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TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS
Monthly Report for January 2008

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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

Enrollment and Penetration, by Plan Type	Current Month: January 2008	Change From Previous Month*	Same Month Last Year	
			January 2007	Change From January 2007- 2008
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	17,228,695	-10,413	16,630,180	+598,515
General	17,105,665	-8,168	16,553,472	+552,193
Employer/Union Only Direct	123,030	-2,245	76,708	+46,322
Duals Auto Enrolled in PDPs**	6,180,053	Not Available	6,270,154	-90,101
All others Enrolled in PDP	11,048,642		10,360,026	+688,616
Total Medicare Advantage (MA)	9,224,895	+217,095	7,728,782	+1,496,113
Medicare Advantage-Prescription Drug (MA-PD)	7,696,081	+166,308	6,704,489	+991,592
Medicare Advantage (MA) only	1,528,814	+50,787	1,024,293	+504,521
Medicare Advantage (MA) by Type				
MA Local Coordinated Care Plans** *	6,616,948	+277,306	5,988,184	+628,764
Health Maintenance Organizations (HMOs)	6,087,172	+265,958	5,574,864	+512,308
Provider Sponsored Organizations (PSOs)	54,213	-24,206	72,279	-18,066
Preferred Provider Organizations (PPOs)	475,466	+35,485	340,992	+134,474
Regional Preferred Provider Organizations (PPO)	241,440	+5,937	99,957	+141,483
Medical Savings Account (MSA)	2,323	+52	Not Applicable	Not Applicable
Private Fee For Service (PFFS)	1,914,192	+210,280	1,047,383	+866,809
General	1,902,407	+209,279	Not Available	Not Available
Employer Direct PFFS	11,785	+1,001	Not Available	Not Available
Cost	270,332	-39,326	294,603	-24,271
Pilot****	86,040	-23,471	Not Applicable	Not Applicable
Other*****	93,620	-213,683	298,655	-205,035
General vs Special Needs Plans****				
Special Needs Plan Enrollees	1,098,754	No Change	Not Available	Not Available
Dual-Eligibles	760,561	No Change	Not Available	Not Available
Institutional	145,583	No Change	Not Available	Not Available
Chronic or Disabling	192,610	No Change	Not Available	Not Available
Other Medicare Advantage Plan Enrollees	8,126,141	+217,095	Not Available	Not Available
Penetration (as percent beneficiaries)*******				
Prescription Drug Plans (PDPs)	39.1%	No Change	37.8%	+1.3%
Medicare Advantage Plans (MA)	20.1%	+0.1%	17.6%	+2.5%
Medicare Advantage-Prescription Drug Plans (MA-PDs)	17.5%	+0.4%	15.2%	+2.3%
Local Health Maintenance Organizations (HMOs),	13.8%	+0.6%	12.7%	+1.1%
Preferred Provider Organizations (PPOs)	1.1%	+0.1%	0.8%	+0.3%
Provider Sponsored Organizations (PSO)	0.1%	-0.1%	0.2%	-0.1%
Private Fee For Service (PFFS)	4.3%	+0.4%	2.4%	+1.9%

January 2008 data is from the 1.11.08 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 December 2007 data is from data released by CMS on 12.17.07 also on its website
**The data for dual eligibles automatically enrolled in PDPs comes from CMS released data "2008 Enrollment-Final LIS by State"-January 2008 also on its website. (http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/01_Overview.asp)
***The data for the breakdown of MA Local Coordinated Care Plans is from the 1.11.08 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**.** ((**http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**)
****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 for January is from the SNP Enrollment Comprehensive Monthly Report released by CMS on 1.11.08 and includes counts of 10 or less. (See: (**http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**)
*******Penetration is calculated using the number of eligible beneficiaries reported in the December 2005 State/County 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 January:

Plan Participation, by type	CURRENT MONTH: JANUARY 2008*	SAME MONTH LAST YEAR	
		JANUARY 2007	CHANGE FROM JANUARY 2007– 2008
MA Contracts (excluding SNP only contracts)**			
Total	721	589	+132
Local Coordinated Care Plan	509	410	+99
Health Maintenance Organizations (HMOs)	333	291	+42
Preferred Provider Organizations (PPOs) (Includes Physician Sponsored Organizations (PSOs))	125	119	+6
Regional Preferred Provider Organizations (rPPOs)	14	14	0
Private Fee For Service (PFFS)	79	48	+31
General	77	Not Available	Not Available
Employee Direct	2	Not Available	Not Available
Cost	25	27	-2
Medicare Savings Account (MSA)	9	Not Available	Not Available
Special Needs Plans	312	Not Available	Not Available
Dual-Eligible	204		
Institutional	65		
Chronic or Disabling Condition	43		
Other***	72	90	-18

*Contract counts for January 2008 are from the 1.11.08 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 also released on its website at: ((**http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**)
**Data for both January 2008 and January 2007 exclude SNP only contracts.
***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 January 31, 2008, CMS released the updated 2008 Personal Plan Finder data on its website. The data includes state and contract level data on quality measures (HEDIS and CAHPS measures) as well as disenrollment information. It also provides plan level information on cost sharing (including monthly premiums, annual deductions, and copays and coinsurance) as well as drug tier information (including cost and availability). This information is located on the following website: http://www.medicare.gov/MPPF/Include/DataSection/Questions/Welcome.asp where you must 1) scroll to the bottom of the page and click "Download the Medicare Plan Compare and Medigap..." and then 2) click on a drop-down box and click MOC Medicare Advantage data.

Relevant to Medicare Advantage

- None

Relevant to Prescription Drug Plans

- This month, CMS released four new files on 2008 drug enrollment data (as of January 31, 2008). http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/01_Overview.asp.
    - “LIS-Eligible Medicare Beneficiaries with Medicare Prescription Drug Coverage (Part D) by State”: This excel file provides information on state-by-state Part D enrollment for: 1) CMS-deemed full dual eligibles; 2) CMS-deemed MSP and SSI Recipients; and 3) LIS Approved and Not Deemed; as well as 4) total LIS eligibles. For full dual eligibles enrolled in Part D, California had the highest number (1,045,340); New York had the second highest enrollment (558,058) and Wyoming had the lowest enrollment with 5,825.
    - “State Enrollment in Prescription Drug Plans”: This excel file provides state-by-state information on 1) Part D eligibles; 2) enrollment in stand-alone PDPs; 3) enrollment in MA-PDPs; 4) Medicare Retiree Drug Subsidy; 5) other prescription drug coverage; 6) total with coverage. California had the highest number of individuals with coverage (3.8 million of their 4.4 million Part D eligibles with coverage); New York, Texas and Florida all had over 2 million individuals with coverage; Pennsylvania, Ohio, North Carolina, New Jersey, Michigan and Illinois all had over 1 million with coverage. Alaska had the least with 47, 239 of their 57,827 eligibles having some type of drug coverage.

    - "LIS-Eligible Medicare Beneficiaries with Drug Coverage": This excel file provided national level information for total beneficiaries eligible for LIS (12.5 million) as well as some information on the breakdown of those with coverage and an estimate of 2.6 million remaining LIS-eligible beneficiaries that may not be currently covered (CMS notes that some of these individuals may not have applied for the LIS).

    - "Total Medicare Beneficiaries with Prescription Drug Coverage": This excel file includes a breakdown of Medicare Part D enrollment by categories including PDP, MA-PDP, as well as Tricare, VA coverage and others.

- This month, CMS released a press release titled "Medicare Prescription Drug Benefit's Projected Costs Continue to Drop: Part D Attracts New Beneficiaries and Achieves High Rates of Satisfaction." In their press release, CMS stated that the overall projected cost of the drug benefit is $117 billion lower over the next ten years than was estimated last summer. CMS stated that the projected cost of the drug benefit is lower for several reasons including: 1) slowing in drug cost trends, 2) lower estimates of plan spending and 3) higher rebates from drug manufacturers. CMS also stated that findings from a CMS survey conducted in January show that beneficiary satisfaction is over 85 percent. This press release is available at: http://www.cms.hhs.gov/apps/media/press_releases.asp

- On January 7, 2008, CMS released a press release titled "CMS Issues Proposed Rule to Expand Plan Choices to Medicare Beneficiaries with Limited Incomes and Resources." The press release provided detail on a proposed rule (published in the *Federal Register* on January 8, 2008) that would reduce the number of beneficiaries with limited income and resources that are randomly reassigned drug plans during open enrollments. CMS stated in its proposed rule that it would do this by allowing certain prescription drug plan sponsors to offer a reduced premium amount for certain LIS beneficiaries (those drug plan sponsors in regions where there otherwise would be fewer than five drug plan sponsors with a "zero premium" plan option). The final rule is expected to be issued at the end of March 2008 so that this policy will be included in the Part D Rate Announcement in April 2008. The press release is available at: http://www.cms.hhs.gov/apps/media/press_releases.asp

Of General Interest

- None

Relevant to Special Needs Plans Specifically

- This month, CMS posted on its website a document on SNP HEDIS reporting requirements. The document provides four pages of answers to "frequently asked questions" regarding SNP HEDIS requirements. For examples, the answers provide information on what HEDIS measures are required for MA plans with SNP benefit

packages to report on as well as how to contact NCQA with specific questions. The document is available at: http://www.cms.hhs.gov/SpecialNeedsPlans/.

OTHER ITEMS OF RELEVANCE

Briefings and Hearings:

- This month, the U.S. Senate Committee on Finance held a hearing on Medicare Advantage Private Fee-for-Service (PFFS) plans. Witness statements included the following:
  - Panel I: Mark Miller, Executive Director, Medicare Payment Advisory Commission. In his statement, Miller discussed MedPAC's view that adhering to the principles of financial neutrality (i.e. paying the same amount as FFS Medicare, but adjusted for risk) is necessary to ensure that private plans add value to the Medicare program. MedPAC believes that when MA benchmarks are set at 100 percent of FFS Medicare rates then they have a greater incentive to undertake innovations in management and care delivery as well as to negotiate with providers on payment. He also discussed how MedPAC is in particular concerned with PFFS since they are not held to the same quality standards and regulations that other MA plans are. MedPAC believes that PFFS plans should report on quality of care so that beneficiaries can use quality as a factor in determining whether or not to enroll in a PFFS plan or other MA plans.
  - Panel II: Elyse Politi, Coordinator, New River Valley Area Agency on Aging, Pulaski, VA; Dr. Albert W. Fisk, Medical Director, The Everett Clinic, Everett, WA; Daryl Weaver, Administrator and CEO, King's Daughters Hospital, Yazoo City, MS; David Fillman, Executive Director, AFSCME Council 13, Harrisburg, PA. This panel focused on PFFS perspectives from those in the field. For example, Politi, who is currently the SHIP coordinator in Pulaski, VA focused her discussion on the marketing problems that continue to affect beneficiaries as well as the frustration of providers in dealing with PFFS plans. She also expressed concerns about the use of the additional funds appropriated for SHIP programs.
  - More information on this hearing, including testimony from all panel members is available on the U.S. Senate Committee on Finance website at: http://finance.senate.gov/sitepages/hearing013008.htm.

Other

- The Kaiser Family Foundation released two reports this month one examining Medicare Advantage plans and the second examining SNPs:

  - "The Value of Extra Benefits Offered by Medicare Advantage Plans in 2006." This report provides background on Medicare Advantage (MA) plans noting that there are now more than 8.8 million people enrolled in such plans. Since Medicare pays MA plans more than traditional Medicare, the study examined if MA plans are able to provide extra benefits than would be provided if beneficiaries were in traditional Medicare. The report found that on average all types of MA plans do provide extra benefits to beneficiaries when compared to traditional Medicare. However, the average net value of extra benefits per month was lower in PFFS plans ($55.92) than when compared to other MA plans ($71.22). PFFS plans are of particular interest since these plans now account for one in five beneficiaries enrolled in MA plans. The report is available on the KFF website at: (http://www.kff.org/medicare/7744.cfm).

  - "Do We Know if Medicare Advantage Special Needs Plans Are Special" prepared by Jim Verdier, Marsha Gold and Sara Davis at Mathematica Policy Research. This report examines the different types of SNPs, how they fit into the marketplace and whether these plans are performing differently than other Medicare Advantage plans. Findings suggest that since there is now an extra year of SNP authorization (President Bush recently signed into law a bill reauthorizing SNPs through 2009), CMS could do more to make information on SNP performance available. SNPs themselves could also be held to higher standards than they have thus far. Both of these recommendations would potentially add value for beneficiaries enrolled in such plans compared to traditional fee-for-service Medicare or other MA plans. (http://www.kff.org/medicare/7729.cfm).

- This month, the Kaiser Family Foundation also released two new Medicare Part D Data Spotlights. (Both spotlights are available on the KFF website at: http://www.kff.org/medicare/med102507pkg.cfm)

  - "Medicare Part D 2008 Data Spotlight: Utilization Management." This spotlight examined all 47 of the stand-alone PDP drug plans in 2008 and the trends and variation in utilization management since 2006 (by both plan and by drug) as well as the relationship between formulary generosity and utilization management. Specifically, the three utilization management techniques include prior authorization, step therapy and quantity limits. The findings included that the share of drugs with utilization management restrictions has increased since 2006-from 20 percent of sample drugs in 2006 to 30 percent in 2008. (The sample of drugs included 169 commonly prescribed drugs as well as some high-cost drugs).

  - "Medicare Part D 2008 Data Spotlight: Formularies." In this spotlight, KFF examined all 47 of the stand-alone PDP drug plans in 2008 and how they have changed since 2006 as well as differences in how plans cover generic and brand name drugs. The findings from the study include that most plans have remained relatively stable since 2006. In addition, while the majority of plans (91 percent) cover 90 percent of generic drugs, only 28 percent of plans cover 90 percent of brand name drugs.

- This month, the Department of Health and Human Services, Office of Inspector General released a report titled "Review of the Relationship Between Medicare Part D Payments to Local, Community Pharmacies and the Pharmacies' Drug Acquisition Costs." In this report, the OIG examined reimbursement by drug plan sponsors to local and community sponsors and analyzed the difference between the payments made by sponsors and the pharmacies' drug acquisition costs (i.e. ingredient costs). The sample included 100 pharmacies randomly selected using the National Council for Prescription Drug Programs (NCPDP) Pharmacy database (see report for more detail). The OIG found that in almost all of the cases, pharmacies were able to acquire drugs for less than the reimbursement amount. The estimated difference between Part D payments to pharmacies and the pharmacies' drug acquisition costs was $9.13 per prescription including rebates (or an average 18.1 percent difference) and was $8.78 (or 17.3 percent difference) when rebates were excluded. The OIG report is available online at: http://oig.hhs.gov/oas/reports/region6/60700107.htm).