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TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS

Monthly Report for April 2009

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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

Enrollment and Penetration, by Plan Type	Current Month: April 2009	Change From Previous Month*	Same Month Last Year	
			April 2008	Change From April 2008- 2009
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	17,447,640	-39,206	17,337,796	+109,844
Individual	16,540,592	-43,311	Not Available	Not Available
Group**	907,048	+4,105	Not Available	Not Available
Total Medicare Advantage (MA)	10,961,832	+100,337	9,841,267	+1,120,565
Individual	9,019,930	+89,383	Not Available	Not Available
Group	1,941,902	+10,954	Not Available	Not Available
Medicare Advantage-Prescription Drug (MA-PD)	9,299,962	+84,751	8,197,657	+1,102,305
Medicare Advantage (MA) only	1,661,870	+15,586	1,643,610	+ 18,260
Medicare Advantage (MA) by Type				
MA Local Coordinated Care Plans** *	7,748,968	+65,187	6,965,505	+783,463
Health Maintenance Organizations (HMOs)	6,828,843	+42,191	6,337,954	+490,889
Provider Sponsored Organizations (PSOs)	15,004	+608	17,118	-2,114
Preferred Provider Organizations (PPOs)	905,075	+22,389	610,377	+294,698
Regional Preferred Provider Organizations (PPO)	405,946	+17,043	269,791	+136,155
Medical Savings Account (MSA)	3,330	+35	3,533	-203
Private Fee For Service (PFFS)	2,407,142	+21,240	2,153,429	+253,713
Individual	1,677,241	+20,166	Not Available	Not Available
Group****	729,901	+1,074	Not Available	Not Available
Cost	286,447	+490	271,026	+15,421
Pilot*****	21,405	-1,667	84,981	-63,576
Other******	88,462	-2,123	93,002	-4,540
General vs Special Needs Plans*****				
Special Needs Plan Enrollees	1,302,525	+1,554	1,146,404	+156,121
Dual-Eligibles	917,787	+2,098	829,493	+88,294
Institutional	119,379	-1,568	136,251	-16,872
Chronic or Disabling	265,359	+1,024	180,660	+84,699
Other Medicare Advantage Plan Enrollees	9,659,307	+98,783	8,694,863	+964,444
Penetration (as percent beneficiaries)********				
Prescription Drug Plans (PDPs)	39.7%	-0.1% point	39.4%	+0.3% points
Medicare Advantage Plans (MA)	24.3%	+0.2% points	22.3%	+2.0% points
Medicare Advantage-Prescription Drug Plans (MA-PDs)	20.6%	+0.2% points	18.6%	+2.0% points
Local Health Maintenance Organizations (HMOs),	15.2%	+0.2 points	14.3%	+0.9% points
Local Preferred Provider Organizations (PPOs)	2.0%	No Change	1.4%	+0.6% points
Private Fee For Service (PFFS)	5.3%	No Change	4.9%	+0.4% points

April 2009 data is from the 4.09.09 Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations—Monthly Summary Report released by CMS on its website at:
(**http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**)
* The March 2009 data is from data released by CMS on 3.19.09 also on its website
**The breakdown by Group includes Employer/Union Only Direct Contract PDP (122,104)
***The data for the breakdown of MA Local Coordinated Care Plans is from the 4.09.09 Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations-Monthly Report by Contract. The total for each CCP plan by type does not sum to the total CCP because the breakdown totals do not include enrollment numbers for contracts whose enrollment is less than 10**.** ((**http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**)
**** The breakdown by Group includes Employer Direct PFFS (13,505)
*****CMS is now including Pilot enrollees in this count. The Pilots refer to contracts to provide care management services for fee-for-service beneficiaries with chronic condition. CMS reports that this data is being included in their monthly count since they are part of the total monthly Medicare payment. However, beneficiaries for whom such payments are made are in the traditional Medicare program. Hence, users probably should exclude these enrollees from analysis and trending.
******Other includes Demo contracts, HCPP and PACE contracts.
*******The SNP total for April is from the SNP Enrollment Comprehensive Monthly Report released by CMS on 4.09.09 and includes counts of 10 or less. (See: **(http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**).
*******Penetration for April and March 2009 is calculated using the number of eligible beneficiaries reported in the August 2008 MA State/County Penetration file. April 2008 is calculated using the number of eligible beneficiaries reported in the December 2005 State/County File.

DEFINITIONS: Coordinated Care Plans, or CCPs, include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs) and preferred provider organizations (PPOs). The Medicare preferred provider organization demonstration began in January 2003. PFFS refers to private fee-for-service plans. Cost plans are HMOs that are reimbursed on a cost basis, rather than a capitated amount like other private health plans. Other Demo refers to all other demonstration plans that have been a part of the Medicare+Choice / Medicare Advantage program. "Special needs individuals" were defined by Congress as: 1) institutionalized; 2) dually eligible; and/or 3) individuals with severe or disabling chronic conditions.

Summary of MA contracts in April:

Plan Participation, by type	CURRENT MONTH: APRIL 2009*	SAME MONTH LAST YEAR	
		APRIL 2008	CHANGE FROM APRIL 2008– 2009
MA Contracts			
Total	747	714	+33
Local Coordinated Care Plan	545	509	+36
Health Maintenance Organizations (HMOs)	375	368	+7
Preferred Provider Organizations (PPOs) (Includes Physician Sponsored Organizations (PSOs))	170	141	+29
Regional Preferred Provider Organizations (rPPOs)	14	14	0
Private Fee For Service (PFFS)	71	79	-8
General	69	77	-8
Employee Direct	2	2	No Change
Cost	22	25	-3
Medicare Savings Account (MSA)	2	9	-7
Special Needs Plans	415	443	-28
Dual-Eligible	252	270	-18
Institutional	63	66	-3
Chronic or Disabling Condition	100	107	-7
Other**	93	78	+15

*Contract counts for April 2009 are from the 4.09.09 Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Organizations—Monthly Summary Report released by CMS on its website at: ((**http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**)) and the SNP Comprehensive Monthly Report also released on its website at: ((**http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**)

**Other includes Demo contracts, Health Care Prepayment Plans (HCPP), and Program for all-inclusive care of Elderly (PACE)

NEW ON THE WEB FROM CMS

Relevant to Both Medicare Advantage and Prescription Drug Plans

- On April 6, 2009, CMS released the final 2010 Medicare Advantage capitation rates and MA and Part D payment policies (This is the final provisions of the Advance Notice that CMS released on February 20, 2009 and responds to comments in that Notice). Several changes have been made from the Advance Notice released in February. The final announcement states that MA growth percentage for aged and disabled beneficiaries is 0.81 percent, which is 0.3 higher than the preliminary estimate of 0.5 percent announced in February. As discussed in the Advanced Notice, for the first time for plan year 2010, CMS will make a "coding pattern differences adjustment" to MA risk scores (to reduce MA payments to account for differences in disease coding patterns between MA organizations under MA and traditional Medicare program). Based on comments received after the Advance Notice was published in February, CMS made some modifications to the methodology. The adjustment that will be applied is a uniform 3.41 percentage reduction to all MA risk scores in 2010. (The Advance Notice proposal was a coding difference adjustment of 3.74 percent). The final announcement also states that CMS revised the Part D benefit parameters to correct calculation errors identified following the release of the Advanced Notice. The Part D deductible is now $310 rather than $305 as reported in the Advanced Notice, the initial coverage limit has also been corrected to $2,830 and out-of-pocket threshold has been corrected to $4,550. The minimum cost-sharing for other generic/preferred or multisource drugs is still $2.50 and for other drugs it has been corrected to $6.30. The full document is available on CMS's website at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/AD/list.asp#TopOfPage.
  - CMS also released a press release and a more detailed fact sheet on final 2010 MA capitation rates and MA and Part D payment policies, which includes a summary of the changes from the Advanced Announcement released in February 2009. The press release is titled "CMS Issues 2010 Payment Information for Part C Medicare Advantage Plans and Part D Prescription Drug Plans." Both documents are available on CMS's website. See: http://www.cms.hhs.gov/apps/media/press_releases.asp (for the press release) and: http://www.cms.hhs.gov/apps/media/fact_sheets.asp (for the fact sheet).
- CMS Office of Actuary also released the CY 2010 Bid forms and instructions on its website this month. This information includes the instructions as well as training slides and particular information regarding changes to dual eligible beneficiaries: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/09_Bid_Forms_and_Instructions.asp#TopOfPage. The website also includes a memorandum which includes technical assistance calls that are provided by CMS to provide further guidance: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/ActuarialBidCallAnnouncement.pdf

Relevant to Medicare Advantage

- None

Relevant to Prescription Drug Plans

- CMS recently added the 2010 Formulary Reference Guidance file to its website. This information includes a factsheet titled "CY 2010 FRF factsheet" released on April 15, 2009. The formulary reference file (FRF) is used by Medicare Part D plan sponsors for the purpose of Health Plan Management System (HPMS) formulary submission (and thus is not necessarily a complete Medicare Part D coverage list): http://www.cms.hhs.gov/PrescriptionDrugCovContra/03_RxContracting_FormularyGuidance.asp#TopOfPage

Of General Interest

- None

Relevant to Special Needs Plans Specifically

- None

OTHER ITEMS OF RELEVANCE

Briefings and Hearings:

- On April 29, 2009, the Senate Finance Committee released a policy options document that included reform options for Medicare Advantage. The document titled "Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs" provides information on current policies and possible options –including proposed payment options that would be linked to performance on quality measures; modifications of the benchmarks, and proposed payment for chronic care management. For more detail, see the Senate Finance document online at: http://finance.senate.gov/sitepages/leg/LEG%202009/042809%20Health%20Care%20Description%20of%20Policy%20Option.pdf

Other

- MedPAC held a public meeting on April 8 and 9, 2009 in the Ronald Reagan Building in Washington DC. The agenda as well as other information pertaining to the meeting is posted on its website at: www.medpac.gov. Two session in particular of relevance included:
  - "MIPPA Medicare Advantage payment report." In this session, Scott Harrison, Dan Zabinski, David Glass, and Carlos Zarabozo: 1) discussed their evaluation of the accuracy of CMS's measurement of county-level FFS

spending (the information CMS uses to determine the MA benchmarks in each county). Overall, MedPAC staff found CMS's methodology accurate for producing FFS spending estimates but found two technical issues that could be addressed (one with Puerto Rico and another with the Veteran Affairs facilities calculations); 2) provided an update of the simulations and features of alternative systems for setting benchmarks for the report to the Congress on MA payment also as required by the Medicare Improvements for Patients and Providers Act, MIPPA (section 169). As discussed in detail last month, MedPAC staff is examining four alternative options for setting benchmarks administratively. MedPAC used data from 2009 plan bids and included all plan types (except SNP and employer group plans) in their analysis. It assumes the plan bids and service areas do not change and all the options it simulates are financially neutral (i.e. the option would reduce the average benchmark from 118 percent of fee-for-service to an average of 100 percent of fee-for-service spending). MedPAC staff continue to recommend that the transition from 118% to 100% FFS benchmarks must be judicious with a little disruption to beneficiaries as possible and one that encourages high quality plans to staff in MA (possibly by paying plans differentially during transition).

- "Quality in Medicare Advantage and Traditional Fee-for-Service Medicare: Update." In this session, John Richardson and Carlos Zarabozo provided an update on the mandated report to Congress (as required by MIPPA section 168) on comparable performance measures and patient experience measures that can be collected and reported for the MA program and the traditional FFS Medicare program. This report is due to Congress in March 2010. MedPAC staff continues to recommend that quality measures be collected for all Medicare plans and in this session provided a draft framework for analyzing quality measurement criteria and trade-offs (see PowerPoint slides for draft framework matrix). The draft framework presents a high level comparison matrix which would allows staff to compare cost/burden of measurement requirements for both FFS and MA as well as the unit of measurement (e.g. provider, plan/population, or both), geographic area, type of quality measure and usefulness for beneficiaries among others. MedPAC staff indicated at the next phase of their analysis will be to complete this matrix and sought input to see if other criteria, measurements etc should be included.

- MedPAC will hold its next meeting on September 17 and 18, 2009 in the Ronald Reagan Building in Washington DC. The agenda as well as other information pertaining to the meeting will be posted on its website one week prior to the meeting. www.medpac.gov

• This month, an article published in *Medical Care,* titled "Market and Beneficiary Characteristics Associated with Enrollment in Medicare Managed Care Plans and Fee-for-Service" (Shimada, S, Zaslavsky, A, Zaborski, L et al.) assessed whether patient enrollment in Medicare managed care (MMC) or traditional fee-for-services (FFS) is related to beneficiary and market characteristics. The authors used data from the 2004 Medicare MMC and FFS CAHPS surveys, the Social Security Administration's Master Beneficiary record, MMC market penetration files and the 2000 Census data. The authors found that enrollees in MMC plans tend to have better

health than those in FFS but that this effect is weaker in areas with more competitions as vulnerable subgroups (e.g. Latinos) are more likely to enroll in MMC plans as well. The authors recommend that because of these findings, CMS should monitor how changes in MA policies and payment methods may affect beneficiaries in these groups.

- The Kaiser Commission on Medicaid and the Uninsured released a new issue brief this month titled "Where Does the Burden Lie?: Medicaid and Medicare Spending for Dual Eligible Beneficiaries." The issue brief describes how the 8.8 dual eligibles are among the Nation's most vulnerable of populations and are a costly population to care for. The issue brief states that in 2005, $196.3 billion was spent on dual eligibles by Medicaid and Medicare. The issue brief analyzed information about patterns of service use and spending for duals under both Medicare and Medicaid. The researchers used the 2003 Medicare Current Beneficiary Survey (MCBS) and the 2003 Medicaid Statistical Information System (MSIS) Summary file for their analysis. The authors found that on a per capita basis, Medicaid and Medicare spending on duals totaled four times that of non-duals; that Medicaid covers nearly 60 percent of the total Medicaid and Medicare spending for the population and that within the dual population, Medicare pays for the majority of acute care services while Medicaid pays for the majority of long-term care services. This issue brief is available at: http://www.kff.org/medicaid/7895.cfm