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

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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

Enrollment and Penetration, by Plan Type	Current Month: February 2009	Change From Previous Month*	Same Month Last Year	
			February 2008	Change From February 2008- 2009
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	17,502,534	+55,333	17,409,977	+92,557
Individual	16,602,272	+40,992	Not Available	Not Available
Group**	900,262	+14,341	Not Available	Not Available
Total Medicare Advantage (MA)	10,772,242	+325,277	9,609,452	+1,162,790
Individual	8,851,959	+283,351	Not Available	Not Available
Group	1,920,283	+41,926	Not Available	Not Available
Medicare Advantage-Prescription Drug (MA-PD)	9,130,993	+327,475	8,012,310	1,118,683
Medicare Advantage (MA) only	1,641,249	-2,198	1,597,142	44,107
Medicare Advantage (MA) by Type				
MA Local Coordinated Care Plans** *	7,625,214	+229,635	6,829,803	+795,411
Health Maintenance Organizations (HMOs)	6,746,975	+140,728	6,255,250	+491,725
Provider Sponsored Organizations (PSOs)	14,030	+1,017	15,800	-177
Preferred Provider Organizations (PPOs)	864,141	+87,864	558,660	+305,481
Regional Preferred Provider Organizations (PPO)	376,965	+38,436	257,104	+119,861
Medical Savings Account (MSA)	3,248	+1,891	3,358	-110
Private Fee For Service (PFFS)	2,366,519	+46,138	2,070,227	+296,292
Individual	1,638,472	+17,035	Not Available	Not Available
Group****	728,047	+29,103	Not Available	Not Available
Cost	284,493	+10,613	271,386	+13,107
Pilot*****	24,202	-1,358	83,815	-59,613
Other******	91,601	-78	93,759	-2,158
General vs Special Needs Plans***** **				
Special Needs Plan Enrollees	1,299,903	-1,020	1,118,061	+181,842
Dual-Eligibles	911,917	+4,424	804,167	+107,750
Institutional	122,473	-3,076	139,084	-16,611
Chronic or Disabling	265,513	-2,368	174,840	+90,673
Other Medicare Advantage Plan Enrollees	9,472,339	+326,297	8,491,391	+980,948
Penetration (as percent beneficiaries)********				
Prescription Drug Plans (PDPs)	39.8%	+0.1% points	39.5%	+0.3% points
Medicare Advantage Plans (MA)	23.9%	+0.8% points	21.8%	+2.1% points
Medicare Advantage-Prescription Drug Plans (MA-PDs)	20.3%	+0.8% points	18.2%	+2.1% points
Local Health Maintenance Organizations (HMOs),	15.0%	+0.4% points	14.2%	+0.8% points
Local Preferred Provider Organizations (PPOs)	1.9%	+0.2% points	1.2%	+0.7% points
Private Fee For Service (PFFS)	5.3%	+0.2% points	4.7%	+0.6% points

February 2009 data is from the 2.18.09 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 January 2009 data is from data released by CMS on 1.05.09 also on its website
**The breakdown by Group includes Employer/Union Only Direct Contract PDP (121,855)
***The data for the breakdown of MA Local Coordinated Care Plans is from the 2.18.09 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 (13,370)
*****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 2.18.09 and includes counts of 10 or less. (See: (**http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**).
*******Penetration for February and January 2009 is calculated using the number of eligible beneficiaries reported in the August 2008 MA State/County Penetration file. February 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 February:

Plan Participation, by type	CURRENT MONTH: FEBRUARY 2009*	SAME MONTH LAST YEAR	
		FEBRUARY 2008	CHANGE FROM FEBRUARY 2008– 2009
MA Contracts			
Total	752	723	+29
Local Coordinated Care Plan	545	509	+36
Health Maintenance Organizations (HMOs)	375	368	+7
Preferred Provider Organizations (PPOs) (Includes Physician Sponsored Organizations (PSOs))	170	141	+29
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	443 207 66 107	-28 +45 -3 -7
Other**	93	74	+19

*Contract counts for February 2009 are from the 2.18.09 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

- On February 23, 2009, CMS re-issued the 2010 Draft Combined Call letter for MA, PDP and other private plans in 2010 for public comment by March 6, 2009 (http://www.cms.hhs.gov/prescriptiondrugcovcontra/). The revised call letter focuses on new regulatory requirements and policy clarifications. It also elicits comments about changes being considered in the future. The substantially longer set of guidance includes information on 2010 MA, MA-PD and cost plans (Section A), 2010 PDPs (Section B), and marketing/beneficiary communications (Section C). MA plan and marketing provisions of potential particular note include the following:

    - CMS indicates that it is considering potentially publicizing MA plans medical loss ratio, with CMS eliciting questions on how to calculate it.

    - CMS again urges plans to avoid indistinguishable plans with low enrollment and notes it is considering new rules limiting plans to no more than a certain number (e.g. two) benefit designs in a given area and solicits comments.

    - CMS elaborates on prior year's efforts to encourage plans to use an out of pocket limit to protect enrollees for high out of pocket costs and address concerns about discriminating against sick people. The limit of $3,400 or less proposed for 2010 is said to be the 85th percentile of beneficiary spending (i.e. 15 percent of traditional Medicare beneficiaries with no supplement would exceed it). CMS also distinguishes the way they will examine such limits for plans using coinsurance versus deductibles and indicates that it is considering amending the regulations to require an out of pocket limit and eliciting comments on how MA cost sharing and benefit design can be strengthened to provide transparent high value low cost nondiscriminatory plan offerings.

    - CMS addresses criteria that apply to use of incentives for use of preventive services in ways that suggest numerous constraints on the form these can take.

    - Consistent with MIPPA, the call letter describes how phase out of discriminatory copayments for Medicare mental health outpatient services will begin in 2010 and continue until 2014.

    - Details of the quality reporting requirements for PFFS and MSA plans in 2010 and 2011 and thereafter are provided consistent with the MIPPA.

    - Details of the SNP changes in 2010 and thereafter are summarized. Changes are most extensive for chronic care SNPs and the draft call letter details how transition of enrollees will be handled. The call letter also emphasizes CMS's support for coordination with states on dual eligible

issues and its intent to create a state resource contact to support state efforts.

- Details on how requirements for provider contracts and networks are being handled in 2010 and 2011 consistent with MIPPA. The draft call letter stipulates that such requirements will apply in "network areas" with at least two network based with any enrollment as of the start of the year when the announcement is made-with a list intended to be provided as part of the payment rate announcements for 2010 and 2011. The call letter also reiterates concern about PFFS plans using prior authorization or referral requirements.

- Details the intent to non-renew cost plans in 2010 when sufficient competition otherwise exists, consistent with MIPPA.

- CMS indicates that emerging practice of organizations paying high referral fees that appear to circumvent limits on agent compensation must cease immediately.

- In 2010, plan names will be standardized by adding plan type to the given name.

- On February 20, 2009, CMS released its Advanced Notice on 2010 MA capitation rates and Part D policies; final rates will be released the first Monday in April. The notice indicates that CMS will not be rebasing FFS rates in 2010 so the 2010 rates are the 2009 rates updated by the national per capita MA growth percentage, with adjustments for over and underestimates for years 2004 and later. The announcement indicates that the MA growth percentage for aged and disabled beneficiaries combined will be 0.5 percent, reflecting a trend of -1.1 percent for 2010 before adjustments. 2010 will be the last year for the phase out of budget-neutral risk adjustment payments, with only 5 percent of budget neutrality applying. (The phase out protected MA sector as a whole from declines in payments with the introduction of risk adjustment). In 2009, CMS's proposed effort to address increases in MA coding greater than FFS increases was controversial (and ultimately dropped). In this year's call letter, CMS presents additional analysis on the topic and a revised approach for dealing with this issue in 2010. Their analysis shows that 50 percent of the difference between the MA and FFS sectors in the growth of risk scores is due to enrollment patterns (more newly eligible and decedents in FFS), and the rest is due to more rapid growth of risk scores for those staying in the same sector. CMS's proposed adjustment is intended to correct for the later factor in 2010 and its impact on rising MA risk scores. CMS's proposed approach, presented for comment, is based on analysis of growth in scores for stayer cohorts between 2007 and 2010. The resulting adjustment, they say, would reduce MA risk scores by 3.74 percent. The Notice also indicates that in 2010, Part D benefit parameters will increase by 3.13 percent, leading to a deductible of $305, initial coverage limit of $2,780, out-of-pocket threshold of $4,500 and total for catastrophic at $6,356.25 after which minimum cost sharing will be $2.50 for generics/preferred or multisource drugs and $6.20 for others. Maximum copayments under Part D for dual eligibles will increase 2.06 percent in 2010, based on changes in the CPI. (This information is available at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/AD/list.asp#TopOfPage. In

addition, a fact sheet summarizing some of this information is available on CMS's website at: http://www.cms.hhs.gov/apps/media/fact_sheets.asp.)

- On February 25, 2009, CMS posted a memorandum it sent to all MA HMOs, PPOs, PFFS, Cost and SNPs in December 2008 regarding the 2009 HEDIS measures required to be reported by managed care plan types (HMO, PPO, Cost and SNPs) in 2009. It also includes information to on HOS and CAHPS data reporting requirements. CMS states (as consistent with the MIPPA) while PFFS and MSA plans can voluntarily collect and submit 2009 HEDIS data, however, they are not required to collect and report to CMS until calendar year 2010. This memorandum is available on CMS's website at: http://www.cms.hhs.gov/SpecialNeedsPlans/

Relevant to Medicare Advantage

- This month, CMS released the 2009 Plan directory for all Medicare Advantage, Cost, Pace, and Demonstration Organizations that have an active contract with CMS. The information is available in an excel file as well as a word document and includes contract number, legal entity name, organization marketing name, parent organization, plan type, contract effective date, contact information as well as enrollment numbers for each organization among other information. CMS states it plans to update this on a monthly basis. The directory is available at: http://www.cms.hhs.gov/MCRAdvPartDEnrolData/PDMCPDO/list.asp#TopOfPage

- Last month (January 15, 2009), CMS posted the "Medicare Part C Plan Reporting Requirements: Technical Specifications Document" (see CMS website at: http://www.cms.hhs.gov/HealthPlansGenInfo/16_ReportingRequirements.asp.) The 2009 reporting requirements outlined result from an extensive process of review consistent with OMB requirements. They require that MA plans begin collecting certain data on January 1, 2009, subject to audit in 2010. The data elements include:

  - Benefit utilization (at the plan benefit package level once a year by 8/31 of following year)

  - Procedure frequency (at the contract level, once a year, by 5/31 of the following year)

  - Serious reportable adverse events (at the contract level once a year, by 5/31 of the following year)

  - Provider network adequacy (at the contract level once a year, by 2/28 of the following year)

  - Grievances (at the plan benefit package level, quarterly (5/31, 8/31 and 11/30 of the current year and 2/28 of the following year)

  - Organization Determination/redeterminations (at the contract level, quarterly (5/31, 8/31 and 11/30 of the current year and 2/28 of the following year)

- Employer group sponsors (at the plan benefit package level, twice a year, 8/31 of the year and 2/28 of the following year)
- PFFS plan enrollment verification calls (at the plan benefit package level, annually, individual plans only, by 2/28 of the following year)
- PFFS plan payment dispute resolution process (at the plan benefit package level, annually, by 2/28 of the following year)
- Agent compensation structure (at the contract level, annually, by 2/28 of the following year)
- Agent training and testing (at the contract level, annually by 2/28 of the following year)
- Plan oversight of agents (at the contract level, quarterly, 5/31, 8/31 and 11/30 of the current year and 2/28 of the following year)
- SNP Plan Management (at the plan benefit package level, annually, 5/31 of following year)

Most requirements apply to all MA, demo and cost contracts but there are exceptions. For examples, PFFS plans are not required to provide provider network adequacy data and some requirements are limited to PFFS or SNP. National PACE plans and 1833 cost plans are excluded. Data are to be uploaded on HPMS. Data on per service costs in benefit utilization, employer names and related facts and total agent compensation are not subject to public disclosure under FIOA.

Relevant to Prescription Drug Plans

- CMS also released the 2009 Plan directory for all PDP and employer/union only direct PDP organizations with active contracts with CMS. The information includes the legal entity name, contract number, organization marketing name, parent organization, contract effective date, CMS region, contact information (name, phone number address) as well as enrollment numbers for each organization among other information. As with the Medicare managed care directory, the information is available in a word document as well as an excel spreadsheet. CMS states it plans to update this information monthly. http://www.cms.hhs.gov/MCRAdvPartDEnrolData/PDPPD/list.asp#TopOfPage
- This month, CMS released several updated data files of total Medicare beneficiaries with drug coverage as of February 1, 2009. These data files have been released annually from CMS for the past three years (since 2006) and include: (1) a national level data file that reports Medicare beneficiaries enrolled in standalone PDP plans (17 million as reported above); MA-PDs (around 9 million also reported above) as well as those receiving drug coverage through TRICARE, Veterans Affairs (VA) coverage among other sources. (2) a state level data file that reports a breakdown of total Medicare beneficiaries with drug coverage by each state. The state level information includes total beneficiaries with stand-alone drug

coverage (e.g. California, Florida and Texas had the most enrollees in PDPs with over 1 million each whereas Alaska and the District of Columbia had the least with less than 30,000 each), MA-PD coverage, those with Medicare retiree drug subsidy (RDS), and those with other prescription drug coverage. (3) a national level data file for low income subsidy (LIS)-eligible Medicare beneficiaries with drug coverage. As of February 1, 2009, there were 12.5 million beneficiaries eligible for the low-income subsidy. There were 6.31 CMS-deemed full dual eligibles with drug coverage and 1.83 million CMS-deemed MSP and SSI recipients with drug coverage. (4) a state level data file on LIS-eligible Medicare beneficiaries with drug coverage. This includes data for each state for total CMS-deemed full dual eligibles (e.g. with California having the largest number with over 1 million, Texas had the second largest enrollment with 348,285. Delaware, North Dakota and Wyoming had the least enrollment all with fewer than 11,000 each). The information also included enrollment numbers by state for CMS-deemed MSP and SSI recipients as well as LIS approved and not deemed. The data files are available at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/

- CMS recently released the 2010 Medicare Part D reporting requirements. The information includes a report that lists timeframes and required levels of reporting for all Part D organizations including enrollment numbers, generic drug utilization, and grievance information among other items. The information released also includes a crosswalk of reporting requirement changes between the contract year 2009 and 2010. For examples, the 2010 reporting requirements include additional data for Part D sponsors to report as required in the MIPPA of 2008 including new enrollment reporting requirements as well as pharmacy support of electronic prescribing and prompt payment by Part D. CMS also included in this release compliant submission worksheets as required by the Paperwork Reduction Act (PRA) in collecting data. This information is available on CMS's website at: http://www.cms.hhs.gov/PaperworkReductionActof1995/PRAL/list.asp#TopOfPage

Of General Interest

- None

Relevant to Special Needs Plans Specifically

- As reported above, CMS posted on its website this month HEDIS quality reporting requirements for SNPs and other managed care plan types for 2009. Specifically, CMS will continue to collect audited data for all SNPs that had 30 or more beneficiaries enrolled as reported in CMS's February 2008 SNP Comprehensive report. (http://www.cms.hhs.gov/SpecialNeedsPlans/).

OTHER ITEMS OF RELEVANCE

Briefings and Hearings:

- None

Other

- The next MedPAC public meeting is on March 12 and 13, 2009 in the Ronald Reagan Building in Washington DC. The agenda as well as other information pertaining to the meeting will be posted on its website a week prior to the meeting www.medpac.gov.

- A *Health Affairs* article was released this month by Y. Zhang, J.M. Donohue, J.P. Newhouse, and J. Lave titled "The Effects of the Coverage Gap on Drug Spending: A Closer Look at Medicare Part D" (*Health Affairs* 28, no. 2. 2009: w317-w325). The authors found that beneficiaries who entered the "doughnut hole" decreased their monthly prescriptions by about 14 percent per month. Specifically, the authors calculated prescription drug use for more than 11,000 Medicare beneficiaries enrolled in either individual MA/PD products (with no coverage in the gap or limited generic drug coverage in the gap) or employer group products (with coverage in the gap) offered by a large Pennsylvania insurer. The authors found that a quarter of those enrolled in the MA/PD products reached the level of spending that put them in the doughnut hole compared to 40 percent of those enrolled in employer plans with coverage in the gap. Those lacking any coverage in the "doughnut hole" reduced their spending by 14 percent while those with limited generic coverage reduced their spending by 3 percent. The authors conclude that the additional spending in the employer plans is consistent with previous studies stating that beneficiaries lacking coverage anticipate the doughnut hole region and reduce their spending accordingly. The authors also stated that those beneficiaries that lack coverage but didn't reach the doughnut hole also likely reduced their use of medications as well. http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.2.w317.

    - Of general interest, the Kaiser Commission on Medicaid and the Uninsured released two new documents pertaining to dual-eligibles this month. In a report titled "Rethinking Medicaid's Financing Role for Medicare Enrollees," the Commission examines the shift in financing of select services of dual eligibles from Medicaid to Medicare and explores several policy options that collectively could provide fiscal relief to states as Congress develops proposals for fiscal stimulus and health reform. The following are the options proposed that would further restructure the federal-state financing relationship for dual eligibles that the authors believe could help advance national efforts to control health spending growth for this population. Collectively, these options could provide as much as $47 billion annually (in 2005 dollars) in fiscal relief to the states. The options include: 1) full federal financing of the payment of Medicare premiums, which would reduce state Medicaid spending by an estimated

3.7 billion in 2005 dollars; 2) Federal assumptions of the full-cost of Medicare covered services (instead of the deductibles and co-insurance Medicaid currently pays). This would decrease state spending in Medicaid by 7.6 billion in 2005 dollars; 3) Federal assumptions of the full cost of Medicaid acute care services that are not currently covered by Medicare. This would include dental, vision and transportation services among others; and would decrease state Medicaid spending by $2.1 billion in 2005 dollars; 4) full federal financing for all Medicaid long-term care services provided to dual eligibles, which would result in an estimated $33.5 billion in state Medicaid savings for states. The Commission also released an issue brief titled "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005," which provided updated national and state data on enrollment and spending for dual eligibles. These two documents are available on the Kaiser Family Foundation website at: http://www.kff.org/medicaid/kcmu021309pkg.cfm

- In addition, the Kaiser Commission on Medicaid and the Uninsured also released an updated fact sheet on dual eligibles titled "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries." This fact sheet is available at: http://www.kff.org/medicaid/4091.cfm.