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

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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

Enrollment and Penetration, by Plan Type	Current Month: February 2008	Change From Previous Month*	Same Month Last Year	
			February 2007	Change From February 2007- 2008
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	17,409,977	+181,282	16,929,499	+480,478
General	17,286,451	+180,786	16,806,636	+479,815
Employer/Union Only Direct	123,526	+496	122,863	+663
Duals Auto Enrolled in PDPs**	Not Available	6,180,053	Not Available	Not Available
All others Enrolled in PDP		11,048,642		
Total Medicare Advantage (MA)	9,609,452	+384,557	8,282,806	+1,326,646
Medicare Advantage-Prescription Drug (MA-PD)	8,012,310	+316,229	6,975,934	+1,036,376
Medicare Advantage (MA) only	1,597,142	+68,328	1,306,872	+290,270
Medicare Advantage (MA) by Type				
MA Local Coordinated Care Plans** *	6,829,803	+212,855	6,064,666	+765,137
Health Maintenance Organizations (HMOs)	6,255,250	+168,078	5,624,318	+630,932
Provider Sponsored Organizations (PSOs)	15,800	-38,413	74,270	-58,470
Preferred Provider Organizations (PPOs)	558,660	+83,194	366,064	+192,596
Regional Preferred Provider Organizations (PPO)	257,104	+15,664	120,770	+136,334
Medical Savings Account (MSA)	3,358	+1,035	2,238	+1,120
Private Fee For Service (PFFS)	2,070,227	+156,035	1,338,026	+732,191
General	2,057,472	+155,065	1,327,826	+729,646
Employer Direct PFFS	12,755	+970	10,200	+2,555
Cost	271,386	+1,054	305,753	-34,367
Pilot****	83,815	-2,225	149,657	-65,842
Other*****	93,759	+139	301,696	-207,937
General vs Special Needs Plans******				
Special Needs Plan Enrollees	1,118,061	+19,307	Not Available	Not Available
Dual-Eligibles	804,167	+43,606	Not Available	Not Available
Institutional	139,084	-6,499	Not Available	Not Available
Chronic or Disabling	174,840	-17,770	Not Available	Not Available
Other Medicare Advantage Plan Enrollees	8,491,391	+365,250	Not Available	Not Available
Penetration (as percent beneficiaries)********				
Prescription Drug Plans (PDPs)	39.5%	+0.4%	38.4%	+1.1%
Medicare Advantage Plans (MA)	21.8%	+1.7%	18.8%	+3.0%
Medicare Advantage-Prescription Drug Plans (MA-PDs)	18.2%	+0.7%	15.8%	+2.4%
Local Health Maintenance Organizations (HMOs),	14.2%	+04%	12.8%	+1.4%
Preferred Provider Organizations (PPOs)	1.2%	+0.1%	0.8%	+0.4%
Provider Sponsored Organizations (PSO)	0.04%	-0.05%	0.2%	-0.16%
Private Fee For Service (PFFS)	4.7%	+0.4%	3.0%	+1.7%

February 2008 data is from the 2.13.08 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 January 2008 data is from data released by CMS on 1.11.08 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 2.13.08 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 February is from the SNP Enrollment Comprehensive Monthly Report released by CMS on 2.13.08 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 February:

Plan Participation, by type	CURRENT MONTH: FEBRUARY 2008*	SAME MONTH LAST YEAR	
		FEBRUARY 2007	CHANGE FROM FEBRUARY 2007– 2008
MA Contracts (excluding SNP only contracts)**			
Total	723	604	+119
Local Coordinated Care Plan	509	410	+99
Health Maintenance Organizations (HMOs)	368	291	+77
Preferred Provider Organizations (PPOs) (Includes Physician Sponsored Organizations (PSOs))	141	119	+22
Regional Preferred Provider Organizations (rPPOs)	14	14	0
Private Fee For Service (PFFS) General Employee Direct	79 77 2	48 47 1	+31 +30 +1
Cost	25	27	-2
Medicare Savings Account (MSA)	9	2	+7
Special Needs Plans Dual-Eligible Institutional Chronic or Disabling Condition	443 207 66 107	Not Available	Not Available
Other***	74	88	-14

*Contract counts for February 2008 are from the 2.13.08 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 February 2008 and February 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 February 22, 2008, CMS issued an 'Advance Notice' memorandum and fact sheet. The Advance notice is on methodological changes for 2009 for MA capitation and Part D payment policies. The final rates will be announced on April 7, 2008. The notice also includes the preliminary growth trend along with other technical updates on calculations affecting MA and PDP sponsors. Key facts laid out in the notice include:

    - CMS's preliminary estimates are that the National Per Capita MA Growth Percentage will increase 4.8 percent in 2008 for aged and blind together, reflecting a 3.4 percent trend change and net +1.4 percent adjustment to CY 2004-2008 estimates. (Rates in CY 2008 were underestimated by 2.4 percent)

    - CMS plans to "rebase" county per capita fee-for-service spending in 2009, the results of which will be reflected in the April 7th rates. These define the upper limit of payments to MA health plans unless the minimum percentage increase (2 percent) would result in higher limits.

    - In 2009, CMS will implement an updated version of the CMS-HCC risk adjustment model, including community, institutional and new enrollee segments of the model. The 2004 and 2005 data will be used with the recalibration. CMS also will adjust the frailty factor (used for PACE and selected demonstrations) to account for the interactions of the two. CMS also announced changes in the factors used to normalize the distributions against FFS, including shifting to a standard five years of data for such recalibration. (Specific amounts to be used for both are included in the documentation.)

    - The 2009 rates will include an adjustment for differences in risk score growth in MA versus traditional Medicare, as called for in the Deficit Reduction Act of 2005. This will involve a downward adjustment because MA risk scores are growing faster than those in the traditional program. To support the development of this adjustment, CMS undertook an extensive analysis of the factors leading to change in relative risk scores so that the adjustment could be properly focused on the kinds of changes that are appropriate for adjustment. To do this, CMS is focusing its MA analysis on those continuously enrolled ("stayers"). CMS is proposing to apply the adjustment to MA contracts where the difference between MA versus FFS change in risk scores is twice the industry average, with exceptions for new contracts and those with fewer than 1,000 enrollees. (CMS estimates that 25 percent of MA enrollees are in contracts twice the industry average). Final adjustments will be incorporated in the April 7th release.

- CMS describes operational policy changes, which they say will result in improved (and higher) identification of dually eligible Medicare beneficiaries.

- CMS defines Part D benefit parameters for 2009, which on average will rise 7.54 percent (reflecting 5.97 percent trend adjustment and 1.48 percent prior year revisions). (Growth in copayments for certain dual eligibles will be constrained by the CPI or 3.18 percent) The standard deductible will be $295, initial coverage limit $2,700, and out of pocket threshold $4,350. In prior years, CMS has transitioned from equal weighting of PDPs to enrolled weighted in calculating the National Average Monthly Bid Amount to reduce the impact on beneficiaries. In 2009, estimates will be fully enrollment weighted. CMS will continue to include 25 percent of unweighted data in calculating the low-income benchmark premium amount.

- Both documents are available on CMS's website. The full memorandum at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/AD/list.asp#TopOfPage; the fact sheet at: http://www.cms.hhs.gov/apps/media/fact_sheets.asp

- CMS has redeveloped parts of its website related to Corrective Action Plans (CAPs) this month. A new web page is now dedicated to CAP information and provides a CAP overview as well as a CAP summary report, updated through February 1, 2008. The summary report provides all audits conducted through January 2008 on MA and MA-PD plans. CMS has also provided on its website a more detailed summary report and data files as well as other informational resources on the auditing process. CMS Acting Administrator, Kerry Weems, stated in his testimony before the Senate Finance Committee this month that this information is now more accessible and is part of CMS's priority to be more proactive and transparent in overseeing the MA program. The redesigned web page is located on CMS's website at: http://www.cms.hhs.gov/MCRAdvPartDEnrolData/CAP/.

- In addition to the new CAP information, CMS also has released a new report on enforcement actions on MA and PDPs from January 2006 through January 2008. The report includes organization name, contract number and type, date of enforcement, type of violation (such as marketing violations) and action taken (such as monetary penalty or marketing and enrollment freeze etc). The report states that CMS has issued a marketing and enrollment freeze for Health Net in January 2008 due to multiple enrollment processing violations as well incorrect annual notification of plan changes. Two other organizations also received the same enforcement action late last year: SDM Healthcare (MAPD) for multiple violations (December 2008) and Chesapeake Life (PFFS) for marketing violations (October 2008). There are a total of 24 enforcement actions listed. This information is also available on CMS's website at: http://www.cms.hhs.gov/MCRAdvPartDEnrolData/EA/list.asp#TopOfPage

Relevant to Medicare Advantage

- None

Relevant to Prescription Drug Plans

- None

Of General Interest

- This month, CMS released a press release titled "Growth in National Health Expenditures Projected to Remain Steady through 2017; Health Spending Growth Expected to Continue to Outpace Economic Growth and Growth in General Inflation." The press release highlights analysis by CMS staff released in *Health Affairs* with additional tabular information provided on site at CMS. CMS analysis indicates that the growth in health care spending is projected to average around 6.7 percent annually through 2017 (compared to economic growth at 4.9 percent and general inflation at 2.4 percent annually). Medicare spending growth is expected to slow to 6.5 percent in 2007 after the 18.7 percent growth experienced in 2006 mostly from the new Medicare Part D benefit program. In 2007, health care spending will be 16.3 percent of the GNP versus 16.0 percent in 2006; CMS's projections indicate it will be 19.5 percent in 2017. The press release is available on CMS's website: http://www.cms.hhs.gov/apps/media/press_releases.asp. In addition, the health care spending projection data is also available on CMS's website at: http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp

Relevant to Special Needs Plans Specifically

- None

OTHER ITEMS OF RELEVANCE

Briefings and Hearings:

- This month the Senate Committee on Finance held a hearing titled "Selling to Seniors: The Need for Accountability and Oversight of Marketing and Sales by Medicare Private Plans." This hearing was divided into two separate dates:
    - On February 7, 2008, part one of the hearing was held. Witnesses at the hearing included 1) Michael McRaith, Director of Insurance, Division of Insurance, State of Illinois; 2) George Harper, Mayflower, AR; 3) Peter

Hebertson, Director of Outreach for Salt Lake County Aging Services, Salt Lake City, UT; and 4) Patrick O'Toole, Vice President, Humana, Louisville, KY.

- On February 13, 2008, part two of the hearing was held. Kerry Weems, Acting Administrator, CMS, was the witness. In his testimony, Weems discussed CMS's recent oversight activities including the PFFS marketing surveillance plan. This includes that all MA organizations offering PFFS plans are now required to conduct outbound education and verification calls to ensure potential enrollees understand the plan rules. This plan is also discussed in the draft call letter CMS released in January 2008 (see also the full call letter for more information, which is available at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf).

- All of the witness statements as well as more information on both parts of the hearing are available on the Senate Committee on Finance website at: http://finance.senate.gov/sitepages/hearings.htm.

- This month the House Committee on Ways and Means held a hearing on Medicare Advantage. The Panel included CMS Acting Administrator, Kerry Weems and GAO Acting Director, James Cosgrove. The Panel also included Byron Thames, Member of the Board of Directors for AARP; Jim Mattes, President and CEO, Grande Rhode Hospital in Oregon; David Lipschutz, Interim President and CEO, California Health Advocates, and Daniel Lyons, Senior Vice President, Government Programs, Independent Blue Cross. A summary of some of the witness testimony is below. The full list of testimony as well as other information on the hearing is available at: http://waysandmeans.house.gov/hearings.asp

  - In his testimony, CMS Acting Administrator, Kerry Weems provided a short overview of the Medicare Advantage payment methodology and spoke on the value of the MA program. He stated that MA enrollees typically benefit from reduced cost-sharing relative to FFS Medicare. Weems also discussed CMS oversight for MA plans stating that one of the agency's top priorities is to be more proactive and transparent. He stated that CMS has now posted updated information on Corrective Action Plans (CAPs) and enforcement actions on their website. In addition, Weems discussed the Final Rule CMS published in December 2007, which includes oversight clarification (such as clarifying that plans have the burden of proof in terms of the appeals process).

  - Acting Director, Health Care Issues, GAO, James C. Cosgrove's testimony was based on the recent GAO report (see below summary of the report for more detail). His testimony is also available on the GAO's website at: http://www.gao.gov/docsearch/app_processform.php

  - Byron Thames of the AARP also testified at the hearing. He stated that AARP does not support the PFFS option for several reasons including that they are not required to provide coordinated care for their enrollees or

quality improvement activities. He also commented that although CMS has made efforts to curtail questionable marketing strategies by MA firms that more must be done. He provided a list of several AARP recommendations, which are intended to improve consumer protections in the MA market. These recommendations include, among others, that 1) outbound education and verification calls should be made to all new enrollees in MA plans to ensure that beneficiaries understand plan rules (and these rules should apply to PFFS as well as other MA options); 2) CMS should develop a mandatory national standardized Medicare training program for all agents selling Medicare products; 3) The same marketing and enrollment should apply to all MA plans. PFFS should not have an unfair advantage in the marketplace, such as extended open enrollment period, which they currently have. Thames also stated that while AARP supports MA plans in the Medicare program, they should co-exist on an 'equal footing.' AARP strongly concurs with the MedPAC recommendation of payment neutrality for all Medicare coverage options.

Other

- GAO released a report this month titled, "Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs." This report examined MA plans' projected rebate allocation for 2007 finding that most of the projected rebates were allocated to reduced cost sharing (69 percent) and then to reduce premiums (20 percent). A small share of the rebates were to be spent on additional benefits (11 percent). In a finding focused on in policy circles and the media, GAO also found that while the average cost sharing in MA is 42 percent of that in traditional Medicare, some beneficiaries would have higher cost sharing for selected services in MA than in the traditional program. (Medicare allows such variation). Nineteen percent of enrollees were in plans with higher projected costs for home health costs and, 16 percent in plans with higher projected costs for inpatient services than in Medicare. GAO notes that this could result in some beneficiaries with high needs having higher total out of pocket costs in MA than traditional Medicare. The report discusses the trade-offs policymakers face in determining whether to modify current MA policy on payments and benefits. The analysis is based on cost projections submitted by MA plans accounting for 71 percent of all MA beneficiaries in 2007. Administrative costs in MA vary; about 30 percent of beneficiaries are in plans with projected spending under 85 percent in medical expenses. The full report is at: http://www.gao.gov/new.items/d08359.pdf

- On February 29, 2008, MedPAC released its March 2008 *Report To the Congress: Medicare Payment Policy*. Chapter 3 is an update in the Medicare Advantage Program. Chapter 4 reviews Part D enrollment, benefit offerings, and plan payments. Among the Commission's recommendations are 7 recommendations on SNPs and one recommending that HHS make Part D claims data available on a timely basis to congressional support agencies and selected executive branch offices for purposes of program evaluation, public health, and safety. The report, downloadable overall or by

chapter, provides a wealth of analysis on the MA program. It also updated MedPAC's estimates of MA payments relative to traditional Medicare, indicating that in 2008 such payments will be 113 percent and that overall MA is now more inefficient than the traditional Medicare program (with costs running 101 percent of Medicare versus 99 percent in 2006. HMOs continue to be more efficient than Medicare (See www.medpac.gov).

- MedPAC's next public meeting will be held March 5 and 6, 2008. An agenda is available on its website at www.medpac.gov. Sessions relevant to Medicare Advantage and PDPs include "Part D and Performance Measures." MedPAC will present ideas on how to evaluate the drug benefit as well as provide findings from recent focus groups with beneficiaries, pharmacists and providers on their experience with the drug benefit.