Cross-Blue Shield Affiliates. In addition to the PDPs these affiliates are offering in most states in 2006, Blues affiliates are sponsoring regional PPOs through Wellpoint's Anthem products in two regions (covering Indiana, Kentucky, and Ohio) and a joint offering covering the seven-state north-central region that includes Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming. Blues-affiliated local HMOs are available to 36 percent of Medicare beneficiaries, and local PPOs are available to 27 percent. Blues affiliates also are offering PFFS plans that are available to about 7.5 percent of beneficiaries.

Other Major MA Firms. Although they are significant players in many of the markets in which they participate, the other major MA firms seem situated to serve a more limited share of the market nationally. Of all these firms, Kaiser's offerings appear least changed in 2006; they continue to offer their steady growth HMO product through integrated systems in selected areas of the country. Aetna and HealthNet are expanding their products, but their geographic focus remains limited. Though its PDP is national, Aetna's MA offerings continue to be more limited than in the early 2000s. Aetna's MA base is the mid-Atlantic, where it is sponsoring regional PPOs spanning four states (Delaware, the District of Columbia, Maryland, and New Jersey). With these and local plans, Aetna's MA plans are available to just under a fifth of all beneficiaries. HealthNet's offerings are concentrated in Arizona (where it is offering a regional

PPO), California, Connecticut, New York, and Oregon. Sierra's MA offerings are concentrated in Nevada (where it also offers a regional PPO), Utah, and Arizona; its PDPs serve ten western states. Cigna, which is sponsoring a national PDP, continues to have a very limited set of MA offerings. The only other MA firm that seems to have a sizeable presence in the market is Sterling, whose MA offerings are available to 37 percent of beneficiaries through PFFS products. Sterling's PDP products are available to 89 percent of beneficiaries and offered in 32 of the 34 PDP regions.

SELECTED CHARACTERISTICS OF THE EMERGING MARKET

The analysis of organizations in the PDP and MA market highlights diversity and the potential that organizations are targeting different (though overlapping) segments of the Medicare market through their PDP and MA products. We review here the market segments and how marketing strategies likely differ across segments. These differences may explain why some sponsors marketing efforts are more publicly visible than others.

Sponsor Diversity and Potential Market Segmentation

Medicare's structure historically has resulted in a complex supplemental market with submarkets designed to reach particular population groups. Firms in this market may have products aimed at one or more submarkets that are focused—for example, on individuals seeking coverage through Medigap or MA, on group accounts aimed to integrate retiree benefits with standard Medicare coverage, or on beneficiaries dually eligible for Medicare and Medicaid. Not all Medicare beneficiaries have supplemental coverage, but the individual market accounts for about half of all beneficiaries if one assumes those without any supplemental coverage also are potential customers in this market; the employer-sponsored group sector accounts for a little more than a third, and the Medicaid sector for 17 percent (Figure 3). It is difficult to understand the private-sector reaction to the MMA unless one considers how each of these submarkets is

affected by the new Medicare drug benefit and how the interests of individual firms are reflected in the kinds of PDP and MA plans they offer.

The Individual Private Market for Medicare Supplements. Most beneficiaries choose Medicare supplemental products individually, selecting among Medigap plans, integrated Medicare MA products, or Medicare alone (i.e., no supplement). All of these individual submarkets are in play with the creation of the new Medicare drug benefit.[15] The new benefit changes the cost of coverage and modifies the options available. Of equal significance, it requires a decision by beneficiaries: keep their existing coverage or enroll in a new plan with drug benefits.

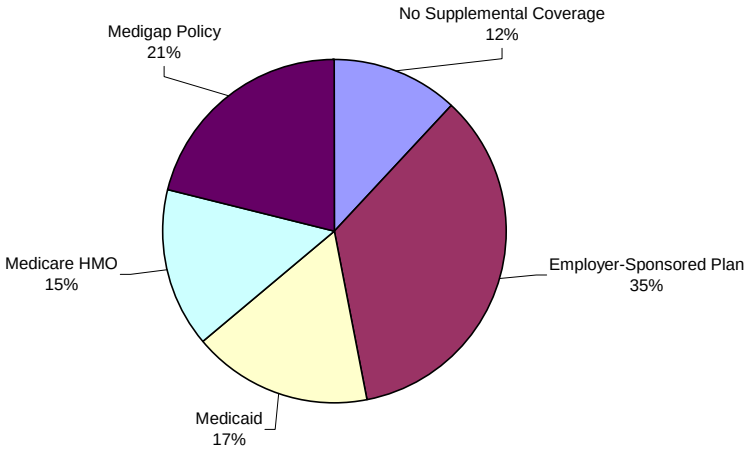
Many firms now participate in the Medigap market in one or more state. Though some firms dominate, the Medigap market includes many firms, some with only limited enrollment that complements a broader product line catering to the senior and individual market.

The MMA poses both an opportunity and a risk for these firms. The drug benefit opens the opportunity for a new product line of prescription drug coverage for Medicare beneficiaries, which may interest companies with an established Medigap customer base and agents and brokers ready to market the product. The risk is that the new drug benefit could destabilize the Medigap market, where enrollment historically has been stable. Specifically, current Medigap carriers who do not offer drug coverage run the risk of losing existing Medigap business if their customers sign up with another firm's offering and then decide to consolidate their coverage. Firm's whose current Medigap products cover drugs are likely to see that business shrink. As a

[15] A subset of those with incomes low enough to qualify for the LIS will find that that influences both their choices and the financial implications of them. Only a subset of plans will be eligible for the full premium subsidy; those that qualify also will have greatly reduced cost sharing, which should insulate them from cost-sharing requirements of plans.

FIGURE 3

SOURCES OF SUPPLEMENTAL INSURANCE COVERAGE AMONG MEDICARE BENEFICIARIES, 2002



Total = 41.8 Million Medicare Beneficiaries, 2002

Source: Kaiser Family Foundation Chartbook, Figure 3.1 based on analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Note: Total number of Medicare beneficiaires is based on weighted number of respondents in the Medicare Current Beneficiary Survey 2002 Cost and Use File.

result, insurers interested in the senior market may be drawn to offering Medicare prescription drug products, whether proactively or defensively. It is not surprising that insurers with large blocks of Medigap business (e.g., United American Insurance Company) are offering PDPs and MA products as well (e.g., Sterling), particularly if they can establish them without having to introduce new elements into their programs (e.g., PFFS plans do not require a network.)

The MMA similarly presents opportunities and risks for companies already in the MA market. Existing firms may fear a loss of enrollment, particularly from less price sensitive beneficiaries who may have been attracted to them mainly because they were the only available source of prescription drug coverage. These beneficiaries now have many sources of subsidized drug coverage, including PDPs that do not require them to limit their choice of providers. The market for MA historically has been dominated by HMOs and the subset of insurers positioned to offer that type of product. As networks become less central to MA products, other firms may

enter the market and compete with existing firms. However the availability of less tightly managed products could expand the size of the market for MA by attracting those who were uninterested before because they wanted wider provider choice.

Many firms may be reluctant to place their bets on only one sector of the market (i.e., Medigap versus MA) because changes associated with the new Medicare drug benefit and expanded MA options could shift the relative size of these markets. Offering a broader product spectrum could be a way to allow them to hedge their bets, especially early on when beneficiary preferences are not well known. But firms that offer a full array of products also could find that one part of their organization is competing with another.

The Market for Retiree Group Coverage. A variety of national and other insurers administer or underwrite coverage for retiree group accounts. These include insurers focused on large national accounts (e.g., Aetna, Cigna, and others as well as PBM firms such as Caremark and Medco) that are responsible for the pharmacy portion of the benefits. Most groups appear to have maintained their existing benefit structure for retirees in 2006, though some may not have and others may change their strategy in the future (KFF, 2005c). Such retention was what Congress sought in the MMA by giving financial subsidies to encourage employers to stay in the retiree market once Medicare added drugs to its traditional benefits. Firms now providing coverage to such employers are likely to be concerned with protecting their markets. Having an approved PDP and/or MA plan could provide firms in this market with the ability to adapt to the diverse interests of purchasers both now and in the future.

Dual Eligibles and Others with LIS. Though dual eligibles represent only about 17 percent of Medicare beneficiaries, they are likely to be a disproportionate share of early enrollment in the prescription drug program because they have been automatically assigned to PDP plans. So may others who qualify for LIS benefits, though their number is less certain and

their auto-enrollment will not occur until June. Sponsors who need high enrollment to offset costs or meet growth targets may view qualifying for the LIS subsidy crucial to their business plan. Conversely, firms that intent to market their product through current group accounts and affiliated insurance agents may find such enrollees at best a distraction and at worst a potential source of added administrative burden and/or potential financial risk (if risk adjustment does not reflect the costs of their care and systems are not set up to handle the needs of such beneficiaries).

The likely relevance of these concerns is potentially embedded in the variation among firms in PDPs that are LIS eligible. Some national and near-national PDP firms have LIS eligible plans in only a few regions (e.g., Aetna and Cigna and many of the firms specializing in Medigap) whereas others—many that appear most aggressive in MA—have them in virtually all (e.g., Humana, PacifiCare, UnitedHealthcare, Wellcare, Wellpoint). The large number of firms in between may reflect the fact that individual firms were able to exert only limited control of how their bids positioned them in 2006 because this was the first year and there were no prior benchmarks to help firms price their products.

Both PDP and MA sponsors also include firms that seem particularly interested in the dual eligibles market. The base of business for Ameri-Health and Wellcare, for example, appears to be built on Medicaid enrollees. On the MA side, both of these firms are active in sponsoring SNPs, as is HealthSpring, Molina, and other local plans specializing in Medicaid (CMS, 2005 However, some SNP sponsors, like UnitedHealthcare, which is very active in the market with both institutional and dual-eligible products, have a business base that extends well beyond traditional Medicaid participating health plans.

Diversity in Likely Sources of Enrollment by Firm

The firms sponsoring plans that provide Medicare prescription drug benefits have structured their offerings with a particular business strategy in mind. Most firms probably are seeking to retain their current enrollment in Medicare-related lines of business and the revenue it generates. Some also are seeking to expand enrollment, either within existing product lines or in new ones.

Maintenance of existing enrollment base. Firms with the primary goal of maintaining the existing enrollment base may be relatively uninterested in advertising and other forms of marketing that are devoted mainly to attracting new enrollees. These firms already know who their targets are. For these firms, it makes sense to spend resources to communicate directly with their current clients (e.g., via firm staff or affiliated agents). Priority tasks in the Medigap market are likely to include educating enrollees about the changes, transitioning Medigap enrollees currently in plans that cover prescription drugs to another Medigap plan, and encouraging current Medigap subscribers to enroll in one of the firm's Medicare drug products rather than a competitor's. In MA, where drug coverage has been more common (Gold et al., 2004), firms will want to be sure beneficiaries understand that they can get the new drug benefit through their MA plan and that a decision to enroll in a PDP means they cannot remain in the MA plan. These firms likely have designed the benefits and premiums in MA plans they offer to further these retention goals.

Expanding Enrollment Bases. Firms seeking to expand their book of business need ways of reaching out to beneficiaries beyond those already enrolled in their plans. Having a variety of distribution outlets is likely to be particularly relevant this year. At least four types of outlets appear to be important to firms in 2006.

Direct–to-Consumer Marketing. Firms can increase the visibility of their PDP and MA products through advertising, health fairs, and one-on-one marketing (subject to CMS's

restrictions). Such strategies have historically been important in the MA market, especially when an organization's enrollment is geographically concentrated and large (e.g., some Blues organizations). Firms experienced with these techniques are likely to have more ready-built capacity to use them than others that have not made much use of them. Firms also are strengthening their ability to market in 2006. For example, as the sole AARP-sponsored PDP sponsor, UnitedHealthcare has positioned itself to take advantage of AARP's membership base as it does in the Medigap market. In a move that has received substantial press coverage, Humana has teamed with Wal-Mart on a major campaign to educate beneficiaries on the benefit. Cigna's affiliation with Nation's Health is providing it access to enrollees in their discount card programs, information that firms like Medco, Caremark, and others presumably also have for their own card holders.

Negotiated Agreements with Intermediaries. Insurance agents and brokers historically have played a role in the Medigap market where they are particularly important to commercial insurers.[16] Some firms currently use agents or brokers who sell only their products under exclusive arrangements; others use agents or brokers who may deal with multiple companies. Such agents have not played a large role in the MA program historically, but appear to be emerging as an important part of PDP marketing strategies. Presumably firms active in Medigap (e.g., Pennsylvania Life, United American Insurance Company, and others) are building on their existing base of agents. Firms without such a base have entered into agreements with partners to tap into these networks. For example, Coventry's website indicates that it has exclusive arrangements with agents for Ceres, Conseco, Continental Life, Mutual of Omaha, New Era Life, and United Teacher's Associates Insurance companies—a group Coventry says has 1 million

[16] An agent is someone who deals exclusively in individual or group insurance. A broker may have other lines of business (e.g., investments for personal pension plans.).

Medicare subscribers. Humana's website describes a relationship with State Farm's 17,000 agents to offer its products, and with American Republic Insurance Company, which Humana says has 140,000 Medicare members among its customer base. Humana also has an agreement with USAA, a Fortune 200 financial services company, to offer Humana's PDP to 750,000 Medicare-eligible members. One national PDP—MemberHealth—appears to have been designed specifically to tap such a capacity. According to the firm's website, the MemberHealth PDP is a partnership with Community Care outreach services, a network of 20,000 licensed brokers who they say insure one out of every 18 Medigap enrollees. The use of insurance agents and brokers adds another source of information to support beneficiary choice, but its effects on beneficiaries' choice--or PDP/MA marketing costs for the new drug benefit—are largely unknown however.

Pharmacy Links. Because the new benefit focuses on prescription drugs, partnerships with specific pharmacies and locations where pharmaceuticals are dispensed can be a way for firms to target and attract beneficiaries. Many firms appear to have taken this into account in structuring their PDP offerings. For example, MemberHealth is in a partnership with 25,000 independent retail pharmacies, some or all of which may be exclusively affiliated with the product. Rx America is owned by companies that own their own pharmacies. UnitedHealthcare's AARP product includes Brooks-Eckard, CVS, Target, and Wal-Mart in their network. Wellpoint has an affiliation with Walgreens. Humana and Wellpoint are also affiliated. Cigna is co-branding its PDP with Kmart and Ahold, which owns Giant, Martin, Stop and Shop, and Tops grocery stores. Coventry's website promotes its nonexclusive arrangement with Rite Aide.

Enrollment via CMS and Auto-Assignment. Firms may capture enrollment without having to necessarily actively pursue it. The CMS website, *Medicare and You Handbook*, 1-800 number, and CMS's local information partners that provide neutral information to beneficiaries

each may generate enrollment, particularly if plans are competitively priced and positioned. The auto-assignment of dual eligibles is likely to be the most important source of enrollment for firms whose plans are LIS eligible. The potential to gain substantial enrollment (and revenue) at little cost to the firm in marketing has the potential to attract firms to the market, and some may be better qualified than others. There are oversight risks if some of the plans are not qualified to handle their responsibilities. State insurance laws, the MMA, and CMS regulations include provisions to limit such risks, but they are hard to eliminate, especially early in a large and rapidly implemented program.

CONCLUSIONS

In 2006, many plans are available to provide beneficiaries with the new Medicare drug benefit. Although the number of plans is relatively large (1,429 PDPs across the nation plus MA plans), the number of firm sponsors is much smaller. Thus, the decisions of a relatively small number of organizations could have substantial effects on the availability of choices and the stability of the Medicare market. Initial experiences with the PDP and MA programs will influence what plans do in the long term. Firms are likely to view such experiences through the individual perspectives each firm brings, including their historical and desired future roles in Medigap, Medicaid, and other markets.

Not only are firms in this market coming from very diverse businesses, they also have differing interests and goals for participation and differing measures of success. For example, observers of the Medicare market may be concerned that the number of PDPs offered are unsustainable in many markets and that this could ultimately lead to instability in plan choice as some or many of them exit. Others may look for such a shake-out to help choice become more manageable for beneficiaries. Firm exit is a relevant question as there are likely to be economies of scale in working with Medicare; small enrollments may reduce what firms gain from

participation. But the question of economies of scale may not apply equally across firms. Some sponsors' goals may be satisfied with relatively low rates of enrollment (and product profitability) as long as the firms' PDP/MA products allow them to achieve other goals important to the mission and financial health of the firm (e.g., continuing to meet needs of group accounts, capitalizing opportunities with particular subgroups.) Similarly, firms that offer a variety of products through the same set of outlets may not find the marginal costs of participating in Medicare that high. For example, the marginal cost of developing a non-network product for Medicare may not be high if the Medicare product uses arrangements already in place and the firm is already supporting sales for the broader product line.

The diversity of sponsorships and motivations also creates oversight challenges for CMS and potentially others with an oversight role in this sector. Early Medicare experience with private plans revealed potential marketing abuses and other problems **(**Rossiter, 2001**).** The diversity of sponsors and the numerous outlets that they are using can increase the risk that beneficiaries will unknowingly make a choice that is not in their interests. Firms that have little experience working with Medicare or other public programs may not be familiar with the way such programs work and the restrictions they place on sponsors. Medicare also now, for the first time, includes sponsoring organizations with limited experience commercially or with Medicare. Because the new drug benefit affects the Medigap markets, issues may emerge that challenge or create conflicts for federal and state regulatory authorities.

Finally, it is important to recognize that 2006 reflects only the initial response to the MMA. Firms' initial strategies probably are designed to protect them in the short term and may not necessarily provide a long-term guide to their intentions. The choices made by beneficiaries about whether to sign up for the benefit and where to enroll will help shape the Medicare market over time, as will decisions by other purchasers (e.g., employers, state Medicaid programs). All

these decisions will influence the ultimate size of the market for plans that include Medicare drug benefits, the relative size of the PDP versus MA market, and the potential for specialized products that meet the needs of particular subgroups of beneficiaries. The outcome of these decisions will heavily influence which firms remain in the market and what role they play. They also will influence the number and kinds of choices available to beneficiaries in the long run.

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