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MEDICARE ADVANTAGE AND MEDICARE BENEFICIARIES
Monthly Tracking Report for November 2004

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: Nov. 2004	Change From Last Month	Same Month Last Year	
			Nov. 2003	Change From Nov. 2003 - 2004
Contracts				
Total	300	+2	285	+15
CCP	154	+1	151	+3
PPO Demo	35	0	33	+2
PFFS	6	0	4	+2
Cost	29	0	30	-1
Other	76	+1	67	+9
Enrollment				
Total	5,472,313	+27,195	5,324,069	+148,244
CCP	4,701,396	+18,685	4,624,965	+76,431
PPO Demo	109,778	+1,869	77,401	+32,377
PFFS	47,494	+3,119	25,274	+22,220
Cost	330,783	+445	335,053	-4,270
Other	282,862	+3,077	261,376	+21,486
Penetration*				
Total MA Penetration	12.8%	+0.0% points	12.6%	+0.2% points
CCP + PPO Demo Only	11.3%	+0.0% points	11.2%	+0.1% points

Penetration rates for November 2004 are calculated using the number of eligible beneficiaries reported in the September 2004 State/County File. Penetration rates for November 2003 are calculated using the number of eligible beneficiaries reported in the September 2003 State/County File.

- There are pending applications for 33 M+C plans, 2 PFFS plans, 3 PACE plans, 7 Cost plans and 3 HCPP plans. Service area expansions are pending for 25 M+C plans, 8 PACE plans, and 5 PPO Demo plans.

NEW ON THE WEB FROM CMS

About Requirements, New Contracts and Withdrawals

- None

Summary of service area expansions announced in November 2004:

Firm	Areas Served	Is this the only plan in the area (yes/no)	Number of beneficiaries
PacifiCare of California, Inc.	San Francisco County, CA	N	287,000
	San Mateo County, CA		
Healthspring, Inc.	Fayette County, TN	N	152,000
	Shelby County, TN		
	Tipton County, TN		
Arcadian Health Plan	Spokane County, WA	N	65,000
Citrus Health Care Inc.	Polk County, FL	N	99,000
Touchstone Health Partnership	Staten Island, NY	N	63,400
Triple-S Inc.	Puerto Rico	N	602,000
Aetna	Howard County, MD	N	19,000
Aetna	Chester County, PA	N	148,000
	Delaware County, PA		
HealthSpring Inc.	Cook County, IL	N	907,000
	DeKalb County, IL		
	Kane County, IL		
	DuPage County, IL		
	Kendall County, IL		
	Will County, IL		

About Medicare Advantage

- On November 8th, CMS held an Open Door forum: "Discussion of Interim Guidance on Special Needs Plans Under the Medicare Modernization Act." During the discussion, CMS officials indicated that 29 managed care plans have applied to offer special needs plans. Seventeen of the plans have been approved under the new Medicare Advantage program, with 12 applications pending. The vast majority of applications are for plans that would enroll beneficiaries who are dually eligible for Medicare and Medicaid (often called dual eligibles). Managed care organizations (MCOs) are currently allowed to apply to offer plans to dual eligibles or to beneficiaries who are institutionalized, but not to a subgroup of either beneficiary category. Plans will be able to apply to offer plans to those with disabling conditions in early 2005. (*BNA's Medicare Report*, November 17th).

- On December 6th (before we went to press) CMS announced the establishment of 26 Medicare Advantage regional PPO regions and 34 Private Drug Plan (PDP) regions. More information on the factors that led to the creation of these regions, and maps showing where the regions are located are available from CMS, at: http://www.cms.hhs.gov/medicarereform/mmaregions/.

About Drug Card and Other Features of Medicare Related to MA

- None.

ON THE CONGRESSIONAL FRONT

MA Specifically

- MedPAC will hold its next public meeting on December 9th and 10th. 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)

- On November 16th and 17th, the Medicare Payment Advisory Commission (MedPAC) held a public meeting to discuss a variety of issues related to the Medicare program including value based purchasing and physician pay for performance. The Commission discussed the growth in Medicare spending (which is outpacing growth in payroll taxes) and the need to ensure that the program gets the most value for money by rewarding efficient healthcare providers. MedPAC Commissioner Bill Scanlon, noted "The idea that Medicare is going to be a value based purchaser is one that I think we really need to emphasize. And emphasizing that to me means that Medicare is trying to efficiently purchase access to quality services for its beneficiaries." The Commission also discussed several mandated reports such as a report on eliminating physician referrals to physical therapy, a report on physician volume, and a report on the impacts of specialty hospitals on community hospitals and markets. Please note: a full transcript of the meeting is now available at: www.medpac.gov.

FROM THE PERSPECTIVE OF BENEFICIARIES

- Thirteen groups, including the American Heart Association and the National Alliance for the Mentally Ill, are circulating their comment letters to CMS on patient protections in the proposed rule governing the Medicare Part D benefit. The groups want CMS to ensure that seniors have access to all medically necessary medications. The groups also want CMS to allow more input from consumers and consumer groups as it develops the benefit and any regulatory rules that could limit access, such as drug formularies and prior authorization requirements. (*BNA's Health Care Policy Report*, November 17th)

FROM OTHER STAKEHOLDERS

- On November 7th, *The New York Times* reported that the National Association of Insurance Commissioners (NAIC) sent a letter to CMS arguing that the agency had gone beyond the scope and purpose of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) in requiring Medigap Insurers to send policyholders a notice indicating that the new drug benefit (Medicare Part D) offers beneficiaries greater value than their current policies. *The Times* reported that the NAIC opposed the requirement because it felt CMS was using "precisely the type of push advertising technique that the NAIC and its members oppose and prohibit at the state regulatory level" especially as the value of the drug benefit is contingent on a number of factors such as medical conditions, drug costs and financial situations. (*The New York Times*, November 7th)

- On November 12th, the HHS Office of the Inspector General (OIG) released an audit reviewing HealthNow New York Inc.'s Senior Blue Health Plan's compliance with Medicare+Choice prompt payment regulations between August 1, 2003 and January 31, 2004. OIG found that HealthNow substantially complied with Federal prompt payment regulations for claims submitted by non-contracted providers and paid over 95 percent of claims within 30 days of receipt. However, OIG found that HealthNow did not pay or deny some claims within 60 days of receipt. OIG recommended that HealthNow ensure all claims are paid or denied within 60 days. The full OIG report is available at: http://oig.hhs.gov/oas/reports/region2/20401016.pdf.

- On November 17th, the *Christian Science Monitor (CSM)* published an article: "Will red tape seal up drug-benefit plans?" The article examines the success of the Medicare drug discount card program and the challenges CMS will face in initiating the Part D program. These challenges include ensuring beneficiaries understand the new program and are able to choose a drug plan, and shifting 6.5 million people from Medicaid to various private plans under Medicare over a 6-week period. *CSM* notes that to date about 5.8 million beneficiaries have signed up for discount cards, including 2.5 million who were auto-enrolled in a discount card by their MA plan. (*Christian Science Monitor*, November 17th) Please note: CMS has not released official numbers on the number of beneficiaries enrolled in discount drug cards since July 30, 2004.

- This month, America's Health Insurance Plans (AHIP) released the results of a post-election survey of people who voted in the 2004 Presidential election. AHIP surveyed 1000 individuals. These individuals were selected by random digit dialing of households across the U.S. The survey covered a broad array of health care and health insurance issues, including health plan choice in the Medicare program. The results showed that approximately three quarters of those surveyed thought it was very important for Medicare recipients to have "the same choices of private health coverage that are available to the rest of the population." Another 19 percent of those surveyed thought it was somewhat important for Medicare beneficiaries to have "the same choices of private health coverage that are available to the rest of the population." More information about the survey methodology and results is available online at: www.ahip.org.

- On October 25th, Milliman, a Seattle-based consulting firm, released the results of its annual Group Health Insurance Survey. The survey used a sample of plans, representing approximately 40 percent of the commercial large-group market. Milliman's results showed that all of the plans surveyed which are currently offering a Medicare Advantage product expect to continue to participate in the program in 2005. Forty-one percent of these respondents expect to expand their service area in 2005. The survey results also showed that the largest reported impediment to offering or expanding

Medicare Advantage products is the uncertainty of future funding levels. (www.milliman.com)

- This month, InterStudy Publications released new research on enrollment in Medicare Health Maintenance Organizations (HMOs). The research uses data from InterStudy's Fall 2004 HMO County Surveyor. The data showed that HMO enrollment in the six largest states – California, Texas, New York, Florida, Illinois and Pennsylvania – increased by 16.4 percent between 2003 and 2004. More information about the Interstudy HMO County Surveyor data (which is available for purchase) can be accessed online at: www.interstudypublications.com.

- On November 15th, *Managed Care Week* reported that several health insurers who participate in the Medicare Advantage program have expanded their service areas because of the increased payment rates authorized by the MMA. Among the insurers that have expanded their service areas are WellCare Health Plans (in Louisiana), Citrus Health Care (in Florida), PacifiCare (in Washington and California), Arcadian Health Plan (in Washington), HealthNet (in California), HealthSpring (in Tennessee), Texas HealthSpring (in Texas) and AmeriHealth HMO (in Pennsylvania). (*Managed Care Week*, November 15th)

NEWLY RELEASED RESEARCH STUDIES NOT PREVIOUSLY DESCRIBED

- **Jackson, J. Elizabeth, Mark Doescher, Barry Saver, and Paul Fishman. "Prescription Drug Coverage, Health, and Medication Acquisition Among Seniors with One or More Chronic Conditions." *Medical Care*, vol. 42, no. 11, November 2004.**

  This study examines the association between prescription drug benefit coverage and medication acquisition for a group of Medicare+Choice enrollees with chronic conditions. The study uses pharmacy fill records for 3073 Medicare beneficiaries aged 67 or older with 1 or more chronic conditions (including hypertension, diabetes, congestive heart failure and coronary artery disease), who were enrolled in the Group Health Cooperative HMO in Washington State between 1998 and 2000. The authors used multivariate regression models to determine the association between prescription drug coverage and two outcome measures: the mean daily number of essential therapeutic drug classes and refill adherence. The authors found a significant, but modest, association between prescription benefits and acquiring medications. Their regressions showed that persons without a prescription benefit acquired medications in 0.15 fewer therapeutic classes daily and experienced lower refill adherence (approximately 7 fewer days of necessary medications during the course of 2 years) than those with a prescription drug benefit after controlling for other factors.

- **Mays, Jim, Monica Brenner, Tricia Neuman, Juliette Cubanski and Gary Claxton. "Estimates of Medicare Beneficiaries" Out-Of-Pocket Drug Spending in 2006." Washington, DC: The Henry J. Kaiser Family Foundation, November 2004.**

  In this study, the authors estimate annual out-of-pocket spending on prescription drugs by Medicare beneficiaries who are expected to enroll in Medicare Part D plans in 2006. The authors use a model developed by Actuarial Research Corporation (ARC) to forecast the effects the Medicare Prescription Drug, Improvement and Modernization Act (MMA) will have on drug spending. The authors project that the 29 million beneficiaries who the Congressional Budget Office assumes will participate in Part D in 2006 will spend an average of 37 percent less out-of-pocket for drugs than they would have in the absence of the MMA. However, the authors found that projected out-of-pocket spending will

vary substantially by income and by total drug costs. Beneficiaries receiving low-income subsidies are projected to spend 83 percent less under the MMA than they would have spent in the absence of the law, while those who are not expected to receive these subsidies are expected to see more modest reductions (28 percent) in out-of-pocket spending. However, the authors predict that the one quarter of Part D participants who will have spending in the "doughnut hole" (the gap in Part D coverage between $2250 and $5,100) will spend more than they would in the absence of the law.

- **Rodgers, Jack and John Stell. "The Medicare Prescription Drug Benefit: Potential Impact on Beneficiaries." Washington, DC: AARP, November 2004. (www.aarp.org)**

  In this report, the authors examine the potential impact that the MMA prescription drug benefit may have on specific categories of Medicare beneficiaries and on all beneficiaries overall. The authors analyzed publicly available data on prescription drug utilization and spending as well as privately developed computerized models to quantify the impacts over the 10-year budget window between 2004 and 2013. The authors found that the overall impact of the MMA is a $407 billion shift in federal spending to Medicare beneficiaries, health plans, employers and states over the period 2006 to 2013. They also found that the new coverage would boost utilization by 6 percent, lower average drug prices by approximately 8 percent, and lower out-of-pocket spending for the average Medicare enrollee by $435 per year. Medicare Part D will also eliminate catastrophic drug costs for almost all Medicare beneficiaries. The authors also indicate that certain groups, especially those with low incomes not currently covered by Medicaid, will benefit from Part D more than others.

- **Rosenthal, Meredith. "Doughnut-Hole Economics." *Health Affairs*, vol. 23, no. 6, November 2004.**

  In this article, the author reviews the so-called "doughnut-hole" provisions of the new Medicare prescription drug benefit (Part D) and the new cohort of consumer-directed health benefit models, which offer doughnut-shaped insurance coverage with large deductibles that begin around the mean annual spending for enrollees. The author examines the effects these provisions are likely to have on the financial risk faced by enrollees and on the growth in healthcare spending. She argues that first dollar deductibles always offer more protection from financial risk than doughnut holes do. The author suggests that despite this increase in risk in doughnut hole plans, they may be favored because many beneficiaries perceive that a doughnut-hole policy is more generous than one with a first-dollar deductible or because they are concerned with getting their "fair" share of annual benefit spending and/or underestimate their risk of having health care spending in the doughnut hole.

OTHER SIGNIFICANT EVENTS

X On November 8th, Express Scripts, one of the largest U.S. pharmacy benefit managers (PBMs), launched Rx Outreach, a generic drug prescription assistance program for low-income U.S. residents. Individuals who qualify for this program will be able to access more than 50 generic medications for a variety of chronic health conditions such as arthritis, asthma, diabetes and heartburn. Participants will pay $18 for a 3-month supply or $30 for a six-month supply of medications, which are only available by mail. More information is available on the program website, at: www.rxoutreach.com.