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TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS
Monthly Report for January 2009

Prepared by Stephanie Peterson and Marsha Gold, Mathematica Policy Research Inc.
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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

Enrollment and Penetration, by Plan Type	Current Month: January 2009	Change From Previous Month*	Same Month Last Year	
			January 2008	Change From January 2008- 2009
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	17,447,201	-37,411	17,228,695	+218,506
Individual	16,561,280	-25,944	Not Available	Not Available
Group**	885,921	-11,467	Not Available	Not Available
Total Medicare Advantage (MA)	10,446,965	+163,889	9,224,895	+1,222,070
Individual	8,568,608	+83,682	Not Available	Not Available
Group	1,878,357	+80,207	Not Available	Not Available
Medicare Advantage-Prescription Drug (MA-PD)	8,803,518	+184,901	7,696,081	+1,107,437
Medicare Advantage (MA) only	1,643,447	-21,012	1,528,814	+114,633
Medicare Advantage (MA) by Type				
MA Local Coordinated Care Plans** *	7,395,579	+134,280	6,616,948	+778,631
Health Maintenance Organizations (HMOs)	6,606,247	+66,493	6,087,172	+519,075
Provider Sponsored Organizations (PSOs)	13,013	-6,847	54,213	-41,200
Preferred Provider Organizations (PPOs)	776,277	+74,624	475,466	-474,967
Regional Preferred Provider Organizations (PPO)	338,529	+24,774	241,440	+97,089
Medical Savings Account (MSA)	1,357	-2,256	2,323	-966
Private Fee For Service (PFFS)	2,320,381	+12,369	1,914,192	+406,189
Individual	1,621,437	-67,626	Not Available	Not Available
Group****	698,944	+79,995	Not Available	Not Available
Cost	273,880	-3,365	270,332	+3,548
Pilot*****	25,560	-1,084	86,040	-60,480
Other******	91,679	-829	93,620	-1,941
General vs Special Needs Plans***** **				
Special Needs Plan Enrollees	1,300,923	-22,209	1,098,754	+202,169
Dual-Eligibles	907,493	-4,457	760,561	+146,932
Institutional	125,549	-2,227	145,583	-20,034
Chronic or Disabling	267,881	-15,525	192,610	+75,271
Other Medicare Advantage Plan Enrollees	9,146,042	+186,098	8,126,141	+1,019,901
Penetration (as percent beneficiaries)********				
Prescription Drug Plans (PDPs)	39.7%	-0.2% points	39.1%	+0.6% points
Medicare Advantage Plans (MA)	23.1%	+0.3% points	20.1%	+3.0% points
Medicare Advantage-Prescription Drug Plans (MA-PDs)	19.5%	+0.4% points	17.5%	+2.0% points
Local Health Maintenance Organizations (HMOs),	14.6%	+0.1% points	13.8%	+0.8% points
Local Preferred Provider Organizations (PPOs)	1.7%	+0.1% points	1.1%	+0.6% points
Private Fee For Service (PFFS)	5.1%	No Change	4.3%	+0.8% points

January 2009 data is from the 1.05.09 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 2008 data is from data released by CMS on 12.08.08 also on its website
**The breakdown by Group includes Employer/Union Only Direct Contract PDP (120,638)
***The data for the breakdown of MA Local Coordinated Care Plans is from the 1.05.09 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/**)**
**** The breakdown by Group includes Employer Direct PFFS (13,324)
*****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 1.05.09 and includes counts of 10 or less. (See: **(http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**).
*******Penetration for January and December 2008 is calculated using the number of eligible beneficiaries reported in the August 2008 MA State/County Penetration file. January 2008 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 2009*	SAME MONTH LAST YEAR	
		JANUARY 2008	CHANGE FROM JANUARY 2008– 2009
MA Contracts			
Total	745	721	+24
Local Coordinated Care Plan	545	509	+36
Health Maintenance Organizations (HMOs)	375	333	+42
Preferred Provider Organizations (PPOs) (Includes Physician Sponsored Organizations (PSOs))	170	125	+45
Regional Preferred Provider Organizations (rPPOs)	14	14	0
Private Fee For Service (PFFS) General Employee Direct	71 69 2	79 77 2	-8 -8 No Change
Cost	22	25	-3
Medicare Savings Account (MSA)	2	9	-7
Special Needs Plans Dual-Eligible Institutional Chronic or Disabling Condition	415 252 63 100	312 204 65 43	+103 +48 -2 +57
Other**	91	72	+19

*Contract counts for January 2009 are from the 1.05.09 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/)**
**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

- CMS 2010 draft Medicare Advantage and Part D call letter was posted on CMS's website this month but later recalled after the change in Administration as part of the new Administration's broader effort to review actions taken late in the Bush Administration. The recall by CMS states that it will repost the letter "pending opportunity for further review of the document". The draft call letter is to provide guidance for Medicare Advantage (MA) organizations and prescription drug plan (PDP) sponsors to assist them in preparing Part C and Part D bids for 2010. Information on the draft call letter recall is available at: http://www.cms.hhs.gov/prescriptiondrugcovcontra/

Relevant to Medicare Advantage

- None

Relevant to Prescription Drug Plans

- On January 6, 2009, CMS released a final rule which changes Medicare's definition of negotiated prices under the Part D program. Currently, CMS allows Part D sponsors that contract with a pharmacy benefit manager (PBM) to report to CMS the amount paid to the PBM (the lock-in price) or the amount the PBM paid to the pharmacy (the pass-through price). However, under the new rule, plans must report to CMS the price actually paid to the pharmacy as the negotiated price and any difference between the price paid by the plan to the PBM and the price paid by the PBM to the pharmacy must be reported as an administrative cost. This change is effective January 1, 2010. The final rule is available at: http://www.federalregister.gov/inspection.aspx#special. More detail on this change is also available in a press release CMS released titled "Medicare Clarifies 'Negotiated Prices' Under Part D: Beneficiaries to Pay Lower Costs at the Pharmacy Counter. Rule Will Bring Greater Transparency to Drug Price Reporting." The press release is available at: http://www.cms.hhs.gov/apps/media/press_releases.asp

- This month, information was released on a CMS proposal to ban additional charges for brand-name prescription charges under Medicare Part D program. Currently, CMS uses reference-based pricing to control costs (where beneficiaries are charged more for brand-name medications if generic versions are available). The proposal would ban such reference-based pricing. The ban would take effect beginning in 2010. This information is available on the Kaiser Family Foundation: http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=56388

Of General Interest

- The January/February 2009 issue of *Health Affairs* contains CMS's most recent estimates of national health spending (M. Hartman et al. "National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998", www.healthaffairs.org). In its Press Release on the topic, ("CMS Reports Lowest Rate of Overall Growth in National Health Spending Since 1998: Health Spending Growing Faster than Economic Growth.") CMS highlights the fact that health spending in the United States grew 6.1 percent in 2007, to $2.2 trillion or $7,421 per person, the slowest rate of growth since 1998 and 0.6 of a percentage point lower than the 6.7 percent growth in 2006. They attribute the slower growth in 2007 mostly to slower growth in both retail prescription drug spending and Medicare spending associated with administering Medicare benefits. But they note that this spending continues to outpace overall economic growth, which grew by 4.8 percent in 2007. (In particular, changes in Medicare partially caused the increase due to the implementation of Medicare Part D as well as MA plans increased enrollment among other reasons.) This press release is available at: http://www.cms.hhs.gov/apps/media/press_releases.asp

Relevant to Special Needs Plans Specifically

- None

OTHER ITEMS OF RELEVANCE

Briefings and Hearings:

- On January 13, 2009, the Senate Budget Committee held a confirmation hearing for the new White House Office of Management and Budget (OMB) Director, Peter Orszag. In his testimony, Orszag highlighted the need to reduce spending on Medicare and Medicaid. He stated that reducing such spending should occur in combination with broader efforts to reduce health care costs otherwise it would just create massive problems for Medicare and Medicaid with providers increasingly unwilling to serve these populations relative to others. This testimony is available on the Senate Budget Committee website at: http://budget.senate.gov/republican/hearingarchive/testimonies/2009/2009-01-13Orszag.pdf

Other

- This month, an article in *Health Affairs*, titled "Special Needs Plans and the Coordination of Benefits and Services for Dual Eligibles" was released. In this article, David Grabowski discusses how SNPs have not greatly expanded the

number of people enrolled in Medicare-Medicaid products and that SNPs need to have a contractual relationship with state Medicaid plans to add value for dually eligible beneficiaries beyond traditional MA plans. Grabowski states that dual-eligible SNP penetration rates are higher in states in which SNPs have the potential to contract with state Medicaid agencies as these contracts have contributed to the expansion of coordinated service delivery models in states such as Massachusetts and Minnesota. Grabowski concludes however that it will be important to continue to evaluate SNPs performance in terms of costs and outcomes for beneficiaries to determine the impact of such coordination. The article is available at: http://content.healthaffairs.org/cgi/content/abstract/28/1/136?ct

- MedPAC held a public meeting on January 9 and 10, 2009 in the Ronald Reagan Building in Washington DC. The agenda as well as other information pertaining to the meeting is available at: www.medpac.gov. One session in particular was relevant to Medicare Advantage and Prescription Drug Plans:

    - "The MIPPA Medicare Advantage payment report simulations." In this session, staff members discussed their current work on simulations of alternative payment systems for the report to Congress on MA payment as required by the MIPPA of 2008. MedPAC's position has been that the payment system should be financially neutral. Currently because the system does not adhere to financial neutrality, MedPAC believes that excessive payments to MA plans have been attracting inefficient plans to Medicare Advantage. The Commission recommended (as previously done so) that Congress set MA benchmarks at 100 percent of fee-for-service costs. In this session, MedPAC examined alternative approaches (other than the approach using payments based purely on county-level fee-for-service spending). The staff members simulated the effects of five different formulas that could be used to set benchmarks: 1) the current law; 2) their prior recommendation of setting benchmarks equal to 100 percent of local fee-for-service spending; 3) setting all benchmarks across the country at a 100 percent of the national average fee-for-service spending. And two approaches that would use both national fee-for-service spending and local influences: 4) a national fee-for-service average adjusted for local price differences but not for utilization differences and 5) the 75 percent local/25 percent national blend that aims to recognize plan costs. The models are based on 2009 plan bids and include HMOs, local PPOs, RPPOs, and PFFS plans but excludes SNPs and employer-group plans. The models also assume no change in plan bidding behavior. Of the alternatives, the 100 percent local fee-for-service benchmarks have the most impact on availability, and the 100 percent national average fee-for-service average benchmark the least. They point out that each of the alternatives except the 100 percent local fee-for-service option would continue to encourage the entry of inefficient plans in some areas.

- On January 28-30, 2009, the World Research Group held a conference in Washington, D.C. on the Business of Medicare Advantage. This Forum included over 50 speakers including Cynthia Tudor, Director of Medicare Drug Benefit Group at the CMS; health care executives from Aetna, Kaiser Permanente, Tufts Health

plan, Universal Health Group and Well point among others; researchers including Marsha Gold, Senior Fellow at Mathematica Policy Research and Eugene Scanzera, Director of Medicare and Pharmacy at the AARP. The sessions focusing on operations, management and compliance as well as Part D and SNP sessions among others. More information on this Forum including presentation materials, the agenda and the full list of speakers is available on the World Research Groups website at: http://www.worldrg.com/showConference.cfm?confCode=HW09014