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# TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS
# Monthly Report for April 2010

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*as part of work commissioned by the Kaiser Family Foundation*

## PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

| Enrollment and Penetration, by Plan Type | Current Month: April 2010 | Change From Previous Month* | Same Month Last Year | |
|---|---|---|---|---|
| | | | April 2009 | Change From April 2009- 2010 |
| **Enrollment** | | | | |
| **Total Stand-Alone Prescription Drug Plans (PDPs):** | 17,584,086 | -150,592 | 17,447,640 | +136,446 |
| Individual | 17,430,365 | +735,518 | 16,540,592 | +889,773 |
| Group** | 153,721 | -886,110 | 907,048 | -753,327 |
| **Total Medicare Advantage (MA)** | 11,563,059 | +93,326 | 10,961,832 | +601,227 |
| Individual | 9,522,371 | +85,123 | 9,019,930 | +502,441 |
| Group | 2,040,688 | +8,143 | 1,941,902 | +98,786 |
| Medicare Advantage-Prescription Drug (MA-PD) | 10,011,964 | +77,338 | 9,299,962 | +712,002 |
| Medicare Advantage (MA) only | 1,551,095 | +15,988 | 1,661,870 | -110,775 |
| **Medicare Advantage (MA) by Type** | | | | |
| MA Local Coordinated Care Plans** * | 8,660,041 | +63,858 | 7,748,968 | +911,073 |
| Health Maintenance Organizations (HMOs) | 7,307,803 | +39,341 | 6,828,843 | +478,960 |
| Provider Sponsored Organizations (PSOs) | 24,568 | +798 | 15,004 | +9,564 |
| Preferred Provider Organizations (PPOs) | 1,327,656 | +23,718 | 905,075 | +422,581 |
| Regional Preferred Provider Organizations (rPPO) | 794,672 | +18,528 | 405,946 | +388,726 |
| Medical Savings Account (MSA) | 597 | -2 | 3,330 | -2,733 |
| Private Fee For Service (PFFS) | 1,683,245 | +7,838 | 2,407,142 | -723,897 |
| Individual | 1,270,904 | +6,452 | 1,677,241 | -406,337 |
| Group and RFB**** | 412,341 | +2,120 | 729,901 | -317,560 |
| Cost | 324,925 | +2,274 | 286,447 | +38,478 |
| Pilot***** | 11,485 | +1,060 | 21,405 | -9,920 |
| Other****** | 88,094 | -230 | 88,462 | -368 |
| **General vs Special Needs Plans******* ** | | | | |
| Special Needs Plan Enrollees | 1,280,573 | +3,253 | 1,302,525 | -21,952 |
| Dual-Eligibles | 968,552 | +11,132 | 917,787 | +50,765 |
| Institutional | 97,872 | -976 | 119,379 | -21,507 |
| Chronic or Disabling | 214,149 | -6,903 | 265,359 | -51,210 |
| Other Medicare Advantage Plan Enrollees | 10,282,486 | +90,073 | 9,659,307 | +623,179 |
| **Penetration** (as percent beneficiaries)******** | | | | |
| Prescription Drug Plans (PDPs) | 37.8% | -0.2% points | 38.7% | -1.1% points |
| Medicare Advantage Plans (MA) | 24.8% | +0.2% points | 24.3% | +0.5% points |
| Medicare Advantage-Prescription Drug Plans (MA-PDs) | 21.5% | +0.2% point | 20.6% | +0.9% points |
| Local Health Maintenance Organizations (HMOs), | 15.7% | +0.1% point | 15.2% | +0.5% points |
| Local Preferred Provider Organizations (PPOs) | 2.8% | No Change | 2.0% | +0.8% points |
| Private Fee For Service (PFFS) | 3.6% | No Change | 5.3% | -1.7% points |

April 2010 data is from the 4.05.10 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 2010 data is from data released by CMS on 3.01.10 also on its website
**The breakdown by Group includes Employer/Union Only Direct Contract PDP (153,721)
***The data for the breakdown of MA Local Coordinated Care Plans is from the 4.05.10 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**.**
****The breakdown by Group includes Employer Direct PFFS (13,802)
*****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 usually available from the SNP Enrollment Comprehensive Monthly Report released by CMS each month was not available for March(**http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**). The total comes from the Monthly Summary Report instead.
********Penetration for April and March 2010 is from the March 2010 State/County Penetration file. March 2009 is calculated using the number of eligible beneficiaries reported in the August 2008 MA State/County Penetration 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 2010* | SAME MONTH LAST YEAR | |
|---|---|---|---|
| | | APRIL 2009 | CHANGE FROM APRIL 2009– 2010 |
| **MA Contracts** | | | |
| Total | 699 | 747 | -48 |
| Local Coordinated Care Plan | 511 | 545 | -34 |
| Health Maintenance Organizations (HMOs) | 368 | 375 | -7 |
| Preferred Provider Organizations (PPOs) (Includes Physician Sponsored Organizations (PSOs)) | 143 | 170 | -27 |
| Regional Preferred Provider Organizations (rPPOs) | 13 | 14 | -1 |
| Private Fee For Service (PFFS)<br>General<br>Employee Direct | 49<br>47<br>2 | 71<br>69<br>2 | -22<br>-22<br>0 |
| Cost | 22 | 22 | 0 |
| Medicare Savings Account (MSA) | 1 | 2 | -1 |
| Special Needs Plans**<br>Dual-Eligible<br>Institutional<br>Chronic or Disabling Condition | 361<br>224<br>50<br>87 | 415<br>252<br>63<br>100 | -54<br>-28<br>-13<br>-13 |
| Other*** | 100 | 93 | +7 |

*Contract counts for April 2010 are from the 4.05.10 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 is usually released on its website at: ((**http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**)**.** SNP contract numbers were not available for April 2010 however. February 2010 numbers were used instead.
***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 5, 2010, CMS released the final 2011 MA capitation rates and Part D payment policies for Medicare Advantage and Prescription Drug Plans, along with the 2011 Final Call Letter. Consistent with the Health Care and Education Reconciliation Act of 2010, capitation rates in 2011 will be the same as in 2010. CMS said it therefore was not including final estimates of the MA growth rates and related assumptions for 2011 though it would continue to release data on county based fee-for-service expenditures. Because 2011 rates are set in legislation, CMS will not rebase county rates in 2011 or adjust them for county based VA-DOD costs and it also will not implement the new risk adjustment models in 2011, as proposed in the preliminary call letter, but will wait until 2012. A coding adjustment of 3.41 percent will be applied in 2011. Network areas for PFFS plans in 2011 have been updated. New methods also will be used to set risk scores for new enrollees in chronic care SNPs. With respect to Part D, the Call Letter addresses policy changes related to manufacturer discounts and cost sharing for generic drugs in the coverage gaps as mandated in recent legislation. In 2011, Part D benefit parameters remain unchanged from 2010 (except for a $10 increase in the initial coverage limit). (http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/).

- On April 6, 2010, CMS issued the final regulations clarifying beneficiary protections and payment policies for Medicare Advantage and Prescription Drug plans effective 2011. (The proposed rule was published in the federal register on October 22, 2009.) The rule seeks to ensure that plan sponsors make available only products that are meaningfully differ from one another taking into account premiums, beneficiary out-of-pocket costs, plan types and formulary offerings, among other changes.

    - The rule establishes limits that MA plans must set on beneficiary out of pocket costs. Local MA plans will be required to establish a maximum out of pocket beneficiary liability, at levels set by CMS annually, with incentives to voluntarily set these lower levels consistent with current CMS policy. In local PPOs, such limits would apply only to network services but a higher catastrophic maximum will be set for all services consistent with current statute for regional PPOs. CMS also may impose limits on out of pocket costs for selected Part A and B services to enhance protections against discriminating against sicker beneficiaries. CMS will provide information to firms with such guidance either through the call letter or similar documents.

    - Because cost sharing is complex and can be confusing, CMS will not allow PPOs and PFFS plans to offer lower cost sharing for out of network services only if the beneficiary or the provider gives prior notification. Only HMOs will be allowed to offer a point of service option.

    - CMS will use standards for MA and Part D plan sponsors to assure that plans represent meaningfully different benefit packages and cost sharing

structures. Plans will also be required to meet minimum enrollment thresholds, which will be set with flexibility to address unique circumstances. More details will be provided outside the rule making process.

- CMS will move forward with their proposed use of minimum enrollment levels.
- The final rule keeps the proposed new automated methods for assessing network adequacy that take into account community patterns of care.

The final regulations were published April 15, 2010 and are available at www.regulations.gov.

**Relevant to Medicare Advantage**

- None

**Relevant to Prescription Drug Plans**

- CMS released a press release on April 9, 2010 titled "Medicare Issues Intermediate Sanction Notice to Aetna Insurance Company Medicare Health and Drug Plans." In the press release, CMS stated that the intermediate sanction prevents Aetna from marketing and enrolling new beneficiaries beginning April 21, 2010 and will remain in effect until Aetna can demonstrate it has corrected its deficiencies and they are not likely to reoccur. Some of Aetna's deficiencies CMS sites in its press release include: 1) failing to meet Medicare's transition requirements by ensuring that existing beneficiaries were able to continue to receive drugs they had been receiving in 2009 that were not on the plans' formularies in 2010 and 2) improperly processing coverage determinations and expedited appeal requests in cases where delays would jeopardize the life or health of the enrollee. This press release is available at: http://www.cms.gov/apps/media/press_releases.asp

**Of General Interest**

- None

**Relevant to Special Needs Plans Specifically**

- None

**Other**

- None