Number 71
February 8, 2005

MEDICARE ADVANTAGE AND MEDICARE BENEFICIARIES
Monthly Tracking Report for January 2005

A Brief Summary of Selected Significant Facts and Activities This Month
to Provide Background for Those Involved in Monitoring and Researching Medicare Advantage

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as part of work commissioned by the Kaiser Family Foundation

PROGRAM STATUS: PLAN OFFERINGS, ENROLLMENT, AND CHANGE

From the CMS Medicare Managed Care Contract Report (http://cms.hhs.gov/healthplans/reportfilesdata/):

Plan Participation, Enrollment, and Penetration by type	Current Month: Jan. 2005	Change From Last Month	Same Month Last Year	
			Jan. 2004	Change From Jan. 2004 – 2005
Contracts				
Total	311	+11	283	+28
CCP	175	+21	145	+30
PPO Demo	34	-1	35	-1
PFFS	6	0	4	+2
Cost	29	0	30	-1
Other	67	-9	69	-2
Enrollment				
Total	5,521,690	+23,196	5,295,392	+226,298
CCP	4,755,231	+34,699	4,592,465	+162,766
PPO Demo	113,941	+2,625	83,064	+30,877
PFFS	58,072	+6,858	26,467	+31,605
Cost	330,731	+66	335,278	-4,547
Other	263,715	-21,052	258,118	+5,597
Penetration*				
Total MA Penetration	12.9%	+0.1% points	12.5%	+0.4% points
CCP + PPO Demo Only	11.1%	+0.1% points	10.9%	+0.2% points

Penetration rates for January 2005 are calculated using the number of eligible beneficiaries reported in the September 2004 State/County File (which was corrected and re-released by CMS on December 1st, 2004). Penetration rates for January 2004 are calculated using the number of eligible beneficiaries reported in the December 2003 State/County File.

- There are pending applications for 6 M+C plans, 2 PFFS plans, 2 PACE plans, 1 PPO Demo plan and 3 Other Demo plans. Service area expansions are pending for 5 M+C plans, 3 PACE plans, 1 PFFS plan, 2 PPO Demo plans and 1 Cost plan.

NEW ON THE WEB FROM CMS

About Requirements, New Contracts and Withdrawals

- On January 21st, CMS posted the final versions of the applications for the 2006 Medicare Advantage products and the final materials to implement the prescription drug benefit program on its website. The materials reflect the final regulations for implementing the Medicare Prescription Drug, Improvement, and Modernization Act. To assist potential applicants for MA contracts in 2006, CMS also posted a new set of questions and answers (Q and As) about the final MA applications and application process. CMS plans to conduct training for the industry on the MA and prescription drug plan applications, as well as on the competitive bidding program during the next two months. Conference dates will be posted on the CMS website as soon as they are confirmed. The Q and A document and the MA applications can be accessed online at: www.cms.gov/healthplans.

- On January 21st, CMS posted an updated calendar for the implementation of the MMA on its website. The calendar has been updated to include comprehensive information related to implementation of Title I and Title II of the Act. The calendar notes that MA capitation rates, MA local area benchmarks and adjustment factors for 2006 will be released on April 4th, 2005. It also notes that MA organizations must submit bids for calendar year 2006 by June 6th. The full calendar is available on the CMS website at www.cms.hhs.gov.

- On January 21st, CMS posted question and answers (Q and As) designed to provide interim guidance for organizations that wish to offer MA Special Needs Plans (SNPs) to Medicare beneficiaries who are also entitled to Medicaid (often called "dual eligibles") and/or those who are institutionalized on its website. The Q and As indicate that MA organizations with an existing MA plan that serves these beneficiaries may apply to CMS to have the plan "re-designated" as an MA SNP. An organization that does not currently have an MA contract and wishes to offer an MA SNP must apply for an MA contract and meet the requirements of an MA plan. The Q and As also indicate that an MA SNP may serve either dual eligibles or institutionalized beneficiaries, or both. MA organizations may not submit applications for new SNPs or re-designation of existing plans to serve chronically ill or disabled beneficiaries at this time. The Q and As can be accessed online at: www.cms.hhs.gov.

Summary of service area expansions and new contracts announced in January 2004:

Firm	Areas Served	Is this the only plan in the area (yes/no)	Number of beneficiaries
Aetna	Baltimore County, MD	N	349,000
Colorado Access (new special needs plan)	Denver County, CO	N	100,000 (dually eligible for Medicare and Medicaid)
	Adams County, CO		
	Boulder County, CO		
	Broomfield County, CO		
	Douglas County, CO		
	Jefferson County, CO		
Blue Cross of California (new PFFS plan)	San Francisco County, CA	N	300,000
	Santa Barbara County, CA		
	Fresno County, CA		
	Yolo County, CA		
UnitedHealthcare of Wisconsin	Brown County, WI	N	75,000
	Outagamie County, WI		
	Winnebago County, WI		
PacifiCare of Colorado	Fremont County, CO	N	8,200
Network Health Insurance Copr. Inc. (new PPO plan)	Brown County, WI	N	173,000
	Calumet County, WI		
	Dodge County, WI		
	Fond du Lac County, Wi		
	Green Lake County, WI		
	Manitowac County, WI		
	Marquette County, WI		
	Outagamie County, WI		
	Portage County, WI		
	Sheboygan County, WI		
	Waupaca County, WI		
	Waushara County, WI		
	Winnebago County, WI		
Neighborhood Health Providers, LLC	Manhattan, NYC	N	920,000
	The Bronx, NYC		
	Brooklyn, NYC		
	Queens, NYC		
Elder Health Maryland	Washington, DC	N	79,000

About Medicare Advantage

- On January 21st, HHS Secretary Tommy Thompson announced the final regulations establishing Title I and Title II of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. The regulations create a new prescription drug benefit for Medicare beneficiaries. The rules also add a regional PPO option in the Medicare Advantage (MA) program and create a competitive bidding system for paying MA plans. The rules were developed after an extensive public comment process that began when the proposed rules were published in August. The rules were published in the Federal Register, and can be accessed at: http://www.gpoaccess.gov /fr/index.html.

About Drug Card and Other Features of Medicare Related to MA

- On January 4th, the United States Pharmacopeial Convention (USP) released its Medicare Prescription Drug Benefit Model Guidelines to the Centers for Medicare and Medicaid Services (CMS). The guidelines consist of a listing of therapeutic and pharmacologic drug categories for private drug plans (PDPs) and Medicare plans to use in developing their formularies for the Medicare prescription drug benefit. The guidelines include 146 types of prescription drugs, including 41 drug categories and 32 drug classes. Although plans are not required to use the model guidelines, USP hopes that the listing will facilitate implementation of the Part D benefit and make the benefit "clear and consistent" to all stakeholders. More information is available from USP at: www.usp.org or from CMS at: http://www.cms.hhs.gov/media/press/release.asp?Counter=1303.

- On January 27th, newly appointed HHS Secretary Mike Leavitt announced proposed regulations that will support electronic prescriptions for Medicare when the prescription drug benefit takes effect in January 2006. The proposed regulations will adopt standards for: (1) transactions between prescribers and dispensers; (2) eligibility and benefits inquiries and responses between dispensers and Part D sponsors; (3) eligibility and benefits inquiries and responses between drug prescribers and prescription drug plans; and (4) formulary and benefit coverage information. The proposed rule will be published in the *Federal Register* on February 4th. Public comments will be accepted through April 5th, 2005. The MMA mandates that private plans participating in the new drug benefit support electronic subscribing, though participation by physicians and pharmacies is voluntary. (CMS, January 27th)

- On January 31st, CMS announced a new initiative to pay health care providers for the quality of the care they provide to Medicare beneficiaries. Under the new initiative, 10 large physician groups across the United States will participate in the first pay-for-performance demonstration. The 3-year "Physician Group Practice" demonstration will reward providers who improve patient outcomes by coordinating care for chronically ill and high-cost beneficiaries by paying them "performance" payments. The providers will continue to receive fee-for-service payments for services rendered. CMS Administrator Mark McClellan said: "Our new pay-for-performance initiative for physicians reflects hard work by physicians, consumer advocates, and other health care payers and purchasers to develop valid measures of quality and efficiency, and to use them effectively to support better care." More information about the demonstration is available at www.cms.hhs.gov/researchers.

ON THE CONGRESSIONAL FRONT

MA Specifically

- The Medicare Payment Advisory Commission (MedPAC) held a meeting on January 11th and 12th to discuss a variety of issues related to the payments Medicare makes to physicians, hospitals, home health agencies, and private health plans. At the meeting, Commission members discussed the appropriate rate for paying local MA plans in 2006. This issue is one of three questions that will be addressed in an upcoming report on Medicare Advantage payment rates, payment areas and risk adjustment that was mandated by the MMA. During the meeting MedPAC staff described their analysis of the appropriate payment rate area. The analysis focuses on the fact that counties – the current payment rate area – often have large year-to-year changes in per capita spending and that adjacent counties often have very different levels of spending. MedPAC staff noted that although

these issues could be addressed by creating more populous payment areas, they also think it is important to consider how well the payment areas match market areas and how greatly costs of serving beneficiaries vary within a payment area. The analysis considered three alternative payment rate area definitions that are larger than the county: (1) collecting urban areas within a state into metropolitan statistical areas (MSAs) and non-urban areas into a single statewide non-MSA area; (2) collecting all counties into health service areas (HSAs); or (3) collecting urban areas into MSAs and non-urban areas into HSAs. The MedPAC Commissioners discussed these options and made some suggestions about other factors and areas to consider in the ongoing analysis. A full transcript of this discussion is available online at www.medpac.gov.

- MedPAC will hold its next public meeting on March 10th and 11th, 2005. The meeting will be held at the Ronald Reagan Building in Washington, DC. An agenda will be available approximately one week before the meeting and transcripts will be available approximately 3 – 5 business days after the meeting ends. Both documents will be available online at: www.medpac.gov.

Broader Medicare Reform (in Brief)

- None

FROM THE PERSPECTIVE OF BENEFICIARIES

- On January 11th, the Henry J. Kaiser Family Foundation and the Harvard School of Public Health released the results of a health survey: "Health Care Agenda for the New Congress." The survey of 1,396 people was designed to assess public opinion on a variety of health-related issues that are likely to face the new Congress. One section of the survey dealt with respondents' views on the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. Almost half of those aged 65 and older who were surveyed had an unfavorable view of the new Medicare law, and about 70 percent thought that lawmakers in Washington should work to fix problems with it. The most commonly cited complaints about the law were that it is too complicated for people on Medicare to understand (81 percent), does not do enough to lower prescription drug prices (78 percent) and does not provide people on Medicare enough help with their drug costs (78 percent). A chartpack containing the full survey results is available at: www.kff.org.

- On January 12th, the Henry J. Kaiser Family Foundation released findings from a new survey on how seniors use the Internet for health information." The nationally representative survey, "e-health and the Elderly," included 1,450 adults aged 50 and older and was conducted between March and April 2004. The key findings of the survey are as follows: (1) less than a third of all seniors have ever gone online and fewer than half have ever used a computer, although as baby boomers and other adults get older, the proportion of seniors using the Internet is likely to increase dramatically; (2) there is a substantial digital divide among seniors based on income, education, age and gender; and (3) the Internet is already a source of health information for one in five senior citizens, however, seniors still rely much more on traditional media such as TV and newspapers for health information. The survey also indicated that few seniors are using the Internet to look for information on Medicare. Only 6 percent of all seniors have used the Internet to look for information on Medicare, while just 2 percent had gone to the Medicare.gov Web site. More information on the survey methodology and results is available online at: www.kff.org.
- The Henry J. Kaiser Family Foundation released a new focus group report: "Medicare's Prescription

Drug Benefit: The Voices of People Dually Covered by Medicare and Medicaid" by Michel Perry, Michelle Kitchman and Jocelyn Guyer. Between September and November 2004, the authors conducted a series of five focus groups with individuals who receive Medicare and Medicaid (so-called "dual eligibles"). The report summarizes the opinions these individuals expressed about impending changes to their prescription drug coverage. The focus group participants were surprised to learn that as of January 2006 Medicaid will no longer be covering their medications. They had many questions about the private drug plans they will be choosing from and the costs associated with these plans. These individuals were generally happy with their current Medicaid prescription drug coverage and say it is working well, so they worry that they will be worse off under Medicare. The full report, which provides more detailed review of the focus group participants' comments on issues related to the new Medicare prescription drug benefit, can be accessed online at www.kff.org.

FROM OTHER STAKEHOLDERS

- On January 9th, *The New York Times* reported that President Bush will try to impose enforceable limits on the growth of federal benefit programs in his budget request to Congress next month. *The Times* reported that the Senator Judd Gregg, the new chairman of the Senate Budget Committee, supports the measures and would like to "establish enforcement mechanisms to put the brakes on the growth of entitlements." As part of his efforts to restrain spending, Senator Gregg plans to re-examine the MMA to ensure that spending on the Medicare prescription drug benefit is limited to $400 billion, saying: "Since it was sold as a $400 billion program, that's what we should keep it at." (*The New York Times*, January 9th)

- *The New York Times* and the *Wall Street Journal* both reported that the newly announced regulations for the creation of a drug benefit in Medicare may allow employers who offer retirees prescription drug coverage to receive more money than they actually spend on retiree benefits. In order to be eligible for government subsidies, employers' prescription drug benefits must be at least actuarially equivalent to the standard Medicare drug benefit. However, according to *The New York Times* and the *Wall Street Journal*, because the calculation of actuarial equivalence is based on total expenditures (including expenditures incurred by employers and expenditures incurred by retirees through cost-sharing requirements), employers may be able to collect more then they actually spend on benefits. The *Wall Street Journal* reports that the rules "don't resolve [retiree advocates'] concern that employers will get reimbursed not just for what they spend on prescriptions but for what retirees spend themselves – even if employers shift more of their own costs onto retirees." (*The New York Times*, January 31st; *The Wall Street Journal*, January 28th)

- The Kaiser Commission on Medicaid and the Uninsured released "Implications of the Medicare Modernization Act for States," a report describing observations from a focus group discussion with 14 state Medicaid officials. Participants were asked to provide "a practical, implementation perspective" on a number issues related to the MMA, including treatment of Medicare beneficiaries who are dually eligible for Medicare and Medicaid (often called "dual eligibles"), monthly payments states make to the federal government to finance a share of the Medicare drug benefit for dual eligibles, and the state's role in the low-income subsidy program. The officials identified several concerns they have with the new Medicare drug benefit. Most of the officials expressed concern that their state would fare poorly as a result of the MMA because they expect the law may require new state resources and may jeopardize continued access to prescription drugs dual-eligibles are taking. Many officials thought the MMA will help many low-income Medicare beneficiaries, but expressed

concern that the drug coverage dual eligibles receive through private drug plans may be more limited than the coverage they have previously gotten through Medicaid. In addition, the officials generally think that the timeframe for moving dual eligibles into Medicare drug plans poses major challenges because state officials will have very little time between the announcement of private drug plans (fall 2005) and the end of Medicaid prescription drug coverage (January 1, 2006) to get dual eligibles into prescription drug plans. The full report is available online at: www.kff.org.

- The Kaiser Commission on Medicaid and the Uninsured released a new issue brief: "The New Medicare Prescription Drug Law: Issues for Enrolling Dual Eligibles into Drug Plans." The issue brief, prepared by Richard Jensen, identifies potential 'glitches' that could occur as dual eligibles transition from Medicaid to Medicare for their prescription drug coverage. The brief is based on a review of the MMA, along with the proposed regulations on the MMA released in August of 2004 by the Department of Health and Human Services. In the issue brief, the author identifies four potential glitches in the transition: (1) more than 6 million dual eligibles must be enrolled in new Medicare drug plans and begin using them for coverage just six weeks after they become available; (2) the short time frame in which dual eligibles are expected to sign up for a private drug plan will make "deliberate and voluntary" choice of plans difficult; (3) automatic enrollment may prove an essential mechanism for enrolling dual eligibles in private drug plans, but may also be problematic in so far as it is difficult to reach, inform and enroll all dual eligibles by January 2006; and (4) once enrolled in a Medicare plan, dual eligibles are likely to need ongoing assistance in figuring out how their plans work, which drugs they cover and working with their physicians to make sure they are able to get the medications that they need. The author argues that major education and outreach efforts aimed at dual eligibles are needed to smooth the transition to Medicare prescription drug coverage. The issue brief can be accessed online at: www.kff.org.

- On January 13th, *Medicare Advantage News* published an interview with CMS Administrator Mark McClellan. In the interview, McClellan discussed the future of the Medicare Advantage program. He said that CMS has seen a lot of interest in Special Needs Plans and that there are a lot of potential regional PPO bidders. He also noted "the local plans are definitely coming back." McClellan predicts that after the MMA is fully implemented, about one third of Medicare beneficiaries will be enrolled in a local or regional MA plan. (*Medicare Advantage News*, January 13th)

- On January 10th, *Managed Care Week* reported that health plan officials say the United States Pharmacopeia (USP) model formulary guidelines released on January 3rd are a reasonable compromise and should not hinder participation in the Medicare Part D program. *Managed Care Week* reported that Kaiser Permanente expects to participate as a Medicare Advantage prescription drug (MA-PD) plan and that the Regence Group will likely submit both MA-PD and prescription drug plan (PDP) applications. (*Managed Care Week*, January 10th)

- On January 27th and 28th, the National Academy of Social Insurance (NAS) held a conference on facing the challenges of modernizing Medicare in a polarized environment. The conference focused on key issues related to the implementation of the Medicare Modernization Act (MMA), including the prescription drug benefit, the future of the Medicare Advantage program, the implications of the MMA for social insurance principles, the challenges of serving low-income beneficiaries and payment incentives for quality care. There were five plenary sessions at the conference: (1) "Goals of the MMA and Congressional Outlook in 2005" with panelist Newt Gingrich, Center for Healthcare Transformation and former speaker United States House of Representatives; (2) " New Survey Results on Beneficiary Attitudes Towards Medicare" with panelist Drew Altman, Kaiser Family

Foundation; (3) "The Future of Medicare Advantage" with panelists Jack Ebeler, Alliance for Community Health Plans and Marsha Gold, Mathematica Policy Research; (4) "The Future of Medicare" with Congressman Pete Stark; and (5) "Reflections on Implementing the MMA" with CMS Administrator Mark McClellan. At the conference, CMS Administrator Mark McClellan A full transcript of each plenary session is available at www.kaisernetwork.org.

- On January 14th, *BNA's Medicare Report* published an article on the challenges CMS will face in 2005 as the agency begins implementing the Medicare prescription drug benefit. The article suggests that the first indicator of whether the Part D program will be successful is likely to appear in February, when CMS receives intent-to-bid documents from plans interested in applying to offer drug coverage. *BNA's Medicare Report* reports that CMS is "hearing a lot of positive stories" about health plan interest in Part D. It also notes that industry sources are predicting that more managed care plans, including preferred provider organizations (PPOs), are likely to offer drug coverage to Medicare beneficiaries because they are already participating in Medicare and have received favorable payment increases in the MMA. (*BNA's Medicare Report*, January 14th)

NEWLY RELEASED RESEARCH STUDIES NOT PREVIOUSLY DESCRIBED

- **Federman, Alex, Bruce Vladeck, and Albert Siu. "Avoidance of Health Care Services Because Of Cost: Impact Of The Medicare Savings Program." *Health Affairs*, vol. 245, no. 1, January/February 2005.**

  The Medicare Savings Program (MSP) pays the Medicare Part B premium and co-payments for Medicare beneficiaries – known as qualified Medicare beneficiaries (QMBs) – with annual incomes below 100 percent of poverty and annual assets less than $4,000 for singles or $6,000 for couples. In this study, the authors examine the association between QMB coverage and avoidance of physician visits, hospital visits, and prescription filling because of costs. The authors used data from the 2001 Study of Seniors' Prescription Coverage, Use and Spending to estimate the likelihood that beneficiaries avoided care because of cost. After controlling for other factors, overall avoidance rates were high. For example, 31 percent of seniors reported avoiding physician visits because of cost in the previous year. The authors found that QMB participation may have had a protective effect: QMB enrollees were half as likely as non-enrollees to say that they avoided a doctor visit and were less likely to avoid a hospital visit or a prescription refill because of cost. When the sample was limited to the subgroup of low-income seniors without Medicaid drug coverage, the authors found that QMBs were less likely than non-enrollees to report avoiding a physician visits because of cost. The authors conclude that QMB participation may facilitate continuity of care by removing financial barriers to outpatient care. However, they note that the MSP is under-enrolled by as much as 65 percent, which means that many low-income seniors are unnecessarily avoiding using healthcare services because of the 20 percent Part B co-payment.

- **Rice, Thomas, Katherine Desmond and Peter Fox. "Does Open Enrollment Control Premiums? A Case Study from the Medigap Market." *Inquiry*, vol. 41, Fall 2004.**

This article provides a case study of Medigap regulation that went into effect in Missouri in 1999. The new regulations liberalized the open enrollment period, allowing Medicare beneficiaries to switch Medigap carriers once a year. The authors evaluated the impact of Missouri's regulatory changes by comparing changes in premium level and variability in Missouri with changes in Kansas and Florida over a seven-year period using premium comparison data made available by the states. They found little evidence that Missouri's open enrollment policy change had an effect on premiums charged by Medigap carriers in the state. The authors also found that consumers in Missouri were more likely than consumers in the other states to switch to low-cost carriers after the policy change. The authors suggested that this finding might indicate that the law afforded beneficiaries greater protection both by encouraging insurers to keep their rates affordable and by allowing a safety valve for those individuals for whom premiums have become too high.

OTHER SIGNIFICANT EVENTS

X None.