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Issue Brief

Paying Medicare Advantage Plans by Competitive Bidding: How Much Competition Is There?

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ABSTRACT: Private health plans that enroll Medicare beneficiaries—known as Medicare Advantage (MA) plans—are being paid $11 billion more in 2009 than it would cost to cover these beneficiaries in regular fee-for-service Medicare. To generate Medicare savings for offsetting the costs of health reform, the Obama Administration has proposed eliminating these extra payments to private insurers and instituting a competitive bidding system that pays MA plans based on the bids they submit. This study examines the concentration of enrollment among MA plans and the degree to which firms offering MA plans actually face competition. The results show that in the large majority of U.S. counties, MA plan enrollment is highly concentrated in a small number of firms. Given the relative lack of competition in many markets as well as the potential impact on traditional Medicare, the authors call for careful consideration of a new system for setting MA plan payments.

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OVERVIEW

As a presidential candidate, Barack Obama consistently supported paying private health insurance plans that enroll Medicare beneficiaries the same amount it would cost to enroll those beneficiaries in traditional fee-for-service (FFS) Medicare. Currently, private Medicare Advantage (MA) plans are paid $11 billion a year in excess of the costs of regular fee-for-service (FFS) Medicare—an average of 13 percent, or $1,000 more, per enrollee.[1] In the past two years, there have been discussions about reducing MA payments to 100 percent of per capita FFS spending and using the savings—estimated by the Congressional Budget Office (CBO) at more than $150 billion over 10 years—to offset the costs of health care reform or other new federal health initiatives.[2]

In the fall of 2008, the Obama campaign stated in a summary of its health care policy: "We need to eliminate the excessive subsidies to Medicare Advantage plans and pay them the same amount it would cost to treat the same patients under regular Medicare."[3] This policy position was generally understood to mean

that an Obama Administration would propose to eliminate extra payments to MA plans.

In late February 2009, the Office of Management and Budget issued a report that described a number of policy options for financing health care reform.[4] One of these options was "Reducing Medicare Overpayments to Private Insurers Through Competitive Payments," which would "replace the current mechanism to establish payments [to MA plans] with a competitive system in which payments would be based upon an average of plans' bids submitted to Medicare Advantage. This would allow the market, not Medicare, to set the reimbursement limits, and save taxpayers more than $175 billion over 10 years, as well as reduce Part B premiums."

An argument in favor of a payment system based on competitive bidding, CBO explains, "is that it would reduce the per capita amount paid for benefits for enrollees in Medicare Advantage plans to levels determined by the plans' bid. The option might also encourage private plans to compete more strongly on the basis of price."[5] The agency estimates that the described competitive bidding–based system would reduce Medicare spending by $158 billion over 10 years.

This study examines the current state of competition among Medicare private plans in U.S. counties using the Herfindahl Index, which is employed as a measure of market concentration by the Department of Justice's Antitrust Division.

Generally, we find that that the MA market is highly concentrated and so not competitive in most counties in the nation. Herfindahl Index scores for MA plans indicate a low level of competition in 2,114 of the 2,958 counties included in our analysis. These counties contain 70 percent of all Medicare beneficiaries and 74 percent of MA plan enrollees.

Among the 100 counties with the largest numbers of Medicare beneficiaries, 73 have highly concentrated MA enrollment, indicating a low level of competition, while only three have a low level of MA enrollment concentration—consistent with a high level of competition. In 33 of the 100 largest counties, a single MA firm has more than 50 percent of MA enrollees.

These findings suggest that if MA plans were to be paid an amount equal to the average of bids in a county weighted for enrollment, payments in most counties would be highly influenced by the bids of one dominant plan or a very few plans in the market, rather than set by a process involving true competition among many firms.

MEASURING COMPETITION IN MARKETS: THE HERFINDAHL INDEX

The Department of Justice's Antitrust Division uses the Herfindahl Index (also referred to as the Herfindahl-Hirschman Index) as a measure of market concentration, or the distribution of market share among the plans in a given market.[6] The calculated value of the Herfindahl Index is the sum of the squares of the market shares of the top 50 firms in a given market. The following Herfindahl Index values are used to categorize market concentration by firms:

- A value above 1,800 is considered to be a concentrated index, and is indicative of a low level of competition within the market.

How the Herfindahl Index Is Calculated

The Herfindahl Index value in a given market is determined both by the number of firms and their shares of the market. Markets with many firms may be classified as having low levels of competition if one or a few of those firms are dominant, while markets with few firms, even with evenly distributed market shares, may be similarly classified.

For example, in a market with 20 firms, where each has an equal market share of 5 percent, the Herfindahl Index value would be $(20 \times 5^2) = 500$, indicating a highly competitive market. In another market with the same number of firms, but where 19 of the firms had an equal market share of 3 percent each and one had a much larger market share of 43 percent, the Herfindahl Index value would be $(19 \times 3^2) + (1 \times 43^2) = 2{,}020$, suggesting a low level of competition. Similarly, in a smaller market of five firms, even with equal market shares of 20 percent each, the Herfindahl Index value would be $(5 \times 20^2) = 2{,}000$, also indicating minimal competition.

Exhibit 1. Level of Market Competition by Medicare Advantage Plans in All U.S. Counties

Level of Market Competition	Percentage of Counties	Percentage of Plans	Percentage of Medicare Beneficiaries	Percentage of MA Plan Enrollees
Low	71.5%	66.5%	70.3%	74.1%
Moderate	26.2	30.5	27.2	24.3
High	2.3	3.1	2.6	1.6

- A value between 1,000 and 1,800 indicates moderate market concentration and competition.
- A value below 1,000 is considered to be an unconcentrated index, and is indicative of a high level of competition within the market.[7]

COMPETITION AMONG MEDICARE ADVANTAGE PLANS

The core assumption of a payment system based on competitive bidding is that plans compete in each market. If one plan, or even a few plans, dominate MA enrollment in an area, then their bids will dominate the calculation of the Medicare payment level to all plans in the area.[8] We define market area at the county level, because that is the level at which plan payment rates are set and the level at which competition for enrollees takes place.

Drawing from February 2009 MA plan enrollment data, we examine market concentration in all counties in the U.S. with 10 or more Medicare beneficiaries enrolled in any plan (a total of 2,958 counties). For illustrative purposes, we then focus on the 100 counties with the largest number of Medicare beneficiaries in 2009.[9] These 100 counties include 38 percent of all Medicare beneficiaries and 50 percent of MA plan enrollment nationwide.

Competition in MA Plan Markets

Of the 2,958 counties included in our analysis, 71 percent (2,114) have a Herfindahl Index value of greater than 1,800 and so are considered to have a highly concentrated MA market with a low level of competition (Exhibit 1). These counties contain 70 percent of Medicare beneficiaries and 74 percent of MA plan enrollees. Only 2 percent of all counties (69) have a competitive market, as indicated by a Herfindahl Index of less than 1,000. These counties contain less than 3 percent of Medicare beneficiaries and 2 percent of MA plan enrollees.

As described above, the Herfindahl Index indicates a low level of competition both in larger markets where market power is concentrated and in smaller markets where there are few competitors. To further illustrate the level of competition in larger markets, we examined the pattern of MA plan enrollment in the 100 counties with the largest number of Medicare beneficiaries. This group of counties contains 38 percent of all Medicare beneficiaries and 50 percent of MA plan enrollees although it includes only 3 percent of all counties nationwide.

This analysis finds that 73 of the 100 largest counties have Herfindahl Index values that indicate highly concentrated MA markets with a low level of competition, while only three of the 100 largest counties would be classified as highly competitive (Exhibit 2 and Appendix Table 1). The counties in which the MA market is highly competitive are Marion County, Indiana (which includes Indianapolis), Sarasota County, Florida, and Lancaster County, Pennsylvania. The counties with a low level of competition have about the same numbers of plans but fewer Medicare beneficiaries and lower aggregate MA penetration than in the other counties among the 100 largest.

The MA markets in many of the 100 largest counties are dominated by a single plan. In 33 of those counties, a single dominant firm has more than half of the MA enrollment; and in 10 of those counties, a

Exhibit 2. Level of Market Competition by Medicare Advantage Plans in 100 U.S. Counties with the Largest Number of Beneficiaries

Level of Market Competition	Number of Counties	Average Number of Plans	Average Number of Medicare Beneficiaries	Average Number of MA Plan Enrollees
Low	73	30	99,974	16,777
Moderate	24	26	167,222	49,294
High	3	31	180,225	55,298

single plan has at least two-thirds of the MA enrollment (Appendix Table 2). The 10 counties in which at least two-thirds of MA enrollees are in a single plan are distributed across the nation, including three counties in California (Alameda, Contra Costa, and Santa Clara), two in Texas (Tarrant and Dallas), and one each in Oklahoma (Tulsa), Michigan (Oakland), Florida (Brevard), New York (Monroe), and Connecticut (Fairfield).

It is notable that the single dominant plan varies across these markets, with seven different plans dominating in the 10 most-concentrated markets. More broadly, among the 73 counties with highly concentrated MA enrollment, Kaiser has the largest MA enrollment in 12 counties, Humana in seven counties, and PacifiCare in six counties (Exhibit 3 and Appendix Table 3). Blue Cross–affiliated plans have the largest enrollment in 15 counties, including the Detroit, Philadelphia, Pittsburgh, and Cleveland regions (Exhibit 3 and Appendix Table 4).[10]

Exhibit 3. Dominant Firm with Largest Share of Enrollees in Counties with Low Level of Competition

Firm	Counties
Kaiser	12
Humana	7
PacifiCare	6
United Healthcare	8
Tufts	4
Blue Cross–affiliated plans	15
Other firms	21
Total	**73**

DISCUSSION

Analysis of MA plan enrollment in 2009 indicates that there is very little competition among Medicare private plans. Nationally, 70 percent of MA enrollees are in counties in which enrollment is highly concentrated in a very few dominant plans and the market is not considered competitive. Among the 100 counties in the nation with the largest number of Medicare beneficiaries, 73 are considered highly concentrated, noncompetitive markets, while only 3 are considered highly competitive markets.

This suggests that if MA plans were to be paid at the amount of the enrollment-weighted average of bids in a county, those payments in most counties would be highly influenced by the bids of the dominant plan or plans in the market, rather than by a competitive process.

The high concentration of MA plan enrollment is likely to become more of an issue in the next few years, as the substantial extra payments to MA plans are reduced or eliminated. Firms may choose to exit areas where they have a small number of members, further decreasing the levels of competition in those markets. If this occurs, it may further reduce the amount of competition among MA plans, making it all the more important to carefully examine and improve the mechanism for determining MA rates.

Notes

1 B. Biles, J. Pozen, and S. Guterman, *The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to $11.4 Billion in 2009* (New York: The Commonwealth Fund, May 2009).

2 Congressional Budget Office, *Budget Options Volume 1: Health Care* (Washington, D.C.: CBO, Dec. 2008), pp. 119–124. Available at http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf.

3 Barack Obama and Joe Biden's Health Care Plan, Sept. 2008; available at www.barackobama.com.

4 Office of Management and Budget, *A New Era of Responsibility: Renewing America's Promise* (Washington, D.C.: OMB, Feb. 2009), p. 28. Available at http://www.whitehouse.gov/omb/assets/fy2010_new_era/a_new_era_of_responsibility2.pdf.

5 CBO, "Option 65: Establish Benchmarks for the Medicare Advantage Program Through Competitive Bidding," in *Budget Options Volume 1*, p. 122.

6 United States Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines* (Washington, D.C.: USDoJ and FTC, revised April 1997). Available at http://www.usdoj.gov/atr/public/guidelines/hmg.htm.

7 Ibid.

8 Under the bidding mechanism established by the Medicare Modernization Act of 2003, all MA plans submit bids equal to the costs of providing traditional Medicare benefits to their enrollees. It should be noted that while "bid" is the term the MMA uses for the amount submitted by each MA plan, the bid amount may not be just any amount that the plan prefers; rather, it must be calculated following the Centers for Medicare and Medicaid Services' detailed, 100-page manual, *Instructions for Completing the Medicare Advantage Bid Pricing Tool*. The bid may thus be viewed as a Medicare prospective cost report for MA plans. The accuracy of plan bids is now beginning to be audited by CMS.

9 George Washington University analysis of Centers for Medicare and Medicaid Services Medicare Managed Care State/County/Contract Data File, released Feb. 2009, and Medicare Managed Care State/County Penetration Data File, released Feb. 2009. The total number of Medicare Advantage enrollees reported here excludes those in cost plans and in Puerto Rico, Guam, American Samoa, and the U.S. Virgin Islands.

10 As of December 20, 2005, UnitedHealth Group acquired PacifiCare. Therefore, their combined share of largest plans in the 100 largest counties with low levels of market competition is 12.

Appendix Table 1. 100 Largest Counties by Number of Medicare Beneficiaries, Sorted by Herfindahl Index

County	Herfindahl Index	Level of Market Competition	Total County MA Plan Enrollment	Total County Medicare Beneficiaries
Tarrant, TX	6810	Low	49,346	173,587
Fairfield, CT	6070	Low	22,565	128,681
Contra Costa, CA	5810	Low	59,662	136,049
Alameda, CA	5660	Low	69,889	175,737
Monroe, NY	5470	Low	68,873	121,215
Tulsa, OK	5220	Low	25,623	84,853
Oakland, MI	4950	Low	42,352	174,936
Brevard, FL	4930	Low	32,267	114,436
Santa Clara, CA	4790	Low	74,799	201,429
Dallas, TX	4690	Low	45,019	231,817
Oklahoma, OK	4660	Low	18,777	99,284
Providence, RI	4460	Low	39,014	101,501
Sacramento, CA	4350	Low	75,556	178,058
Macomb, MI	4290	Low	26,941	133,524
Nassau, NY	4170	Low	41,025	219,565
New Haven, CT	4130	Low	25,932	136,721
Honolulu, HI	4130	Low	27,509	139,922
San Mateo, CA	4120	Low	40,805	97,560
Clark, NV	4110	Low	80,248	221,389
Bucks, PA	4090	Low	37,899	119,074
Worcester, MA	4090	Low	44,226	100,657
Delaware, PA	3960	Low	32,207	89,749
Middlesex, MA	3870	Low	48,551	214,482
Norfolk, MA	3860	Low	19,718	103,789
Montgomery, PA	3850	Low	47,751	126,906
Palm Beach, FL	3790	Low	74,903	246,880
Bexar, TX	3790	Low	63,880	201,148
Bernalillo, NM	3730	Low	37,594	88,672
Wayne, MI	3690	Low	60,028	283,538
Volusia, FL	3550	Low	40,260	109,289
San Diego, CA	3520	Low	150,087	376,543
Duval, FL	3340	Low	20,497	110,245
San Francisco, CA	3210	Low	41,588	120,842
Hennepin, MN	3200	Low	33,095	143,831
Suffolk, NY	3190	Low	35,579	226,775
Baltimore City, MD	3150	Low	10,436	88,950
Fresno, CA	3020	Low	27,150	103,529

County	Herfindahl Index	Level of Market Competition	Total County MA Plan Enrollment	Total County Medicare Beneficiaries
Jefferson, AL	2820	Low	42,636	109,290
Ventura, CA	2800	Low	26,649	103,198
Mecklenburg, NC	2760	Low	12,794	88,755
Pima, AZ	2700	Low	67,017	154,475
Allegheny, PA	2680	Low	136,531	232,857
Jackson, MO	2680	Low	28,665	99,225
Philadelphia, PA	2640	Low	104,108	223,525
Montgomery, OH	2610	Low	27,786	92,820
Bergen, NJ	2570	Low	13,886	141,913
Broward, FL	2530	Low	110,009	243,640
Milwaukee, WI	2490	Low	31,307	131,495
King, WA	2480	Low	55,221	221,368
Westchester, NY	2440	Low	24,114	144,471
Erie, NY	2440	Low	85,657	120,292
Orange, FL	2440	Low	34,121	170,920
Ocean, NJ	2430	Low	17,955	131,139
Middlesex, NJ	2410	Low	10,965	105,566
Wake, NC	2330	Low	14,150	83,256
Summit, OH	2320	Low	28,417	144,753
Hartford, CT	2320	Low	24,943	88,911
St. Louis, MO	2270	Low	43,768	163,883
Cook, IL	2230	Low	61,433	681,359
Bronx, NY	2180	Low	65,707	159,382
Bristol, MA	2160	Low	12,089	93,345
Los Angeles, CA	2150	Low	403,346	1,114,034
Pasco, FL	2100	Low	42,297	98,193
Cuyahoga, OH	2080	Low	53,715	223,020
Monmouth, NJ	2000	Low	10,064	93,888
Essex, MA	1970	Low	20,548	118,590
Kern, CA	1940	Low	30,464	89,137
Franklin, OH	1930	Low	40,826	133,310
Hillsborough, FL	1900	Low	58,576	112,740
Shelby, TN	1900	Low	18,621	154,603
San Bernardino, CA	1840	Low	93,062	202,740
Hamilton, OH	1830	Low	36,139	125,114
Marion, FL	1810	Low	19,220	86,817
Queens, NY	1800	Moderate	98,992	287,588
New York, NY	1760	Moderate	60,822	225,906
El Paso, TX	1740	Moderate	26,261	92,679

County	Herfindahl Index	Level of Market Competition	Total County MA Plan Enrollment	Total County Medicare Beneficiaries
Salt Lake, UT	1700	Moderate	31,922	97,689
Orange, CA	1690	Moderate	143,946	355,904
Pinellas, FL	1670	Moderate	68,803	194,633
Riverside, CA	1660	Moderate	118,868	257,183
Harris, TX	1650	Moderate	94,442	299,252
Kings, NY	1650	Moderate	97,119	354,017
Pierce, WA	1640	Moderate	21,132	101,266
Prince George's, MD	1630	Moderate	3,299	84,653
Baltimore, MD	1630	Moderate	8,196	126,884
Essex, NJ	1600	Moderate	13,136	99,215
Suffolk, MA	1550	Moderate	12,206	87,531
Maricopa, AZ	1530	Moderate	199,191	454,221
Multnomah, OR	1500	Moderate	46,345	88,626
DuPage, IL	1410	Moderate	6,009	112,085
Jefferson, KY	1400	Moderate	24,587	117,159
Fairfax, VA	1380	Moderate	3,096	100,564
Miami-Dade, FL	1370	Moderate	171,675	353,100
Montgomery, MD	1210	Moderate	2,875	113,418
Polk, FL	1100	Moderate	34,042	110,194
Fulton, GA	1090	Moderate	16,488	91,173
Lee, FL	1020	Moderate	23,708	120,467
Lancaster, PA	980	High	21,922	83,394
Sarasota, FL	890	High	14,159	101,155
Marion, IN	760	High	14,250	115,374

Appendix Table 2. Among 100 Largest Counties by Number of Medicare Beneficiaries, Counties in Which a Single Plan Has a Market Share Greater Than 50 Percent

County	Largest Plan in County	Total County MA Plan Enrollment	Plan Market Share
Tarrant, TX	PACIFICARE OF TEXAS, INC.	49,346	82.4%
Fairfield, CT	HEALTH NET OF CONNECTICUT	22,565	77.4%
Contra Costa, CA	KAISER FOUNDATION HP, INC.	59,662	74.1%
Alameda, CA	KAISER FOUNDATION HP, INC.	69,889	73.8%
Tulsa, OK	COMMUNITY CARE HMO, INC	25,623	71.2%
Monroe, NY	ROCHESTER AREA HMO/ DBA PREFERRED CARE	68,873	70.1%
Brevard, FL	HEALTH FIRST HEALTH PLANS, INC.	32,267	68.9%
Oakland, MI	BLUE CROSS BLUE SHIELD OF MICHIGAN	42,352	68.7%
Dallas, TX	PACIFICARE OF TEXAS, INC.	45,019	67.9%
Santa Clara, CA	KAISER FOUNDATION HP, INC.	74,799	67.2%
Oklahoma, OK	PACIFICARE OF OKLAHOMA, INC.	18,777	65.1%
Sacramento, CA	KAISER FOUNDATION HP, INC.	75,556	63.3%
New Haven, CT	HEALTH NET OF CONNECTICUT	25,932	62.5%
Macomb, MI	BLUE CROSS BLUE SHIELD OF MICHIGAN	26,941	62.0%
Bucks, PA	KEYSTONE HEALTH PLAN EAST, INC.	37,899	61.4%
Nassau, NY	HIP OF GREATER NEW YORK	41,025	61.0%
Worcester, MA	FALLON COMMUNITY HEALTH PLAN	44,226	61.0%
San Mateo, CA	KAISER FOUNDATION HP, INC.	40,805	60.4%
Providence, RI	BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND	39,014	60.3%
Honolulu, HI	KAISER FOUNDATION HP, INC.	27,509	59.5%
Delaware, PA	KEYSTONE HEALTH PLAN EAST, INC.	32,207	59.4%
Palm Beach, FL	HUMANA MEDICAL PLAN, INC	74,903	59.3%
Norfolk, MA	TUFTS ASSOCIATED HMO, INC.	19,718	59.2%
Montgomery, PA	KEYSTONE HEALTH PLAN EAST, INC.	47,751	59.2%
Middlesex, MA	TUFTS ASSOCIATED HMO, INC.	48,551	58.7%
Clark, NV	HEALTH PLAN OF NEVADA, INC.	80,248	56.0%
Bexar, TX	PACIFICARE OF TEXAS, INC.	63,880	55.5%
Duval, FL	HUMANA MEDICAL PLAN, INC	20,497	54.1%
Hennepin, MN	UCARE MINNESOTA	33,095	53.7%
Wayne, MI	BLUE CROSS BLUE SHIELD OF MICHIGAN	60,028	53.4%
Baltimore City, MD	BRAVO HEALTH MID- ATLANTIC INC.	10,436	51.9%
Volusia, FL	HUMANA MEDICAL PLAN, INC	40,260	51.4%
Fresno, CA	KAISER FOUNDATION HP, INC.	27,150	51.2%

Appendix Table 3. Among 100 Largest Counties by Number of Medicare Beneficiaries, Distribution of Dominant Commercial Firms

County	Largest Plan in County	Total County MA Plan Enrollment	Plan Market Share
Palm Beach, FL	HUMANA	74,903	59.3%
Duval, FL	HUMANA	20,497	54.1%
Volusia, FL	HUMANA	40,260	51.4%
Broward, FL	HUMANA	110,009	46.1%
Pasco, FL	HUMANA	42,297	41.1%
Hillsborough, FL	HUMANA	58,576	39.1%
Cook, IL	HUMANA	61,433	38.9%
Contra Costa, CA	KAISER	59,662	74.1%
Alameda, CA	KAISER	69,889	73.8%
Santa Clara, CA	KAISER	74,799	67.2%
Sacramento, CA	KAISER	75,556	63.3%
San Mateo, CA	KAISER	40,805	60.4%
Honolulu, HI	KAISER	27,509	59.5%
Fresno, CA	KAISER	27,150	51.2%
San Francisco, CA	KAISER	41,588	48.4%
Ventura, CA	KAISER	26,649	43.9%
Los Angeles, CA	KAISER	403,346	39.0%
Kern, CA	KAISER	30,464	32.4%
San Bernardino, CA	KAISER	93,062	32.2%
Tarrant, TX	PACIFICARE	49,346	82.4%
Dallas, TX	PACIFICARE	45,019	67.9%
Oklahoma, OK	PACIFICARE	18,777	65.1%
Bexar, TX	PACIFICARE	63,880	55.5%
San Diego, CA	PACIFICARE	150,087	45.8%
Pima, AZ	PACIFICARE	67,017	41.7%
Norfolk, MA	TUFTS	19,718	59.2%
Middlesex, MA	TUFTS	48,551	58.7%
Bristol, MA	TUFTS	12,089	35.3%
Essex, MA	TUFTS	20,548	31.8%
Clark, NV	UNITEDHEALTHCARE	80,248	56.0%
Mecklenburg, NC	UNITEDHEALTHCARE	12,794	46.9%
Montgomery, OH	UNITEDHEALTHCARE	27,786	46.0%
Milwaukee, WI	UNITEDHEALTHCARE	31,307	45.2%
Wake, NC	UNITEDHEALTHCARE	14,150	43.3%
St. Louis, MO	UNITEDHEALTHCARE	43,768	32.9%
Hamilton, OH	UNITEDHEALTHCARE	36,139	32.5%
Hamilton, OH	UNITEDHEALTHCARE	36,139	32.5%

Appendix Table 4. Among 100 Largest Counties by Number of Medicare Beneficiaries, Distribution of Dominant Blue-Affiliated Plans

County	Top Plan in County	Total County MA Plan Enrollment	Plan Market Share
Providence, RI	BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND	39,014	60.3%
Oakland, MI	BLUE CROSS BLUE SHIELD OF MICHIGAN	42,352	68.7%
Macomb, MI	BLUE CROSS BLUE SHIELD OF MICHIGAN	26,941	62.0%
Wayne, MI	BLUE CROSS BLUE SHIELD OF MICHIGAN	60,028	53.4%
Cuyahoga, OH	COMMUNITY INSURANCE CO/ANTHEM BLUE CROSS	53,715	37.9%
Suffolk, NY	EMPIRE HEALTHCHOICE HMO, INC.	35,579	49.1%
Westchester, NY	EMPIRE HEALTHCHOICE HMO, INC.	24,114	44.7%
Middlesex, NJ	HORIZON HEALTHCARE OF NEW JERSEY, INC.	10,965	40.2%
Ocean, NJ	HORIZON HEALTHCARE OF NEW JERSEY, INC.	17,955	37.2%
Monmouth, NJ	HORIZON HEALTHCARE OF NEW JERSEY, INC.	10,064	33.9%
Bucks, PA	KEYSTONE HEALTH PLAN EAST, INC.	37,899	61.4%
Delaware, PA	KEYSTONE HEALTH PLAN EAST, INC.	32,207	59.4%
Montgomery, PA	KEYSTONE HEALTH PLAN EAST, INC.	47,751	59.2%
Philadelphia, PA	KEYSTONE HEALTH PLAN EAST, INC.	104,108	43.0%
Allegheny, PA	KEYSTONE HEALTH PLAN WEST, INC.	136,531	44.6%

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