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MEDICARE ADVANTAGE AND MEDICARE BENEFICIARIES
Monthly Tracking Report for March 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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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: Mar. 2005	Change From January*	Same Month Last Year	
			Mar. 2004	Change From Mar. 2004 – 2005
Contracts				
Total	316	+5	285	+31
CCP	179	+4	145	+34
PPO Demo	34	0	35	-1
PFFS	7	+1	4	+3
Cost	29	0	33	-4
Other	67	0	68	-1
Enrollment				
Total	5,634,125	+112,435	5,297,384	+336,741
CCP	4,838,080	+82,849	4,582,809	+255,271
PPO Demo	118,828	+4,887	91,195	+27,633
PFFS	77,108	+19,036	29,950	+47,158
Cost	325,543	-5,188	331,403	-5,860
Other	274,566	+10,851	262,027	+12,539
Penetration*				
Total MA Penetration	13.0%	+0.1% points	12.4%	+0.6% points
CCP + PPO Demo Only	11.5%	+0.1% points	11.1%	+0.4% points

Penetration rates for January and March 2005 are calculated using the number of eligible beneficiaries reported in the December 2004 State/County File. Penetration rates for March 2004 are calculated using the number of eligible beneficiaries reported in the March 2004 State/County File.
* February data were not released. January data are used instead.

NEW ON THE WEB FROM CMS

About Requirements, New Contracts and Withdrawals

- CMS has decided not to post a list of organizations that submitted a notice of intent to apply for a Medicare Part D contract. Several organizations had asked CMS to post the list so that potential partners could target their contracting efforts on those organizations; however; due to the proprietary nature of this information, CMS decided against releasing the information. Instead, CMS is inviting organizations that would like to partner with Part D sponsors to submit their contact information so that CMS can display these details on its website starting on April 1st, 2005. More details are available at: www.cms.hhs.gov/pdps.

- This month CMS issued draft instructions and a pricing tool for submission of Medicare Advantage and Prescription Drug Plan (PDP) bids beginning in contract year 2006. The instructions describe the steps to complete the MA and PDP bid forms. The MA bid form replaces the previous adjusted community rate (ACR) worksheet. CMS solicited comments on these bid forms and instructions through March 17th. The final bid form and instructions will be available for download on April 8th via the HPMS system. The bid forms are available online at: www.cms.hhs.gov/healthplans.

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
Oxford Health Plan of New York	Westchester County, NY	N	145,000
Universal Health Care	Polk County, FL	N	100,000
Humana Health Plan	Cook County, IL	N	688,000
SummaCare	Stark County, OH	N	70,000
Three Rivers Health Plans Inc.	Berks County, PA	N	64,000
United Healthcare Insurance Co. (new PPO plan)	Sedgwick County, KS	Y	62,000
New York-Presbyterian Community Health Plan (new HMO plan)	New York City, NY (not including Staten Island)	N	980,000
LIFE Pittsburgh (new PACE plan)	N/A	N/A	N/A

About Medicare Advantage

- This month, CMS announced that it will host a Medicare Modernization Act (MMA) Bidding Conference in Washington, DC on April 4th and 5th. The conference will have two concurrent tracks – a Medicare Advantage (MA)/Prescription drug track and an Actuarial track. Topics that will be covered by the Actuarial Track include: the statutory and regulatory basis for bidding, the bid form, special plan types, and review / negotiation of bids. Topics that will be covered by the

MA/Prescription Drug Track include: formulary review, prescription drug and MA negotiation, the Medicare Personal Plan Finder, employer groups, and an overview of the pricing tool and risk adjustment. For more information about topics covered during the conference and registration, please log on to: www.cms.hhs.gov.

- This month, CMS released a draft chart that "maps" the benefit categories from the MA Plan Benefit Package (PBP) with those from the MA Bid Pricing Tool (BPT). The draft 2006 MA BPT and MA PBP contain benefit categories that do not correlate one-for-one. This chart is intended to help MA plans match up the benefit categories from these tools. CMS solicited comments on the usefulness of this chart from MA plans and other users through March 25th, 2005. The chart is available at www.cms.hhs.gov/healthplans.

About Drug Card and Other Features of Medicare Related to MA

- On March 23rd, the Medicare Trustees released their annual report. In the report, the Trustees estimate that: (1) the Hospital Insurance (HI) Trust Fund will remain solvent until the year 2020; (2) Part B spending is experiencing growth averaging almost 11 percent per year over the last 5 years, with costs expected to nearly double over the next 10 years; and (3) taken together, total costs for the Part A, B and D trust funds are projected to increase substantially over the next 75 years – growing from 2.6 percent of gross domestic product (GDP) today to 13.6 percent by 2079. The full report is available online at www.cms.hhs.gov/publications/trusteesreport.

ON THE CONGRESSIONAL FRONT

MA Specifically

- None.

Broader Medicare Reform (in Brief)

- On March 4th, the Congressional Budget Office (CBO) released its analysis of the President's budget for fiscal year 2006, which includes revised estimates of spending for the Medicare Part D prescription drug program. In November 2003, CBO estimated that the Medicare Modernization Act (MMA) would result in additional direct spending totaling about $395 billion over the 2004 – 2013 period. CBO currently estimates that net Medicare spending for the Part D program will total $593 billion over the same period, in part because CBO now expects that prescription drug plans (PDPs) will be slightly less effective at controlling drug spending than was thought before CMS issued formulary guidance last month. CBO also calculated spending for the period 2006 – 2015, which encompasses two more years of the drug benefit. CBO estimates that net mandatory spending for Medicare Part D will total about $258 billion during those two additional years. More information is available online at: www.cbo.gov.

FROM THE PERSPECTIVE OF BENEFICIARIES

- None.

FROM OTHER STAKEHOLDERS

- On March 14th, the Henry J. Kaiser Family Foundation hosted a policy workshop on the use of drug formularies in the private sector and their potential implications for the new Medicare drug benefit, which goes into effect January 1, 2006. The workshop featured a panel of experts including Dan Mendelson, Health Strategies Consultancy; Jack Hoadley, Georgetown University; Babette Edgar, CMS; Tom Paul, UnitedHealth Group Company; Sara Rosenbaum, George Washington University; George Taler, Washington Hospital Center and Jay Russell Teagarden, Medco. Kaiser Family Foundation Executive Vice President Diane Rowland moderated the panel. At the workshop Dan Mendelson noted that there are fundamental differences between the Medicare population and the private sector. He said: "You have an older population, a sicker population, general lower income status than you see formularies operating in the commercial sector." He also noted that the risk arrangement differs because prescription drug plans (PDPs) will take risk for drugs. Tom Paul said that the Medicare program also differs from the commercial market in the sense that most commercial programs are based on groups or group packages. By contrast, the Medicare program is a consumer-based program, meaning "people will make decisions based on the information they have on how the formulary, content, and how the overall benefit design is laid out." He noted that the "key to that is simplicity and how simple you can make it." A full transcript of the workshop is available online at: www.kaisernetwork.org.

- On March 3rd, *CQ HealthBeats* reported that CMS officials are "taking a number of steps" to ensure that individuals who are dually eligible for Medicare and Medicaid (often called "dual eligibles") with mental illnesses who currently receive prescription drug coverage under Medicaid will experience a smooth transitions when they are automatically enrolled into PDPs on January 1, 2006. However, the article notes that some advocates are concerned because the random assignment of dual eligibles to PDPs could mean that a beneficiary is enrolled in a plan that does not meet their needs. (*CQ HealthBeats*, March 3rd)

- This month, the Henry J. Kaiser Family Foundation updated its Medicare Health Plan Tracker website. The website, which provides basic information about Medicare private plans such as plan participation and beneficiary enrollment at the national, state and county level, now provides data by Medicare Advantage region. In addition, the Kaiser Foundation has added a new feature that allows users to download data from the site for further research and analysis. The Medicare Health Plan Tracker can be accessed at: http://www.kff.org/medicare/healthplantracker/index.jsp.

- On March 18th, the *Wall Street Journal* reported that UnitedHealth Group plans to partner with Walgreen to offer a prescription drug plan (PDP) under Medicare beginning in 2006. According to the Journal, officials for UnitedHealth said that they decided to partner with Walgreen because of the pharmacy chain's consumer experience and large retail presence (4,738 pharmacies nationwide), which they expect will attract Medicare beneficiaries. Walgreen PBM, Walgreens Health Initiatives, will administer the PDP. (*Wall Street Journal*, March 18th)

- On March 21st, the *Cleveland Plain Dealer* reported that the Social Security Administration (SSA) is planning a pilot program to identify problems in the application that beneficiaries will use to apply for financial assistance with the Medicare prescription drug program. The SSA plans to send the application to 2,050 randomly selected beneficiaries. According to the *Plain Dealer*, the SSA will conduct follow up phone calls with beneficiaries who do not return the application form within two weeks so that the agency can identify and correct problems with the form. However, glitches identified by the pilot program will not be fixed before the SSA mails 20 million more applications out in May. In related news, the *New York Times* reported that the Bush Administration has sent the first of some 20 million applications to low-income people who might qualify for financial assistance with Medicare's new prescription drug benefit. The applications have been sent to Medicare beneficiaries in 42 zip codes in 21 states. However, according to the Times, some advocates for low-income people are concerned the form is so complex that they expect fewer than 5 percent of the people to respond. James Firman, President of the National Council on Aging, said that some low-income people would be confused or intimidated by parts of the seven-page application form. However, Jo Anne Barnhart, the Commissioner of Social Security defended the form. She said: "this is the most comprehensively evaluated form we have ever produced." (*Cleveland Plain Dealer*, March 21st, *New York Times*, March 28th)

- On March 21st, the *Orlando Sentinel* reported that millions of low-income seniors are "missing out" on the transitional assistance subsidies available through the Medicare discount drug card program because they do not know that the subsidies are being offered. According to the *Sentinel*, Medicare is trying to reach more eligible people before March 31st – the deadline for the full $600 subsidy for 2005. (*Orlando Sentinel*, March 21st)

- On March 24th, the *Chicago Tribune* reported that three quarters of the 7 million low-income Medicare beneficiaries who are eligible for transitional assistance subsidies on prescription drugs have not enrolled in the prescription drug discount card program. In fact, as of February 28th, only 1.73 million beneficiaries had enrolled in the transitional assistance program. According to the *Tribune*, some critics attributed the problem to a complicated enrollment process. However, Medicare officials have said that many eligible beneficiaries who have not enrolled in the program are enrolled in other drug-assistance programs, such as those administered by state and local governments. (*Chicago Tribune*, March 24th)

- This month the Henry J. Kaiser Family Foundation released a new fact sheet on the Medicare Part D prescription drug benefit. The fact sheet explains how the Part D benefit is structured. The fact sheet also provides estimates of the number of beneficiaries likely to enroll in Part D (29.3 million), the number of beneficiaries eligible for Part D low-income subsidies (14.5 million) and the number of beneficiaries expected to receive drug coverage comparable to Part D under an employer plan (9.8 million). Finally, the fact sheet describes how Part D benefits interact with other sources of coverage such as employer-sponsored plans, Medicaid, Medicare Advantage plans, Medigap plans and State Pharmaceutical Assistance Programs. The fact sheet can be accessed at: www.kff.org.

- This month the Henry J. Kaiser Family Foundation released a new table: "A Comparison of Proposed and Final Regulations Governing Medicare Part D Plan Enrollment and Part D Benefit Appeal and Grievance Procedures" prepared by Sara Rosenbaum. The table provides a comparison of the proposed and final regulations on key aspects of appeals and grievance protections under the MMA, from Subpart M (Grievances, Coverage Determinations, and Appeals) and Subpart P (Premiums and Cost-Sharing Subsidies for Low-Income Individuals) in the final rule. This analysis follows up on an

earlier analysis of Part D appeals and grievance rights, which was released in September 2004. The table is available online at www.kff.org.

- On March 28th, the *Wall Street Journal* reported that premiums for Medicare Part B will increase by an estimated 12 percent in 2006, from $78.20 to $87.70 per month. In the article, CMS Chief Actuary Richard Foster noted: "many of tomorrow's Social Security beneficiaries might not be able to afford their Medicare benefits. That could slow down their consumption of health care in a way that none of us wants." Foster also noted that the Medicare Part B premiums could increase by 14 to 15 percent if Congress increases Medicare reimbursements to physicians in 2006. (*Wall Street Journal*, March 28th)

- On March 25th, the *New York Times* reported that many states are finding that they will lose money when the new prescription drug benefit goes into effect. According to the *Times*, Congress intended to relieve states of prescription drug costs for low-income people when it passed the MMA. However, due to provisions in the MMA that require states to make contributions (called clawback payments) to the federal government to cover some of the prescription drug costs for these Medicare beneficiaries, some states may fare worse under the new law. The *Times* reported that the Bush Administration expects state to realize savings of $7.9 billion over the next five years, in part because Medicare will cover drug costs for retired state employees. However, some state officials, including many governors, are concerned that the clawback payments will result in a net loss for states. (*New York Times*, March 25th)

NEWLY RELEASED RESEARCH STUDIES NOT PREVIOUSLY DESCRIBED

- **Danzon, PM, GR Wilensky and KE Means. "Alternative strategies for Medicare payment of outpatient prescription drugs – Part B and beyond."** ***American Journal of Managed Care*****, vol. 11, no. 3, March 2005.**

  In this study, the authors examine how reimbursement options for pharmaceuticals covered under Medicare Part B (physician-dispensed drugs) are changing and how the new Part D Medicare outpatient drug benefit brings further changes. The MMA replaces the traditional policy of reimbursing Part B drugs at 95 percent of average wholesale price (AWP) with a percentage markup over the manufacturer's selling price with a new policy. Under the new policy, which will be introduced in 2005, an indirect competitive procurement option will be introduced. The authors argue that, although AWP-based reimbursement has been "fraught with problems in the past," constraining AWP growth and periodically adjusting the discount off the AWP could solve the issue, preserve incentives for competitive discounting and deliver savings to Medicare. The authors also argue that basing Medicare reimbursement on a manufacturer's average selling price undermines incentives for discounting and may result in higher prices to both public and private purchasers.

- **Gold, Marsha and Lindsay Harris. "Profile and Analysis of the 26 Medicare Advantage Regions." Menlo Park, CA: The Henry J. Kaiser Family Foundation, March 2005. (www.kff.org).**

  In this issue brief, the authors review the characteristics of the new Medicare Advantage (MA) regions and the extent of MA presence in those regions currently. They also analyze how regions compare to current service markets for some of the firms that may be best positioned to offer regional MA plans and what that may mean for regional MA offerings. They found that the number of beneficiaries in each region, the mix of urban and rural beneficiaries, and current experience with MA varies widely between regions. They also found that although there is extensive choice (i.e. availability of MA plans) in 11 of the 26 regions, in many others significant barriers to regional entry and stable offering exist. The authors also discuss national firms that currently dominate the MA market. They argue that the speed of implementation and infrastructure requirements may make it easier for experienced firms to participate in the regional market beginning in 2006, but that the decision to offer a regional MA plan involves a trade-off between potentially larger markets in regions and the control firms now have with the local option to define the market and shape their product to meet it. Their analysis "highlights the substantial gap between the current availability and enrollment in Medicare's private plans with that intended after 2006."

- **Gross, David, Stephen Schondelmeyer, Susan Raetzman and Molly Melvin. "Trends in Manufacturer List Prices of Generic Prescription Drugs Used by Older Americans – Second and Third Quarter 2004 Update." Washington, DC: AARP Public Policy Institute, March 2005. (www.aarp.org)**

  This study reports on changes in the prices generic drug manufacturers charge wholesalers and direct purchasers during the second and third quarters of 2004. The authors identified the most widely used prescription medications using sales data from the AARP Pharmacy Service. The authors identified the wholesale drug prices using costs published in the Medi-Span Price-Chek PC database. The authors found that manufacturer list prices for a sample of 75 commonly used generic drugs rose by 4.8 percent in the 12 months ending with the second quarter (June) of 2004 and 1.2 percent in the 12 months ending with the third quarter (September) of 2004 (when measured as a 12-month rolling average and weighted by actual 2003 sales to Americans age 50 and over). The authors also measured "year-to-date" percentage changes through the first three quarters of 2004. They found that only 7 of the 75 generic drugs studied had an increase in manufacturer list price over this time period.

- **Hoadley, Jack. "The Effects of Formularies and Other Cost Management Tools on Access to Medications: An Analysis of the MMA and the Final Rule." Menlo Park, CA: The Henry J. Kaiser Family Foundation, March 2005. (www.kff.org)**

  This policy brief examines the provisions of the Medicare Modernization Act (MMA), the final regulations governing the Medicare Part D benefit, and CMS guidance with regard to the use of cost management tools such as formularies. Specifically, the brief considers how these provisions affect beneficiaries' access to needed medicines and plans' ability to manage drug costs. In the brief, the author argues that formularies, cost-sharing and the use of tools like prior authorization will be critical to whether beneficiaries can get the drugs that they need. The author concludes that it will be critical that CMS give careful consideration to key beneficiary protections by ensuring: (1) the review of formularies and cost management tools with regard to the non-discrimination test is meaningful and can be enforced; (2) the therapeutic classification system provides appropriate access to drugs

that beneficiaries need; (3) that the actuarial equivalence standard prevents the use of cost-sharing that is prohibitive to beneficiaries; and (4) that pharmacy and therapeutic (P&T) committees can base decisions on scientific evidence and that their role in advising plan sponsors is more than symbolic.

- **Lin, CJ, D Musa, M Silverman and HB Degenholtz. "Do managed care plans reduce racial disparities in preventive care?"** ***Journal of Health Care for the Poor and Underserved*****, vol. 16, no. 1, February 2005.**

  In this study, the authors examined whether managed care plans reduce racial disparities in use of influenza vaccination, mammography, and prostate-specific antigen screening. The study analyzed the use of three types of preventive care in a population-based sample of 463 African-American and 592 white adults who were 65 years or older and were enrolled in a Medicare managed care or private fee-for-service plan in Allegheny County, Pennsylvania. The authors found that fewer African-Americans than white reported having had an influenza vaccination (64.4 percent versus 76.5 percent) or a prostate-specific antigen test (64 percent versus 71.2 percent) during the previous year. Slightly more African American women reported having a mammogram (66.1 percent versus 63.8 percent). Using logistic regression, and controlling for health plan type, the authors found that African Americans were significantly less likely to have an influenza vaccination than whites. There was no significant difference in rates between managed care and private-fee-for service plans.

OTHER SIGNIFICANT EVENTS

X None.