Number 66
September 7th, 2004

MEDICARE ADVANTAGE AND MEDICARE BENEFICIARIES
Monthly Tracking Report for August, 2004

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

Prepared by Lindsay Harris, Lori Achman and Marsha Gold, Mathematica Policy Research Inc.
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: August 2004	Change From Last Month	Same Month Last Year	
			August 2003	Change From Aug. 2003 - 2004
Contracts				
Total	294	+2	270	+24
CCP	151	+2	150	+1
PPO Demo	35	0	31	+4
PFFS	5	0	4	+1
Cost	29	0	30	-1
Other	74	0	55	+19
Enrollment				
Total	5,398,835	+22,185	5,304,299	+94,536
CCP	4,650,745	+16,611	4,622,154	+28,591
PPO Demo	104,744	+2,110	69,471	+35,273
PFFS	39,358	+2,001	23,555	+15,803
Cost	329,381	-700	335,114	-5,733
Other	274,607	+21,63	254,005	+20,602
Penetration*				
Total MA Penetration	12.7%	+0.0% pts	12.7%	+0.0% pts
CCP + PPO Demo Only	11.2%	+0.0% pts	11.2%	-0.0% pts

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

- There are pending applications for 23 M+C plans, 1 PFFS plan, 3 PACE plans, and 1 other demonstration plan. Service area expansions are pending for 19 M+C plans, 6 PACE plans, 1 PFFS plan and 5 other demonstration plans.

NEW ON THE WEB FROM CMS

About Requirements, New Contracts and Withdrawals

- On August 16th, CMS approved a request by AmeriChoice of New York, Inc., a subsidiary of UnitedHealth Group, to expand managed care coverage to Medicare beneficiaries in the Bronx, NY. There are approximately 154,000 Medicare beneficiaries in the Bronx. The area is also served by 9 other Medicare Advantage (MA) plans including Aetna, Empire Blue Cross and Blue Shield, HIP Health Plan and Oxford Health Plan of New York. Beneficiaries can sign up for the AmeriChoice plan during the MA open enrollment period.

About Other Program Features

- On July 29th, CMS posted a letter to managed care organizations detailing the implementation of the Medicare Managed Care System (MMCS) on its website. In the letter, CMS indicated that it is planning to have the MMCS assume processing of managed care enrollments and beneficiary-level payments immediately after the September 1st monthly run in mid-August. More information on the MMCS is available on the CMS website: http://www.cms.hhs.gov/healthplans/systems/systeminfo.asp.

- CMS has updated its list of frequently asked questions (FAQs) regarding the 2005 Call Letter instructions for MA plans wishing to participate in the 2005 contract year, which was posted in June. The updated list of FAQs includes a question regarding the benefits preferred provider organizations (PPOs) must offer when the MMA goes into effect in 2006. CMS indicated that PPOs must cover identical in- and out-of-network services; therefore a PPO cannot restrict payment for covered services if an out-of-network provider provides them. PPOs are permitted to impose higher cost sharing for out-of-network services, but cannot impose different annual payment limits for in- and out-of-network services. The list of questions and answers is available online at: http://www.cms.hhs.gov /healthplans/letters/callletter2faq.pdf.

- On August 3rd, CMS published a proposed rule establishing the Medicare Advantage (MA) program in the Federal Register. The proposed rule carries through on Title II of the MMA by establishing a new Medicare managed care program. The MA program, which incorporates the prior Medicare+Choice (M+C) program, will include regional and local preferred provider organizations (PPOs), a competitive bidding system, and separate plans for special populations, such as those with disabling diseases. The comment period will last 60 days, closing on October 4th, 2004. The rule can be viewed online at: http://www.gpoaccess.gov /fr/index.html.

- During an Open Door forum on August 16th, CMS officials indicated that they are seeking comments from outside experts on a variety of topics related to the proposed Medicare Prescription Drug, Improvement, and Modernization Act (MMA) regulations. In particular, CMS is seeking comments related to: (1) how it can approach auto-enrollment of dual eligibles; (2) out-of-network access to emergency drugs covered by the benefit; (3) how state Medicaid programs will reimburse the federal

government for the Medicare drug costs for dual-eligibles; and (4) how to structure rules for special needs plans that cover individuals with complex and disabling diseases. During the forum, CMS officials also indicated that CMS is proposing modifications to the rules that would allow MA plans greater flexibility to disenroll Medicare beneficiaries. Comments on all of these topics are due on October 4th. (BNA's *Health Care Policy Report*, August 25th)

- On August 17th, CMS published its calendar for the MA, MA private drug and cost plan 2006 renewal/non-renewal process and a 2005 transition timeline. The calendar indicates that the final date to submit a 2005 application for a coordinated care plan (CCP), including local PPOs, is February 1st, 2005. It also notes that CMS will begin accepting 2006 plan applications near the end of 2005. The calendar and timeline are available online at: http://www.cms.hhs.gov/healthplans/nonrenewal/2006calendar805.pdf.

- CMS has posted guidelines for discount drug card sponsors to use when developing information and outreach materials for Medicare beneficiaries on its website. The guidelines are intended to help discount card program sponsors in their efforts to educate people with Medicare. Specifically, the guidelines aim to: (1) establish uniform standards by which beneficiaries can review each approved card program; (2) ensure consistent materials across the nation; and (3) assist sponsors in developing information and outreach materials that appropriately educate people with Medicare about the Medicare Prescription Drug Discount and Transitional Assistance Program and the sponsor's own approved card program. The guidelines are available online at: http://www.cms.hhs.gov/discountdrugs/guidelines8-12-04.pdf.

- The United States Pharmacopeia (USP) has issued draft Medicare prescription drug benefit model guidelines for public comment. The guidelines are intended to provide a starting point for structuring formulary categories and classes to be used by prescription drug plan sponsors beginning in 2006. USP will be accepting public comments on the guidelines through September 17th. The draft guidelines are available online at: www.usp.org. CMS has also published a discussion paper on the role of these guidelines in determining formulary adequacy for the Medicare drug benefit. The discussion paper can be accessed at: http://www.cms.hhs.gov/medicare reform/USPWhitePaper.pdf.

- CMS published a discussion paper: "Retiree Drug Coverage under the MMA: Issues for Public Comment to Maximize Enhancement in Drug Coverage and Reductions in Drug Costs for Retirees" on its website (in advance of an Open Door forum on August 19th). The discussion paper outlines proposed regulations for employers and unions that offer enhanced drug coverage to retirees and factors that CMS anticipates will affect employer and union responses to the MMA. CMS is currently seeking comments from these organizations. In particular CMS is interested in learning what employers are likely to do under the various proposed options. The discussion paper is available online at: http://www.cms.hhs.gov/opendoor/retireewhitepaper.pdf.

ON THE CONGRESSIONAL FRONT

M+C Specifically

- None.

Broader Medicare Reform (in Brief)

- MedPAC will hold its next public meeting on September 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.

FROM THE PERSPECTIVE OF BENEFICIARIES

- On August 8th, the *Chicago Tribune* published an article examining the growing popularity of discount drug cards (including the Medicare prescription drug discount cards) and problems associated with their increased use. The *Tribune* reported that individuals using the cards save an average of 35 percent on their prescriptions. It also noted that according to estimates from the Consumer Health Alliance, an association of 11 discount card companies, over 20 million people nationwide have a discount card plan for dental, vision or other types of coverage. The *Tribune* reported that some people have inadvertently dropped insurance plans in favor of the cards because they think the card plans will provide them with insurance. (*The Chicago Tribune*, August 8th)

- AARP has released a new report: "State Government Retiree Health Benefits: Current Status and Potential Impact of New Accounting Standards" by Stan Wisniewski and Lorel Wisniewski. The study examines the potential impact of new standards adopted by the Governmental Accounting Standards Board on state governments and retiree health benefits. It also documents the types of plans, benefits and premiums available to state government retirees. The study is available online at: http://research.aarp.org/health/2004_08_benefits.html.

- The Commonwealth Fund has released a new report: "State Pharmacy Assistance Programs: A Chartbook" by Thomas Trail, Kimberley Fox, Joel Cantor, Mina Silberberg and Stephen Crystal. The report provides current, national data on trends in state pharmaceutical assistance programs (SPAPs). SPAPs provide prescription drug coverage to elderly or disabled residents that do not qualify for Medicaid drug coverage. These programs are changing because the MMA included language allowing states to use SPAPs to "wrap around" the Medicare benefit to fill gaps in coverage. The report addresses: (1) state approaches to addressing drug affordability; (2) program design; (3) program funding and administration; (4) program enrollment and (5) program expenditures and utilization. The data used in the report come from surveys of SPAPs conducted in 2000 and 2002. The full report is available at: http://www.cmwf.org/programs/child/trail_spap_chtbk_758.pdf.

FROM THE OTHER STAKEHOLDERS

- On August 16th, OIG released an audit reviewing the 'related-party' management fees reported by four MA organizations owned by subsidiaries of United HealthCare Services, Inc. in their 1999 financial disclosure reports. OIG was unable to determine whether the administrative costs reported in the organizations' 2001 proposals (which are based on 1999 financial disclosures) represented a fair distribution of costs due to the fact that the organizations did not have effective procedures to compile data on the costs of operations. The full report is available online at: http://oig.hhs.gov/.

- The Government Accountability Office (GAO) released a new report on Medicare Call Center responses to policy-oriented questions from healthcare providers. This report updates information from a 2002 report showing that CMS needed to improve its communications with providers who deliver medical care to Medicare beneficiaries. In 2002, GAO reported that 85 percent of the responses it received from call centers were incorrect or incomplete. GAO undertook the current investigation to determine whether the call centers now provide correct and complete information to providers. GAO found that only 4 percent of the responses it received in 300 calls to 34 call centers were correct and complete. To resolve these issues, GAO recommends that CMS develop a process to route policy questions to staff with appropriate expertise, develop clear and easily accessible policy-oriented materials to assist customer service staff and develop an effective monitoring program for call centers. The full report is available at: http://www.gao.gov/new.items/d04669.pdf.

- During an Open Door forum with CMS on August 19th, union representatives (including representatives from the AFL-CIO, the International Association of Machinists and Aerospace Workers, the Communication Workers of America and the American Federation of State, County and Municipal Employees) urged regulators to make changes to proposed MMA rules in order to safeguard retiree health benefits. The representatives expressed concern that the rules do not include a means for retirees to challenge whether or not an employer's drug benefit is actuarially equivalent to the Medicare Part D benefit. They argued that the final regulations should increase disclosure and transparency requirements and should include an appeals mechanism. CMS is considering the unions' concerns. (*BNA's Medicare Report*, August 27th)

- On July 30th, the White House Office of Management and Budget (OMB) increased its estimate of Medicare spending projections from fiscal year 2005 to fiscal year 2009 by more than $67 billion over its February 2004 forecast. OMB projects that Medicare will spend $290.4 billion in fiscal year 2005 and $345.2 billion in fiscal year 2006 (when the Medicare Part D benefit is implemented). In its report, OMB noted that Medicare and Medicaid spending must be controlled in order to reign in overall spending increases. The full report is available online at: http://www.whitehouse.gov/omb/.

- On August 30th, *BNA's Health Care Policy Report* published the article: "Medicare Part D Proposed Retiree Drug Rules Lack Some Clarity for Employers" by Martha Priddy Patterson. In the article, the author discusses incentives in the MMA that are designed to encourage employers who provide prescription drug coverage for their retirees to continue to provide that coverage when Medicare Part D goes into effect. The author describes the four options available to employers under the law, which include receiving a 28 percent subsidy for the permitted drug costs of Medicare-eligible participants, using its plan to provide benefits that wrap around the Part D benefit, providing an employer-created private prescription drug plan or subsidizing the monthly beneficiary premium for any Medicare Part D prescription drug plan. The author notes that employers will face many challenges in the coming months as they try to weigh their options. (*BNA's Health Care Policy Report*, August 30th)

- On August 11th, the HHS Office of Inspector General (OIG) released an audit reviewing Maricopa Integrated Health System's compliance with Medicare+Choice prompt payment regulations between May 1, 2003 and October 31, 2003. OIG was unable to determine whether Maricopa was compliant or not because it had not designed and implemented an electronic claims processing system to process Medicare+Choice claims and had not established adequate policies and procedures to track claims processed manually. After OIG's investigation, Maricopa initiated a search for an outside contractor

to process claims. The full OIG report is available at: http://oig.hhs.gov/oas/reports/region9/90400026.pdf.

- The USP draft guidelines for the creation of a prescription drug formulary for Medicare Part D (mentioned earlier in this report) have sparked an intense debate between pharmaceutical firms and insurance companies. The guidelines currently list 146 drug classes. Insurers and PBMs contend that a Medicare formulary should have a smaller number of classes so that it creates more competition among drug makers. Pharmaceutical firms are arguing for more drug classes both to increase the likelihood that their products are listed on the formulary and to give consumers broader access to drugs. (*The Charlotte Observer*, August 26th)

- On August 22nd, *The New York Times* reported that the Blue Cross and Blue Shield Association (BCBSA) and America's Health Insurance Plans (AHIP) have sent separate letters to CMS stating that the federal government needs to designate 50 state-based regions if it wants private insurers to participate in Medicare after 2006. The two organizations argue that it is not feasible for private plans to establish networks of physicians and hospitals that span large, multi-state regions or to charge all beneficiaries the same premium when costs vary widely among states. *The New York Times* quoted Diana Dennett, executive vice president of AHIP, as saying: "plans will be discouraged from participating in Medicare if they have to obtain insurance licenses and sign contracts with providers in states where they have never done business." The article also quoted Alissa Fox, policy director for BCBSA, who said: "the only way to assure vibrant competition and expand choices for beneficiaries is to establish 50 state-based regions." (*The New York Times*, August 22nd)

NEWLY RELEASED RESEARCH STUDIES NOT PREVIOUSLY DESCRIBED

- The Summer 2004 issue of the *Healthcare Financing Review* focuses on the Health Outcomes Survey (HOS), a longitudinal survey designed to assess Medicare beneficiaries' physical functioning and mental health over time. The HOS was implemented nationally in Medicare managed care organizations in 1998 and continues today. The HOS was not implemented in fee-for-service Medicare until 2001. Below are summaries of the two articles that most directly relate to the Medicare+Choice program. The other articles in this issue can be accessed at: http://www.cms.hhs.gov/review/04Summer/

    - **Lied, Terry R. and Samuel C. Haffer. "Health Status of Dually Eligible Beneficiaries in Managed Care Plans" *Health Care Financing Review*, vol. 25, no. 4, Summer 2004. (www.cms.gov/review/summer04)**

      In this study, the authors examined the health status of dually eligible Medicare/Medicaid beneficiaries. They used a sample from the Medicare HOS to measure health status of enrollees in Medicare managed care. The authors found that dually eligible beneficiaries were sicker, more depressed and reported more pain than Medicare-only beneficiaries. In general, they found that these beneficiaries had poorer health status then both the Medicare-only population and the general population.

- **Pope, Gregory C. et al. "Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model"** ***Health Care Financing Review*****, vol. 25, no. 4, Summer 2004. (www.cms.gov/review/summer04)**

  In this article, the authors describe the CMS hierarchal condition categories (HCC) model implemented in 2004 to adjust Medicare capitation payments to private health plans for the expenditure risk of their enrollees. The authors describe the model's principles, elements, organization, calibration and performance. They also discuss how the model has been modified to reduce the burden of reporting for health plans and adapted for a variety of subpopulations (such as disabled, newly enrolled and secondary payer groups).

- **Bryant, Jennifer, John Correa and Allison Sydlaske "Assessment of Beneficiary Savings in the Medicare Drug Discount Card Program." Washington, DC: The Healthcare Leadership Council. (http://www.hlc.org/)**

  In this paper, the authors examine savings available to Medicare beneficiaries who enroll in a Medicare discount drug card program. The authors compare drug discount card prices with average retail prices in each state for the 150 most commonly prescribed drugs to seniors. The authors also compared discount card and retail prices for a basket of the 25 most frequently prescribed drugs and for typical drug regimens used to treat chronic conditions. The authors found that more than half of the cards delivered savings of more than 17.2 percent per prescription and that beneficiaries participating in the program would save an average of $1,247 per capita over an 18-month period. Additionally, the authors found little variation in discounted prices between rural and urban areas. The authors conclude that aggregate savings of up to $7.7 billion could be achieved, but that these savings are contingent on high beneficiary participation through 2005.

- **Harvard School of Public Health and Henry J. Kaiser Family Foundation. "Views of the New Medicare Drug Law: A Survey of People on Medicare." Washington, DC: Henry J. Kaiser Family Foundation, August 2004. (www.kff.org)**

  The authors conducted a survey of 1,223 Medicare beneficiaries (including 973 people aged 65 and older and 250 people aged 18 to 64 with physical and/or mental disabilities). The authors found that more beneficiaries have an unfavorable impression than have a favorable impression of the new Medicare drug law. The primary reason cited for a negative impression was that the new law does not provide people on Medicare with enough help with their drug costs. A quarter of the people on Medicare that responded to the survey indicated that they had either signed up for a Medicare-approved drug discount card already, or plan to sign up for a card this year. The authors also found that beneficiaries that do not currently have prescription drug coverage are significantly more likely to say that they plan to enroll in the full Medicare benefit when it becomes available than those who already have coverage.

- **Tseng, Chien-Weng, Robert Brook, Emmett Keeler, W. Neil Steers, and Carol Mangione. "Cost-Lowering Strategies Used by Medicare Beneficiaries Who Exceed Drug Benefit Caps and Have a Gap in Drug Coverage."** ***The Journal of the American Medical Association (JAMA)*****, vol. 292, no. 8, August 25, 2004.**

  In this article the authors examine strategies adopted by Medicare+Choice plan beneficiaries who exceed their annual drug benefit caps to lower prescription drug costs. To examine these strategies the authors surveyed 1,308 enrollees in a Medicare+Choice plan in one state, who had filled a least one prescription in 2001. They used the different caps on the health plan's share of medication costs offered in different counties as a natural experiment to test the effects of exceeding a cap. Through multivariate analysis, the authors found that Medicare beneficiaries often decreased the use of essential medications and experienced difficulty paying for prescriptions during gaps in coverage. Twelve of the 20 therapeutic classes most often affected by decreases in the use of medication were for chronic health problems such as hypertension, hyperlipidemia, emphysema or asthma. The authors argue that their findings provide insight into how beneficiaries' medication use may be affected if they fall into the gaps in Medicare Part D coverage.

OTHER SIGNIFICANT EVENTS

X UnitedHealth Group and Travelers Insurance (a Citigroup subsidiary) have settled a civil suit that alleged the companies falsified reports in order to defraud Medicare for more than $700 million. Neither company has admitted any wrongdoing in the settlement; however, Travelers Insurance has agreed to pay $10.9 million and UnitedHealth Group has agreed to pay $9.7 million. (*Kaiser Network Daily Health Policy Reports*, August 14th)