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

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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

Enrollment and Penetration, by Plan Type	Current Month: April 2007	Change From Previous Month**	Same Month Last Year	
			April 2006	Change From April 2006- 2007
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	16,926,207	-29,199	13,898,083	+3,028,124
General*	16,802,895	-29,507	Not Available	Not Available
Employer/Union Only Direct	123,312	+308	Not Available	Not Available
	Not Available	(Total Enrollees)		Not Available
Duals Auto Enrolled in PDPs***		6,270,154	5,826,789	
All others Enrolled in PDP		10,360,026	8,071,294	
Total Medicare Advantage (MA)	8,508,544	+157,779	6,831,626	+1,676,918
Medicare Advantage-Prescription Drug (MA-PD)	7,132,071	+91,162	5,919,562	+1,212,509
Medicare Advantage (MA) only	1,376,473	+66,617	910,475	+465,998
Medicare Advantage (MA) by Type				
MA Local Coordinated Care Plans*** *	6,125,284	+34,549	5,679,600	+445,684
Health Maintenance Organizations (HMOs)	5,668,807	+23,924	5,335,225	+333,582
Provider Sponsored Organizations (PSOs)	76,704	+2,243	76,946	-242
Preferred Provider Organizations (PPOs)	379,763	+8,380	267,429	+112,334
Regional Preferred Provider Organizations (PPO)	135,546	+9,663	54,378	+81,168
Medical Savings Account (MSA)	2,329	+147	Not Applicable	Not Applicable
Private Fee For Service (PFFS)	1,494,955	+115,678	579,041	+915, 914
General	1,484,393	+115,601	Not Available	Not Available
Employer Direct PFFS	10,562	+77	Not Available	Not Available
Cost	307,135	-1,476	313,312	-6,177
Pilot*****	138,528	-2,062	Not Applicable	Not Applicable
Other******	304,767	+1,280	Not Available	Not Available
General vs Special Needs Plans***** **	Not Available	(Total Enrollees)	Not Available	Not Available
Special Needs Plan Enrollees		842,840		
Other Medicare Advantage Plan Enrollees		7,665,704		
Penetration (as percent beneficiaries)********				
Prescription Drug Plans (PDPs)	38.4%	-0.1%	31.6%	+6.8%
Medicare Advantage Plans (MA)	19.3%	+0.4%	15.5%	+3.8%
Medicare Advantage-Prescription Drug Plans (MA-PDs)	16.2%	+0.3%	13.4%	+2.8%
Local Health Maintenance Organizations (HMOs),	12.9%	+0.1%	12.2%	+0.6%
Preferred Provider Organizations (PPOs)	0.9%	+0.1%	0.6%	+0.2%
Provider Sponsored Organizations (PSO)	0.2%	No Change	0.2%	No Change
Private Fee For Service (PFFS)	3.4%	+0.3%	1.3%	+2.1%

April 2007 data is from the 4.10.07 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**)
*CMS did not provide a breakdown of general and employer/union only direct plans until July 2006.
** The March 2007 data is from data released by CMS on 3.19.07 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 4.10.07 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 for March 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 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 April:

Plan Participation, by type	CURRENT MONTH: APRIL 2007*	SAME MONTH LAST YEAR	
		APRIL 2006**	CHANGE FROM APRIL 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) General Employee Direct	48 47 1	21	+27
Cost	27	18	+9
Medicare Savings Account (MSA)	2	0	+2
Other***	88	Not Available	Not Available

*Contract counts for April 2007 are from the 4.10.07 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**)
** 2006 data are based on contacts approved January 2006 and included in the November 2005 release of the Personal Plan Finder. Those data showed a total of 398 contracts, excluding HCPP, PACE and "other" which were not listed in the file.
***Other includes Demo contracts, Health Care Prepayment Plans (HCPP), and Program for all-inclusive care of Elderly (PACE)

Pending Applications

- No Information Available

Summary of new MA contracts announced in April:

- None

NEW ON THE WEB FROM CMS

Relevant to Both Medicare Advantage and Prescription Drug Plans

- This month CMS released a memorandum to all Medicare Advantage organizations, Prescription drug plans, cost plans and PACE organizations and demonstrations announcing that draft MA and PDP enrollment and dissenrollment guidance is available for comments for a three-week period. Comments are due no later than cob on May 7, 2007. (The guidance was last updated in September 2006). The draft guidance along with a summary of the changes are on the CMS's website at: http://www.cms.hhs.gov/HealthPlansGenInfo/06_MedicareHealthPlanEnrollmentandDisenrollment.asp#TopOfPage

- On April 2, 2007, CMS released the final calendar year 2008 MA Capitation Rates and Payments, along with a related fact sheet titled, "CMS Announces 2008 Medicare Advantage Payment Rates and Part D Payment Updates." This fact sheet is available at: http://www.cms.hhs.gov/apps/media/fact_sheets.asp. The complete announcement can be accessed from the fact sheet or directly at www.cms.hhs.gov/MedicareAdvtgSpecRateStats/AD/list.asp#TopOfPage The latter includes a detailed response to comments received in response to the initial notice.

    - For Medicare Advantage plans, CMS says the capitation rate will increase about 3.5 percent on average in 2008. (This compares to CMS's calculated 4.3 percent in the underlying 2008 growth). The percentage incorporates statutorily mandated adjustments include the budget neutrality adjustments. (CMS calculates payment by (1) backing out of the final 2007 rates the budget neutrality adjustment for that year (3.9 percent); (2) updating the 2007 amount by the National Per Capita MA growth Percentage for 2008 (5.7 percent including prior year adjustments); and (3) reducing the calculated 2008 amount by the 2008 budget neutrality factor (1.7 percent)).

    - CMS also released information on Low Income Benchmark Premium Amounts for Part D. In 2008, the low-income benchmarks will be a blend of (1) 50% equal weighting of Part D premiums in plans; and (2) 50% enrollment weighted Part D premiums. CMS is using the blend to reduce the number of beneficiaries who would otherwise be mandated to switch plans since enrollment weighted premiums are below average unweighted premiums. CMS also will allow plans to avoid charging premiums when there is a $1 or less difference between the benchmark and premium.

- In 2008, the Part D deductible will be $275, the Initial coverage limit will be $2,510, and the out of pocket threshold will be $4,050, an increase of 4.64 percent from 2007. Copayments for dual eligible beneficiaries will increase by 2.42 percent.

- The monthly actuarial value of Medicare deductible and coinsurance amounts for 2008 is $142.40 for Part A/B combined, a 5 percent increase from 2007. (The figure is $134.24 for non-ESRD beneficiaries).

- The maximum allowable deductible for MSAs will rise to $10,050 in 2008.

- The Part D risk sharing corridor will be modified. From 2008 to 2011, PDPs are fully at risk for +/- 5% of the target amount; there is a 50/50 sharing of risk from 5 to 10 percent of the target; and the government takes 80 percent of the risk above 10 percent (+ or -) with the plan absorbing the rest. The effect of this is to increase the amount of risk born by plans compared to 2006 and 2007.

Relevant to Medicare Advantage

- None

Relevant to Prescription Drug Plans

Of General Interest

- This month CMS released a press release announcing that the Medicare Trustees Annual Report was released. The report describes that cost projections for Part D through 2015 are 13 percent lower than estimated in last year's annual report. Plan bids for 2007 were 10 percent lower than in 2006. The report details that this is due to competition among plans as well as the increased use of inexpensive generic drugs (www.cms.gov).

Relevant to Special Needs Plans Specifically

- CMS released a document titled "Final SNP Fact Sheet & Summary" this month. This document provides detail on the legislative history of SNPs and information on the different types of SNPs available (i.e. institutional; dual eligible; or severe or disabling chronic conditions). CMS also includes a section on the 'Value of SNPs.' CMS describes the Medicare and Medicaid integration under dual SNPs, stating that CMS has taken various steps to facilitate integration and create incentives for states and plans to work together. CMS provides an 'Evaluation' section, describing evaluations currently underway on the impact of SNPs on the cost and quality of services provided to enrollees. Finally, CMS also provides a section on the 'Future of SNPs' in which CMS states that they are currently refining their guidance on SNPs to continue to encourage partnerships with states in the case of dual eligible SNPs. The document is available on CMS's website at: http://www.cms.hhs.gov/SpecialNeedsPlans/01_Overview.asp#TopOfPage

OTHER ITEMS OF RELEVANCE

Briefings and Hearings:

- On April 11, 2007, the U.S. Senate Committee on Finance held a hearing on Medicare Advantage: http://www.senate.gov/~finance/sitepages/hearing041107.htm. Witness statements included:

    - Glen Hackbarth, Chairman, Medicare Payment Advisory Commission (MedPAC). Hackbarth discussed the MedPAC's MA payment plan recommendations. He stated that MA has become a program in which there are few incentives for efficiency. He stated that the Commission believes that the payment policy in the MA program should be built on a foundation of financial neutrality between payments in the traditional FFS program and payments to private plans. Hackbarth notes that because of the impact on beneficiaries currently enrolled in private plans with extra benefits (financed, he stated, from excess payments rather than savings from efficiencies), the Congress may wish to employ a transition approach in implementing the Commission's recommendation on payment rates. He states possible approaches might be to 1) freeze all county rates at their current levels until each county's rate is at the FFS level; 2) differentially reduce MA rates; or 3) reduce rates in all counties at the same percentage each year until arriving at FFS rates in each county. His statement is available on MedPAC's website: www.medpac.gov.

    - Peter Orszag, Director, 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. Orszag discussed that expanding the reporting of health outcomes would be useful in assessing the value of the care management services provided by the private plans. He also states that reducing the payment differential between MA and traditional FFS could result in substantial savings (for example, CBO estimated that eliminating the payment differential all together would result in a 54 billion dollars in savings over the next 5 years). His testimony is available at: www.cbo.gov.

    - Debra Draper, Associate Director, Center for Studying Health Systems Change. Draper's statement focused on care management activities (such as disease management, case management, and health promotion and wellness) offered in commercial health plans. She stated although they have not specifically looked at MA plans in recent years, in general, there has been a growing trend in commercial health plans offering case

management. She also stated that there is limited evidence to date as to what impact, if any, many of the care management activities that commercial health plans offer have on costs, quality and outcomes. Thus, she stated, financial support for these activities is difficult to rationalize unless those providing the funding expect that as health plans gain more experience and sophistication, results will eventually justify the investment. Draper's statement is available online at: http://www.senate.gov/~finance/sitepages/hearing041107.htm

- Steven Udvarhelyi, Senior Vice President and Chief Medical Officer, Independence Blue Cross. Udvarhelyi stated that Independence Blue Cross offers a range of coverage options to Medicare beneficiaries (most in the greater Philadelphia region) including HMO plans, point-of-service (POS) plans, PPO plans, Medicare Part D coverage, and supplemental coverage. His testimony focused on three broad areas: 1) a conceptual rationale for why BCBS believes MA plans add value over the Medicare fee-for-service program; 2) a BCBS analysis on advances in care coordination and disease management that are significantly improving patient care for beneficiaries enrolled in MA plans; and 3) information on the value the MA program offers to beneficiaries, particularly those who need assistance managing their multiple chronic conditions. Udvarhelyi's statement is also available on the Senate Finance Committee website at: **http://www.senate.gov/~finance/sitepages/hearing041107.htm**

Other

- On April 12 and 13th, the Medicare Payment Advisory Commission (MedPAC) held a meeting at the Ronald Reagan Building in Washington DC. Agenda details and transcripts are provided on their website at: www.medpac.gov. Relevant meeting sessions included:

  - "Issues in the delivery of Medicare drug benefits under Part B and Part D." In this session, Joan Sokolovsky of MedPAC discussed issues surrounding how drug plans, pharmacists, and physicians have handled situations where drugs can be covered under both Part B and Part D. She also discussed how Part D benefits are provided to residents of long-term care facilities.

  - "The role of beneficiary-centered assignment for Medicare Part D." In this session, Jack Hoadley, Research Professor at the Institute for Health Care Research and Policy at Georgetown University discussed initial results examining state pharmacy assistance programs and Medicaid programs use of a policy of "beneficiary-centered assignment" to assign their members to plans that covered most of their drugs and minimized their cost sharing. Key research questions included: 1) Would beneficiary assignment be more appropriate in the future (as opposed to random assignment), especially as we are beyond the first year of the program and if so, is it feasible?; 2) Do beneficiaries end up in plans covering the drugs that best serve their needs?; 3) does the federal government face higher cost when beneficiaries are randomly assigned? Hoadley discussed that their initial results indicate that beneficiary centered assignment is feasible and could be designed in

several different dimensions. It could also be used to reduce federal program cost. However, Hoadley notes that there are some trade-offs and other implications of using this approach.

- This month the Kaiser Family Foundation and the Alliance for Health Reform co-hosted a Webcast titled "Medicare 101: What You Really Need to Know." Ed Howard of the Alliance for Health Reform moderated the session. The panel included Diane Rowland, and Tricia Neuman of the Kaiser Family Foundation; Tom Auit of Health Policy Alternatives and Cynthia Tudor from CMS. In particular, Cynthia Tudor focused on Medicare Part D, discussing Part D history, eligibility and enrollment information as well as contract summary and benefit analysis. Slides from her presentation as well as others and more information on this session, see: http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=2067