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TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS
Monthly Report for March 2007

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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

Enrollment and Penetration, by Plan Type	Current Month: March 2007	Change From Previous Month*	Same Month Last Year	
			March 2006	Change From March 2006- 2007
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	16,955,406	+25,907	Not Available	Not Available
General	16,832,402	+25,766		
Employer/Union Only Direct	123,004	+141		
	Not Available	(Total Enrollees)		
Duals Auto Enrolled in PDPs**		6,270,154		
All others Enrolled in PDP		10,360,026		
Total Medicare Advantage (MA)	8,350,765	+67,959	Not Available	Not Available
Medicare Advantage-Prescription Drug (MA-PD)	7,040,909	+64,975		
Medicare Advantage (MA) only	1,309,856	+2,984		
Medicare Advantage (MA) by Type			Not Available	Not Available
MA Local Coordinated Care Plans***	6,090,735	+26,069		
Health Maintenance Organizations (HMOs)	5,644,883	+20,565		
Provider Sponsored Organizations (PSOs)	74,461	+191		
Preferred Provider Organizations (PPOs)	371,383	+5,319		
Regional Preferred Provider Organizations (PPO)	125,883	+5,113		
Medical Savings Account (MSA)	2,182	-56		
Private Fee For Service (PFFS)	1,379,277	+41,251		
General	1,368,792	+40,966		
Employer Direct PFFS	10,485	+285		
Cost	308,611	+2,858		
Pilot****	140,590	-9,067		
Other*****	303,487	+1,791		
General vs Special Needs Plans****			Not Available	Not Available
Special Needs Plan Enrollees	842,840	Not Available		
Other Medicare Advantage Plan Enrollees	7,507,925	Not Available		
Penetration (as percent beneficiaries)*******				
Prescription Drug Plans (PDPs)	38.5%	+0.1%	Not Available	Not Available
Medicare Advantage Plans (MA)	18.9%	+0.1%		
Medicare Advantage-Prescription Drug Plans (MA-PDs)	15.9%	+0.1%		
Local Health Maintenance Organizations (HMOs),	12.8%	No Change		
Preferred Provider Organizations (PPOs)	0.8%	No Change		
Provider Sponsored Organizations (PSO)	0.2%	No Change		
Private Fee For Service (PFFS)	3.1%	+0.1%		

March 2007 data is from the 3.19.07 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/PrescriptionDrugCovGenIn/02_EnrollmentData.asp**)
* The February 2007 data is from data released by CMS on 2.15.07 also on its website
**The data for dual eligibles automatically enrolled in PDPs comes from CMS released data "State Enrollment in Prescription Drug Plans-January 2007 also on its wesbite.
***The data for the breakdown of MA Local Coordinated Care Plans is from the 3.19.07 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/PrescriptionDrugCovGenIn/02_EnrollmentData.asp).
**** 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 is from the 2006 SNP Enrollment by Type PDF released by CMS on 3.21.07 and includes counts of 10 or less through March 2007. (See: http://www.cms.hhs.gov/SpecialNeedsPlans)
*******Penetration rates for March 2007 and February 2007 are 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 March:

Plan Participation, by type	CURRENT MONTH: MARCH 2007*	SAME MONTH LAST YEAR	
		MARCH 2006***	CHANGE FROM MARCH 2006– 2007
MA Contracts (excluding SNP only contracts)			
Total	604	Not Available	Not Available
Local Coordinated Care Plan	410	314	+96
Health Maintenance Organizations (HMOs)	291	198	+93
Preferred Provider Organizations (PPOs) (Includes Physician Sponsored Organizations (PSOs))	119	116	+3
Regional Preferred Provider Organizations (rPPOs)	14	11	+3
Private Fee For Service (PFFS)	48	21	+27
General	47		
Employee Direct	1		
Cost	27	18	+9
Medicare Savings Account (MSA)	2	0	+2
Pilots	15	NA	NA
Other**	88	NA	NA

*Contract counts for March 2007 are from the 3.19.07 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/PrescriptionDrugCovGenIn/02_EnrollmentData.asp)
**Other includes Demo contracts, Health Care Prepayment Plans (HCPP), and Program for all-inclusive care of Elderly (PACE)
***March 2006 data are from the Geographical Service Area report for March 2006 (see Gold and Peterson (2006) report on *Analysis of the Characteristics of Medicare Advantage Plan Participation.* July 17, 2006). Available on **www.mathematica-mpr.com** 2006 data do not include HCCP, PACE, and "other" contracts. Excluding these types, there were 398 contracts.

Pending Applications

- No Information Available

Summary of new MA contracts announced in March:

- None

NEW ON THE WEB FROM CMS

Relevant to Both Medicare Advantage and Prescription Drug Plans

Briefings and Hearings:

- On March 21, 2007, a hearing on Medicare Advantage was held by the Committee on Ways and Means Subcommittee on Health. The hearing focused on the structure and cost of the Medicare Advantage plan program to determine if the government is overpaying MA plans (based on MedPAC's recent report to Congress that found Medicare reimbursements for MA plans are 12 percent more than fee-for-service program equivalent benefits-see below). While payments are the same for all MA plans within the same county, overpayments vary by plan type because plans of different types vary in their locations. On average, PFFS plans are paid 19 percent more than traditional Medicare whereas HMOs are paid 10 percent more. See: http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=543. The witnesses included the following:
    - Mark Miller, Executive Director of Medicare Payment Advisory Commission. In his testimony, Miller stated that setting benchmarks above the cost of traditional Medicare signals that the program welcomes plans that are more costly than traditional Medicare. He stated that this is inefficient because plans can use the excess payments-rather than the savings from efficiencies-to finance the extra benefits that in turn attract enrollees to such plans. Instead, to pay MA plans appropriately, MedPAC recommends that MA payments should be set at 100 percent of Medicare FFS expenditures (currently, on average, MA program payments are at 112 percent of Medicare FFS levels). Miller also stated that Congress may wish to employ a transition approach in order to implement MedPAC's recommendation on payment rates and provided three potential approaches. The report and commendations are available at www.medpac.gov.
    - Leslie Norwalk, CMS Acting Administrator. Norwalk discussed trends in MA plan access and enrollment, payment history, and what CMS views as the value of MA in terms of improved benefits at lower cost, providing plan options that are especially valuable to low income and minority beneficiaries. She also argued that MA has led the way in developing care management programs for chronic diseases and for quality measurement and public reporting. Norwalk's testimony is available on the Committee

on Ways and Means web page at: http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=543.

- Peter Orszag, Director of the Congressional Budget Office. Orszag discussed anticipated trends in the Medicare Advantage Program. He stated that unexpected strong growth in enrollment in MA program during 2006 and the beginning of 2007 led the CBO to increase its projections for both enrollment and spending in the program. He also stated that because Medicare's payments for beneficiaries enrolled in MA plans are higher on average than what the program would spend if those beneficiaries were in traditional fee-for-service sector, it is important for policymakers to weigh carefully additional costs against any differential benefits. CBO now estimates that enrollment in MA will be 22 percent of total Medicare enrollment in 2008 and 26 percent by 2017; payments to these organizations also will increase. CBO has estimated that eliminating the payment differential between MA and FFS would result in government savings of $65 billion over the next five years (2008-2012). A more limited reduction that caps rates at 120 percent of FFS would save $18 billion over the five-year period. Orszag's full testimony is available at: http://www.cbo.gov/showdoc.cfm?index=7879&sequence=0&from=7

Relevant to Medicare Advantage

- This month CMS released two reports about Medicare Advantage plans (www.cms.gov):
    - "Overview of the Medicare Advantage Program" This report provides basic information on Medicare Advantage (MA) plans as well as a brief summary of the legislative history to date affecting Medicare managed care plans. It also provides information on MA benchmarking; rural and low-income MA beneficiaries; preventive services and access to care trends.
    - "Medicare Advantage in 2007." This report provides more detailed information on legislative history and its effect on enrollment in Medicare managed care since the 1970s. In addition, this report provides some information on MA enrollment by plan type from August 2006 to February 2007. Private Fee for Service, for example, has increased 66 percent within this timeframe. In addition, information is provided by plan type for urban/rural enrollment for 2007 (for example, 68.8 percent of all PFFS enrollees are from urban areas and 31.2 are from rural areas whereas 92.9 percent of all local CCP enrollees are from urban areas and only 7.1 percent are from rural areas). Information on low-income and minority MA beneficiaries and payment methodology (including benchmark amounts; plan bids; and beneficiary rebates) is also provided. CMS also provides their interpretation of how MA plan enrollment/choices would be affected if the MA payment policy could not exceed 100 percent of FFS. Finally, other issues for MA in the future are also included in the report.

Relevant to Prescription Drug Plans

- On March 1, 2007, CMS Acting Administrator, Leslie Norwalk spoke at the Generic Pharmaceutical Association 2007 Annual Meeting. In her presentation she stated that generic drugs have been a cornerstone of CMS's drive for a competitive Part D market and that CMS continues to provide outreach to beneficiaries to help increase awareness of generic drugs available. Norwalk stated that generics have meant and will continue to mean big savings for seniors. She referenced a report released last month by CMS that found that generic use was especially high among those in the Medicare drug benefit (as compared to those enrolled in private commercial insurers), with generics accounting for nearly 60 percent of the drugs dispensed to those in stand alone Part D and Medicare Advantage plans. She provided an example that there has been a steady growth in generics over the past year in stand-alone plans, from 55.9 percent in the first quarter of 2006 to 66.3 percent in the third quarter. Norwalk's presentation is available online at CMS's website. See: http://www.cms.hhs.gov/apps/media/speeches.asp

- This month, CMS Acting Administrator, Leslie Norwalk also spoke at the American Medical Group Association Annual Conference. Norwalk discussed the continued effort to move CMS toward 'value-based purchasing.' She discussed that one of the ways to do this, as outlined in the MedPAC report released this month (see also below), is to focus on evidence-based medicine. Norwalk highlighted the proposed new policy to use Medicare Part D program data for more research oriented-tasks. http://www.cms.hhs.gov/apps/media/speeches.asp

Relevant to Special Needs Plans Specifically

- CMS has posted a new report titled: "Special Needs Plans Comprehensive Report" on plan-by-plan SNP enrollment as of March 2007. Total enrollment is 842,840. Enrollment by type is as follows: chronic: 81,093; dual eligible: 621,986; and institutional: 139,761. There are a total of 310 contracts (43 chronic; 205 dual eligible; 63 institutional). In addition, there are a total of 476 plans (71 chronic plans; 321 dual eligible plans; and 84 institutional plans). The report is available at: http://www.cms.hhs.gov/SpecialNeedsPlans

OTHER ITEMS OF RELEVANCE

- This month, the Kaiser Family Foundation hosted a policy workshop to better understand the increase in Private fee-for-Service Plans. Speakers for the session included Diane Rowland, Executive Vice President, Kaiser Family Foundation; Mark Miller, Executive Director, MedPAC; Joyce Dubow, Senior Advisor, AARP; Catherine Schmitt, Vice President, Federal Programs Business Unit, Blue Cross Blue Shield of Michigan; Jonathan Blum, Avalere Health; Marsha Gold, Senior Fellow, Mathematica Policy Research; and Gary Jacobs, Senior Vice President, Universal American Financial Corp. More information on this session is available at http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=2076.

- This month Kaiser Family Foundation also released four new issue briefs on Medicare Advantage plans (http://www.kff.org/medicare/med031407pkg.cfm):

    - "Private Plans in Medicare: A 2007 Update." In this issue brief Marsha Gold, Mathematica Policy Research, extends earlier work reviewing available PDP and MA choices to examine how the marketplace has evolved over the last year. The brief focuses primarily on the MA market but also provides updates on PDPs. The report is the first using November 2006 enrollment data to capture trends in enrollment by state and urban/rural areas. The brief also looks at market dynamics, identifying firms that dominate and are driving the market as well as how they and others are positioning themselves in 2007. http://www.kff.org/medicare/7622.cfm

    - "An Examination of Medicare Private Fee-for-Service Plans." In this brief, Jonathon Blum, Ruth Brown, and Miryam Frieder of Avalere Health LLC, review the brief history of PFFS plans, and examine how they differ from other MA plans. The authors also discuss implications of the rapid increase in PFFS plans for both beneficiaries and the Medicare program. http://www.kff.org/medicare/7621a.cfm

    - "Medicare Consumer-Directed health Plans: Medicare MSAs and HSA-Like Plans in 2007." This paper, written by Beth Fuchs and Lisa Potetz of Health Policy Alternatives reviews Medicare Medical Savings Account plans, which were authorized in 2006. The article provides a summary of MSA basics (including eligibility; plan requirements; covered services; premiums; cost sharing among other items). The article also examines the three MSA plan offerings in 2007 (two which meet the MSA requirements and one that is an MA MSA Demonstration plan). http://www.kff.org/medicare/7623.cfm

    - "Medicare Payments and Beneficiary Costs for Prescription Drug Coverage." Mark Merlis of the Henry J. Kaiser Family Foundation provides an overview of the Part D reimbursement system including an overview of Part D benefits; the bidding and payment system and the special provisions for low-income enrollees. It also provides information on how specific aspects of the payment system may affect the total cost of the Part D program, as well as the quality and coverage for beneficiaries. http://www.kff.org/medicare/7620.cfm

- MedPAC held a public meeting on March 8-9, 2007. Sessions of relevance included (transcripts are available on MedPAC's website: www.medpac.gov):

    - "Medicare Advantage/Special needs plans" in which Carlos Zarabozo and Jennifer Podulka discussed trends in Medicare Advantage plan payments, enrollment, and benefits provided to plan enrollees. Discussion centered on PFFS growth- i.e. how enrollment in Medicare Advantage plans has grown by 700,000 between August 2006 and February 2007, primarily coming from PFFS (70 percent of those newly enrolled in MA are enrolled in PFFS now). Three quarters of PFFS enrollees are located in floor

counties. MedPAC estimates that about $2 of the Part B premium a month actually goes to support overpayments to MA plans—at least in 2006). Commission staff presented various options for moving from the current level of overpayments towards MedPAC's stated goal of a level playing field. They also raised the issue of a potential inequity because beneficiaries get all the savings below bid in MSAs, but only 75 percent in other MA types. The SNP discussion focused on 2006 data, including that the majority of SNPs (87 percent) were offered by parent organizations that offer regular MA plans as well, suggesting that these organizations are offering SNPs as one of a menu of options. Podulka also stated that next month's MedPAC meeting she would provide more updated information on SNPs in 2007.

- "Part D and long-term care pharmacies" in which Rachel Schmidt discussed the effects of the Part D program on the roughly 5 percent of Medicare beneficiaries that reside in long-term care facilities. The discussion centered on the Harvard Medical School's Department of Health Care Policy work that was contracted by MedPAC to examine the impact of long-term care pharmacies by interviewing stakeholders including nursing homes, long-term care pharmacies, group purchasing organizations, Part D plans, clinicians and others. The Harvard researchers report tension between the nursing homes' need to dispense drugs quickly and long-term care pharmacies assuring coverage for these drugs. In addition, the Harvard researchers conclude that while the competitive impact of Part D on long-term care pharmacy section is currently unclear, the potential impact of changing rebate structures will be an important issue of continual focus.

- "Interaction of Parts B & D on payments for drugs" in which Joan Sokolovsky discussed how drug plans, pharmacists, and physicians are handling situations where drugs can be covered under both Part B and Part D. The presentation focused on the results of interviews with health plans, pharmacists and beneficiary advocates about the issues they have experienced. In some cases, they found that plans have been unable to determine which program covers a particular drug without additional information.

- The next MedPAC meeting will be held April 12-13, 2007 at the Ronald Reagan Building in Washington DC. Agenda details are posted 3-5 days before the meeting and transcripts are provided shortly afterwards. More information is also available at www.medpac.gov.

- The Blue Cross and Blue Shield Association has released a report entitled "Medicare Advantage: Improving Care through Prevention, Coordination, and Management" (February 2007). The report briefly summarizes ongoing initiatives in affiliated plans and what they report to be the outcomes from these initiatives. http://www.bcbs.com/issues/medicare/