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

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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

Enrollment and Penetration, by Plan Type	Current Month: March 2009	Change From Previous Month*	Same Month Last Year	
			March 2008	Change From March 2008- 2009
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	17,486,846	-15,688	17,412,675	+74,171
Individual	16,583,903	-18,369	Not Available	Not Available
Group**	902,943	+2,681	Not Available	Not Available
Total Medicare Advantage (MA)	10,861,495	+89,253	9,715,707	+1,145,788
Individual	8,930,547	+78,588	Not Available	Not Available
Group	1,930,948	+10,665	Not Available	Not Available
Medicare Advantage-Prescription Drug (MA-PD)	9,215,211	+84,218	8,096,355	+1,118,856
Medicare Advantage (MA) only	1,646,284	+5,035	1,619,352	+ 26,932
Medicare Advantage (MA) by Type				
MA Local Coordinated Care Plans** *	7,683,781	+58,567	6,890,674	+793,107
Health Maintenance Organizations (HMOs)	6,786,652	+39,677	6,295,357	+491,295
Provider Sponsored Organizations (PSOs)	14,396	+366	16,483	-2,087
Preferred Provider Organizations (PPOs)	882,686	+18,545	578,772	+303,914
Regional Preferred Provider Organizations (PPO)	388,903	+11,938	261,962	+126,941
Medical Savings Account (MSA)	3,295	+47	3,328	-33
Private Fee For Service (PFFS)	2,385,902	+19,383	2,108,721	277,181
Individual	1,657,075	+18,603	Not Available	Not Available
Group****	728,827	+780	Not Available	Not Available
Cost	285,957	+1,464	270,850	+15,107
Pilot*****	23,072	-1,130	86,826	-63,754
Other******	90,585	-1,016	93,346	-2,761
General vs Special Needs Plans***** **				
Special Needs Plan Enrollees	1,300,971	+1,068	1,130,264	+170,707
Dual-Eligibles	915,689	+3,772	815,569	+100,120
Institutional	120,947	-1,526	138,097	-17,150
Chronic or Disabling	264,335	-1,178	176,598	+87,737
Other Medicare Advantage Plan Enrollees	9,560,524	+88,185	8,585,443	+975,081
Penetration (as percent beneficiaries)********				
Prescription Drug Plans (PDPs)	39.8%	No Change	39.5%	+0.3% points
Medicare Advantage Plans (MA)	24.1%	+0.2% points	22.0%	+2.1% points
Medicare Advantage-Prescription Drug Plans (MA-PDs)	20.4%	+0.1% point	18.3%	+2.1% points
Local Health Maintenance Organizations (HMOs),	15.0%	No Change	14.2%	+0.8% points
Local Preferred Provider Organizations (PPOs)	2.0%	+0.1% point	1.3%	+0.7% points
Private Fee For Service (PFFS)	5.3%	No Change	4.7%	+0.6% points

March 2009 data is from the 3.19.09 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 February 2009 data is from data released by CMS on 2.18.09 also on its website
**The breakdown by Group includes Employer/Union Only Direct Contract PDP (122,157)
***The data for the breakdown of MA Local Coordinated Care Plans is from the 3.19.09 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 (13,430)
*****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 March is from the SNP Enrollment Comprehensive Monthly Report released by CMS on 3.19.09 and includes counts of 10 or less. (See: **(http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**).
*******Penetration for March and February 2009 is calculated using the number of eligible beneficiaries reported in the August 2008 MA State/County Penetration file. March 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 March:

Plan Participation, by type	CURRENT MONTH: MARCH 2009*	SAME MONTH LAST YEAR	
		MARCH 2008	CHANGE FROM MARCH 2008– 2009
MA Contracts			
Total	747	727	+20
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	78	+15

*Contract counts for March 2009 are from the 3.19.09 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 March 30, 2009, CMS issued the final 2010 Combined Call letter for MA, PDP and other private plans in 2010. CMS stated that it received approximately 190 comments on the draft Call Letter, which it released on February 23, 2009. CMS stated it has made revisions and clarifications in regards to some of the comments and other comments -such as changes to the reassignment process for LIS and how it should calculate and disseminate information about plans' medical loss ratios- it will consider in future contracting years. The final call letter focuses on new regulatory requirements and policy clarifications with detailed set of guidance for 2010 MA, MA-PD and cost plans included in Section A, 2010 PDPs in Section B and marketing/beneficiary communications in Section C. Some of the MA plan and marketing provisions of particular note include the following:

    - CMS states it will be taking new steps to address concerns about discriminating against sick people by placing limits on out-of-pocket charges for certain health care services. CMS states it will be reviewing plan benefits to ensure that particular services such as renal dialysis as well as home health and skilled nursing services are not higher than the cost sharing amounts under traditional Medicare FFS. In addition, plans that do not cap annual out-of-pocket costs at $3,400 or less will receive greater scrutiny of cost sharing amounts for individual services in determining whether the plan is discriminatory (see page 13 of the call letter for additional detail).

    - CMS is trying to address the difficulty of beneficiaries trying to choose from so many indistinguishable plans by asking MA organizations to make sure each plan they offer in 2010 differs significantly from one another. CMS states that it will review all MA plans with low enrollments (including MA plans with 10 or fewer beneficiaries) for more than three years since this can be an indication of financial instability and thus can adversely affect the ability for the plan to provide high quality care at a reasonable price. However, CMS stated that it recognizes some instances such as beneficiary population served and geographic location which might make lower enrollment reasonable. CMS will take such information into account when reviewing these plans. CMS plans to consider making a rule to limit plans to specific amount of benefit designs in a given service area as well as consolidate MA plans with low enrollments (see page 12 of the call letter for additional detail). While some press have referred to this as requiring termination of small plans, CMS is not explicit about this point and seems to leave itself with opportunity for negotiation with industry overall and/or over specific applications of the rule.

    - Prescription drug plan sponsors in 2010 will be required to outline their utilization management criteria on their websites (This criteria includes ways in which a plan is lowering costs and improving

outcomes. The plans must provide specific details on quality limits and step therapy requirements).

- PDP plans are also now required to provide 'additional and easy to understand' information about the coverage gap on the Plan Finder website this fall.
- The final 2010 Combined Call Letter is available on CMS website at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/2010CallLetter.pdf In addition to the call letter, CMS also provides a brief summary of some of the new requirements in its press release titled "CMS Issues Guidance for Medicare Advantage and Prescription Drug Plans for 2010" also available on CMS's website at: (http://www.cms.hhs.gov/apps/media/press_releases.asp).

Relevant to Medicare Advantage

- CMS recently released a document titled "network areas for non-employer PFFS plans for 2011" on its website. We assume that this file shows the counties in which PFFS plans will have to develop networks for in 2011 because the county meets the criteria of having 2 or more CCPs. However, the file is not very interpretable and CMS does not provide a description. The excel file lists the SCC code, state, county and zip code (if applicable) for each network area. The file is located at: http://www.cms.hhs.gov/PrivateFeeforServicePlans/

Relevant to Prescription Drug Plans

- On March 17, 2009, CMS posted on its website a document titled "CMS Guide to Requests for Medicare Part D Prescription Drug Event (PDE) data". This guide provides detailed information for Part D data requesters. The document provides background information on the final rule released last year (on June 27, 2008), information on ResDAC, which helps manage the data, as well as the appropriate data use agreement (DUA) form to use as well as CMS's process for submitting, reviewing and approving PDE data requests. This document is available at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/08_PartDData.asp#TopOfPage
- CMS recently released a new document on its website titled "Low Income Subsidy Guidance for States." The guidance provides states with detailed information about making the subsidy determination (i.e. who qualifies for the subsidy etc) as well as how to expedite the determination for the subsidy as well as for the Medicare Savings Program (MSP). This document is available on CMS's website at: http://www.cms.hhs.gov/LowIncSubMedicarePresCov/02_EligibilityforLowIncomeSubsidy.asp#TopOfPage

Of General Interest

- None

Relevant to Special Needs Plans Specifically

- CMS recently posted on its website information on the 2009 SNP reporting requirements. This information included: 1) a detailed document on the 6 required structural and process measures for 2009. There are three new structural and process measures as of this year: a care transitions measure; an institutional SNP relationship with facility measure; and a coordination of Medicare and Medicaid benefits measure and 2) a document on frequently asked questions regarding the HEDIS reporting requirements. There are 15 required HEDIS measures for 2009, which include two new measures required for the first time in 2009. The two new HEDIS measures are a care for older adults measure and a medication reconciliation post discharge measure. National Committee for Quality Assurance (NCQA) developed these new measures as part of their contract with CMS to develop a strategy to evaluate the quality of care provided by SNPs. More information on this is available at: http://www.cms.hhs.gov/SpecialNeedsPlans/

OTHER ITEMS OF RELEVANCE

Briefings and Hearings:

- On March 17th the Subcommittee on Health of the Committee on Ways and Means held a hearing on MedPAC's annual March Report to the Congress on Medicare Payment Policy. Testimony was from Glen Hackbarth, Chairman of MedPAC in which he stated that while MA plans provide enhanced benefits, overwhelmingly these benefits are not financed out of plan efficiency but rather by the Medicare program and other beneficiaries at a high cost (e.g. each dollar worth of enhanced benefits in PFFS plan costs Medicare program over 3 dollars). He stated that MedPAC continues to support financial neutrality between FFS and MA. In addition, to encourage efficiency across Medicare, CMS needs to exert comparable and consistent financial pressure on both FFS and MA programs, coupled with meaningful quality measurement and P4P programs (also as recommended in previous years). A more detailed summary of MedPAC's report pertaining to MA and Part D is included below. In addition, Hackbarth's testimony is available on the Committee's website (http://waysandmeans.house.gov/hearings.asp).

Other

- This month, MedPAC released its March 2009 Report to Congress on recommendations for Medicare spending in 2010. The report includes a chapter on the status of the Medicare Advantage Program and Part D Program.

- In the chapter on Medicare Advantage, MedPAC reiterates its 2005 recommendation to Congress that MA plans should be financially neutral (i.e. Congress should set the benchmarks CMS uses to evaluate MA plan bids at 100 percent of FFS costs). MedPAC states that paying a plan more than FFS spending for delivering the same services in not an efficient use of Medicare funds in the absence of evidence that such payments result in better care. MedPAC also recommends that Congress should eliminate the stabilization fund for regional PPOs and remove the effect of payments for indirect medical education from the MA plan benchmarks. In addition, MedPAC discusses how quality for MA plans is not uniform among MA plans or MA plan types (e.g. high quality plans tend to be in established HMOs). MedPAC recommends that pay-for-performance be done in MA to reward plans with higher quality of care. Clinical measures for the FFS program should also be done in order for CMS to compare the FFS with MA plans. http://www.medpac.gov/document_search.cfm

- In the chapter on the status of the Part D Program, MedPAC describes Part D enrollment in 2008 and plan offerings for 2009 including benefit designs, premiums, formularies, and cost-sharing requirements. As of January 2008, 90 percent of Medicare beneficiaries received some form of drug coverage. Twenty-one percent of Medicare beneficiaries received Part D's low income subsidy (LIS), however, an estimated 2.6 million beneficiaries eligible for the LIS were not enrolled to receive it. In 2009, there was a 7 percent decline in the number of PDP plans and premiums are significantly higher than in 2008 (e.g. if enrollees stayed in the same plan, their premiums rose $6 on average or to $31 dollars per month). However, sponsors are offering 6 percent more MA-PDs in 2009 than in 2008. MedPAC also includes detailed information on medication therapy management programs (MTMPs), which are intended to promote quality. PDPs and MA-PDs must implement MTMPs (costs are included as an administrative expense in plan bids) for enrollees with chronic conditions that take multiple drugs, which are expected to average at a minimum $4,000 per year in drug costs. However, MedPAC states that CMS does not provide much guidance on these programs in terms of design or implementation and it is unclear to whether MTMPs are improving the quality of pharmaceutical care for such beneficiaries as evaluations have been limited due to the small number of enrollees involved.

- MedPAC also held a public meeting 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 is posted on its website at: www.medpac.gov. One session in particular of relevance was titled "MIPPA Medicare Advantage Payment report." In this session, Scott Harrison, David Glass, Dan Zabinski and Carlos Zarabozo continued their discussion from the January 2009 MedPAC meeting on simulations and features of alternative systems for setting benchmarks for MA payments as required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, section

169). This study is part of MedPAC's report it is preparing to Congress, which is due March 2010; MedPAC indicated they planned to submit it earlier (June 2009) in response to Congressional interest. Specifically, MedPAC staff is examining four alternative options for setting benchmarks administratively. MedPAC used data from 2009 plan bids and included all plan types (except SNP and employer group plans) in their analysis. It assumes the plan bids and service areas do not change and all the options it simulates are financially neutral (i.e. the option would reduce the average benchmark from 118 percent of fee-for-service to an average of 100 percent of fee-for-service spending). Option one would be to set benchmarks to local fee-for-service. A second option would be a 'hybrid' of this by setting a floor at the low end and a ceiling at the high end and use fee-for-service spending rates in the middle. Another option would take into account expected plan costs (i.e. benchmarks would be higher in areas where plan costs would be expected to be higher and lower in areas where they were expected to be lower). This essentially is a blend of local FFS and the national average. Option four would be to assume the national average service use in all areas but adjust it by including local input prices to set the benchmarks. MedPAC discussed plan availability if the benchmarks are changed-MedPAC found in their analysis that of the four options, option four, the input price adjusted blend, would maintain the highest levels of plan availability. Option one, the local fee-for-service benchmarks, would result in the lowest plan availability. MedPAC also discussed the need for retaining high-quality plans in MA as well as continued extra benefits plans may offer. MedPAC stated that the transition from 118% to 100% FFS benchmarks needs to be judicious-it needs to limit disruption to beneficiaries and encourage high quality plans to stay in MA by paying them differently during transition (i.e. pay high quality plans more). At the meeting, MedPAC discussed the competitive bidding proposal for MA in President Obama's 2010 proposed budget. They concluded that there is too much uncertainty to do fiscal estimates of the impact of bidding; instead, they will provide conceptual/qualitative analysis of potential effects of this strategy versus changes in administrative pricing.

  - MedPAC will hold its next meeting on April 8 and 9, 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 one week prior to the meeting. www.medpac.gov

- The Kaiser Family Foundation released a report this month titled "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" The study was done by Jonathan Gruber of Massachusetts Institute of Technology (MIT). Gruber used retail pharmacy claims from 2005 and 2006 for Part D enrollees aged 65 and older to examine 2006 plan choice based on 2005 claim experience. Gruber found that only 6 percent of seniors chose the lowest-cost plan offered in their area in 2006. He found that enrollees who did not choose the lowest-cost plan would have saved $520 on average in 2006 if they had done so. Gruber concludes most seniors did not handle choice very well in terms of maximizing savings when selecting a Medicare Part D plan, however, he acknowledges that there are several other factors other than savings that likely drive Part D plan enrollment decisions. These factors include choosing to pay more for a plan that has fewer utilization restrictions, choosing a plan with a strong brand name or good reputation or choosing a plan that

contracts with a convenient pharmacy that is not in the network of the lowest-cost plan. This report is available at: http://www.kff.org/medicare/7864.cfm.

- AARP released two new reports this month on Medicare Advantage using newly released CMS data. Both reports were written by Marsha Gold and Maria Hudson of Mathematica Policy Research and are available on AARP's website at: http://www.aarp.org/research/medicare/advantage

    - "A First Look at How Medicare Advantage Benefits and Premiums in Individual Enrollment Plans are Changing from 2008 to 2009." In this report, the authors describe benefits and premiums of MA plans in 2008 and how they have changed in 2009. The authors found a small increase in the number of regular MA plans offered for individual enrollees (from 3,307 in 2008 to 3,354 in 2009). While the average MA-PD had a premium of $63 per month in 2008, most enrollees tended to prefer lower premium plans (the average premium paid by an enrollee was $46 per month) and over half were in a plan with no premium. In addition, the authors estimated that the average MA-PD enrollee paid $413 in 2008 in out of pocket cost and $421 in 2009. However, this cost varied widely across plans (it was much higher in regional PPOs and lowest in HMOs). Enrollees with chronic needs also had higher out of pocket regardless of their plan type.

    - Medicare Advantage Benefit Design: What Does it Provide, What Doesn't It Provide, and Should Standards Apply?" In this report, the authors examine how MA plans modify the structure of Medicare Part A and Part B benefits and cost sharing requirements, and how this affects enrollees' financial protection. The authors also compare the current MA benefit structure with the standardized Medigap options which were developed in 1990. The authors found that most MA plans have modified the structure of Medicare Part A and Part B benefits-most have simplified the benefit structure with a shift toward copayments and away from deductibles and coinsurance. The authors found that in 2008, a little over half of MA enrollees (53 percent) were in a plan that had an out-of-pocket limit but these limits tend to be relatively high. The authors note that historically such a limit was less relevant for HMOs but as cost sharing has increased this is becoming a key concern. The authors state that policymakers may want to consider whether greater standardization would be desirable and includes certain incremental changes that could be done to limit financial exposure of MA enrollees.