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# TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS
# Monthly Report for April 2008

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*as part of work commissioned by the Kaiser Family Foundation*

## PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

| Enrollment and Penetration, by Plan Type | Current Month: April 2008 | Change From Previous Month* | Same Month Last Year | |
|---|---|---|---|---|
| | | | April 2007 | Change From April 2007- 2008 |
| **Enrollment** | | | | |
| **Total Stand-Alone Prescription Drug Plans (PDPs):** | 17,337,796 | -74,879 | 16,926,207 | +411,589 |
| General | 17,254,204 | -34,924 | 16,802,895 | +451,309 |
| Employer/Union Only Direct | 123,592 | +45 | 123,312 | +280 |
| 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)** | 9,841,267 | +125,560 | 8,508,544 | +1,332,723 |
| Medicare Advantage-Prescription Drug (MA-PD) | 8,197,657 | +101,302 | 7,132,071 | +1,065,586 |
| Medicare Advantage (MA) only | 1,643,610 | +24,258 | 1,376,473 | +267,137 |
| **Medicare Advantage (MA) by Type** | | | | |
| MA Local Coordinated Care Plans** * | 6,965,505 | +74,831 | 6,125,284 | +840,221 |
| Health Maintenance Organizations (HMOs) | 6,337,954 | +42,597 | 5,668,807 | +669,147 |
| Provider Sponsored Organizations (PSOs) | 17,118 | +635 | 76,704 | -59,586 |
| Preferred Provider Organizations (PPOs) | 610,377 | +31,605 | 379,763 | +230,614 |
| Regional Preferred Provider Organizations (PPO) | 269,791 | +7,829 | 135,546 | +134,245 |
| Medical Savings Account (MSA) | 3,533 | +205 | 2,329 | +1,204 |
| Private Fee For Service (PFFS) | 2,153,429 | +44,708 | 1,494,955 | +658,474 |
| General | 2,140,558 | +44,627 | 1,484,393 | +656,165 |
| Employer Direct PFFS | 12,871 | +81 | 10,562 | +2,309 |
| Cost | 271,026 | +176 | 307,135 | -36,109 |
| Pilot**** | 84,981 | -1,845 | 138,528 | -53,547 |
| Other***** | 93,002 | -344 | 304,767 | -211,765 |
| **General vs Special Needs Plans******** | | | | |
| Special Needs Plan Enrollees | 1,146,404 | +16,140 | 842,840 | +303,564 |
| Dual-Eligibles | 829,493 | +13,924 | Not Available | Not Available |
| Institutional | 136,251 | -1,846 | Not Available | Not Available |
| Chronic or Disabling | 180,660 | +4,062 | Not Available | Not Available |
| Other Medicare Advantage Plan Enrollees | 8,694,863 | +109,420 | 7,665,704 | +1,029,159 |
| **Penetration** (as percent beneficiaries)******** | | | | |
| Prescription Drug Plans (PDPs) | 39.4% | -0.1% points | 38.4% | +1.0% points |
| Medicare Advantage Plans (MA) | 22.3% | +0.3% points | 19.3% | +3.0% points |
| Medicare Advantage-Prescription Drug Plans (MA-PDs) | 18.6% | +0.3% points | 16.2% | +2.4% points |
| Local Health Maintenance Organizations (HMOs), | 14.3% | +0.1% points | 12.9% | +1.4% points |
| Preferred Provider Organizations (PPOs) | 1.4% | +0.1% points | 0.9% | +0.5% points |
| Provider Sponsored Organizations (PSO) | 0.04% | No Change | 0.2% | -0.16% points |
| Private Fee For Service (PFFS) | 4.9% | 0.2% points | 3.4% | +1.5% points |

April 2008 data is from the 4.22.08 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 March 2008 data is from data released by CMS on 3.04.08 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 4.22.08 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 April is from the SNP Enrollment Comprehensive Monthly Report released by CMS on 4.02.08 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 April:

| Plan Participation, by type | CURRENT MONTH: APRIL 2008* | SAME MONTH LAST YEAR | |
|---|---|---|---|
| | | APRIL 2007 | CHANGE FROM APRIL 2007– 2008 |
| **MA Contracts (excluding SNP only contracts)**** | | | |
| Total | 726 | 604 | +122 |
| 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)<br>General<br>Employee Direct | 79<br>77<br>2 | 48<br>47<br>1 | +31<br>+30<br>+1 |
| Cost | 25 | 27 | -2 |
| Medicare Savings Account (MSA) | 9 | 2 | +7 |
| Special Needs Plans<br>Dual-Eligible<br>Institutional<br>Chronic or Disabling Condition | 443<br>270<br>66<br>107 | Not Available | Not Available |
| Other*** | 78 | 88 | -10 |

*Contract counts for April 2008 are from the 4.22.08 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 April 2008 and April 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 April 7, 2008, CMS released a fact sheet with the final Calendar Year 2008 MA capitation rates and MA/Part D policies. The final estimate of the National Per Capital MA growth percentage in 2008 combined aged and disabled beneficiaries is 4.24 percent. This will be the minimum update percent in 2008 except for state ESRD rates, which will be subject to a 2 percent minimum update under the statute. County rates were rebased in 2009 and benchmarks will be the higher either of the rebased amount or the minimum percent increase over 2008. CMS also reviewed in the release selected other payment calculations and policies. The fact sheet is available at: http://www.cms.hhs.gov/apps/media/fact_sheets.asp. Some notable findings are as follows:

    - The monthly actuarial value of Medicare deductible and coinsurance in 2008 is $37.94 for Part A and $97.97 for Part B per month in 2009, for a total $135.91. This is a reduction from 2008 ($142.40) because there was a drop in the estimate for Part B between the years.

    - In 2009, the maximum deductible for MSAs is $10,500. For demonstrations, the 2009 minimum is $2,200, the maximum is $10,500 and the minimum difference between the deductible and deposit is $1,000.

    - CMS is adopting the CMS-HCC model as proposed in the advance notice. In response to a significant number of comments disagreeing with their proposed adjustment for MA coding differences, CMS has decided not to make a coding intensity adjustment for 2009. CMS will continue to study the issue with the results of the first year plan-level annual MA audits and additional utilization data. CMS will not make an adjustment to rates for VA-DOD costs as they originally hoped because DOD had not yet supplied the necessary data.

- CMS noted that the final version of their rule for calculating the Low Income Benchmark Premium Amount was published on April 3. The final rule changes the calculation of regional benchmarks and eliminates the need, CMS says, for the LIS transition demonstration in 2009.

- On April 18, 2008, CMS released draft PDP and MA enrollment and disenrollment guidance for a three-week comment period (comments on the draft revisions must be received by CMS by 5:00 pm EDT on Monday, May 12, 2008). Both sets of guidance (MA and PDP) are consistent with the information contained in the 2009 Call letter. The information for both the MA and PDP draft guidance documents are on CMS's website and includes three documents for each: 1) the track changes made to the full manuals; 2) shorter summary charts of the updates; and 3) comment charts for organizations submitting revisions/comments. The information for the MA guidance is at: http://www.cms.hhs.gov/MedicareMangCareEligEnrol/ The PDP guidance is at: http://www.cms.hhs.gov/MedicarePresDrugEligEnrol/

- The MA enrollment and disenrollment guidance, in particular, references MA local plans, MA RPPOs, and MA-PDs, including SNPs. The updates include new SNP guidance (discussed below), new guidance on the Special Election Period (SEP) as well as new guidance on employer/union and group enrollment mechanisms. A new separate model PFFS enrollment form is also included. In addition, CMS removed all references to the limited open enrollment period (L-OEP).

- The PDP enrollment and disenrollment guidance also includes update on the Special Election Period (SEP) for enrollment and additional communications to beneficiaries regarding their PDP plans (for example, CMS will now also notify beneficiaries who have voluntarily elected a zero premium plan if their plan will increase premium. CMS will send a letter similar to those auto enrolled letting them know other options but in addition will emphasize CMS will *not* move them to a new plan).

**Relevant to Medicare Advantage**

- On April 11, 2008, CMS released a memorandum titled "2009 Employer Group Waiver – Modification of the 2008 Service Area Extension Waiver Granted to Certain MA Local Coordinated Care Plans." The memorandum provides information on a CMS modification of service area for contract year 2009 for Medicare Advantage organizations (MAOs) offering "800 series" local CCPs. In effect, the shift in policy makes it easier for coordinated care plans seeking to enroll employer groups to qualify to serve them despite some retirees living outside the State/ service area of the plan. The modification provides additional detail on CMS policy for when the MAOs can not secure contracts with an adequate number of network providers to satisfy the necessary network adequacy requirements for 800 plans operating outside of their State/service area. Plans must be able to meet network adequacy standards for at least 50 percent of the particular employer or union group and enrollees must still receive the same covered benefits at the preferred in-network cost sharing for all covered benefits. Provider payment in such circumstances must be at least at Medicare A/B rates. CMS requires sponsors to submit such plans for approval. The document notes that the policy is consistent with what CMS requires for RPPOs that have access limitations. The memorandum is on CMS's website at: http://www.cms.hhs.gov/EmpGrpWaivers/30_Guidance.asp#TopOfPage

**Relevant to Prescription Drug Plans**

- On April 2, 2008, CMS finalized a rule to establish Part D e-prescribing standards for four types of information: 1) formulary and benefits; 2) medication history; 3) fill status notification; and 4) identification of individual health care providers. E-prescribing is not required but will apply to all Part D sponsors as well as prescribers and dispensers who choose to electronically transmit prescriptions or prescription-related information about Part D covered drugs prescribed for Part D eligible individuals. The new e-prescribing rule will take effect on April 1, 2009. The final

rule is available at: http://www.cms.hhs.gov/Eprescribing/. CMS also released a press release titled "E-Prescribing Tools to Help Prevent Adverse Drug Interactions: New Medicare Standards Will Help Doctors Offer Lower-Cost Generic Options When Writing a Prescription", which provides additional information. The press release is available at: http://www.cms.hhs.gov/apps/media/press_releases.asp

**Of General Interest**

- None

**Relevant to Special Needs Plans Specifically**

- Within the April 18, 2008 draft MA enrollment and disenrollment guidance released for comment, CMS included new guidance for enrollment and disenrollment specifically for SNPs. In particular, such organizations must now confirm severe/chronic disabling condition status, prior to enrolling the individual. The organization can either contact the beneficiary's provider to confirm status or alternatively, the organization can utilize a CMS-approved prequalifying assessment tool prior to enrollment (and then receive verification from the provider within one month of enrollment or the individual will be disenrolled effective the end of the second month). In addition, two new model notices for loss of SNP status are now included in the guidance. http://www.cms.hhs.gov/MedicareMangCareEligEnrol/

**OTHER ITEMS OF RELEVANCE**

**Briefings and Hearings:**

- On April 1, 2008, the Committee on Ways and Means Subcommittee on Health held a hearing on the 2008 Medicare Trustees Report. Richard Foster the Chief Actuary for CMS was the only witness. In his testimony, he discussed the newly released 2008 annual report of the Medicare Board of Trustees. In regards to MA, Foster stated that paying MA plans the same rates as traditional Medicare would delay insolvency in the program's hospital trust fund by 18 months past the projected insolvency date of early 2019. Foster also stated that the 10-year cost projection for the PDP benefit is 37 percent lower than the 2003 projection and 17% lower than last year's estimate. Foster stated that much of this is due to greater-than-expected competition among drug plans. More information on this hearing including his testimony is at: http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=621.

**Other**

- On April 11, 2008, the National Health Policy Forum held a meeting on "Employer Use of Private Fee-for-Service Plans as a Retiree Health Benefit". Speakers included

Abby Block (CMS), Mark Miller (MedPAC), Lawrence Becker (Xerox) and Steven Kreisberg (American Federal of State, County, and Municipal Employees). In addition to the summary below, more information including presentation slides are available at: http://www.nhpf.org/index.cfm?fuseaction=Details&key=688

- CMS indicated that in early 2008, there were over 500,000 beneficiaries enrolled in 170 employer group plans compared to 36,000 beneficiaries in 127 plans in 2006. Of enrollees in PFFS, 26 percent are in employer group plans.
- MedPAC reviewed the growth of MA plans nationwide, noting that in 2008 the average beneficiary had 35 plans available to them. MedPAC reviewed its analysis of MA payments vis a vis traditional Medicare noting that payments were 113 percent of PFFS with bids 101 percent of that. In addition, employer group plans bid higher, on average, relative to individual MA plans. For HMOs, the bid is 108 percent for groups versus 97 percent and for PFFS the bid is 112 percent versus 108 percent. MedPAC is uncertain of the reason, but speculates that the difference in part is because higher MA bids in group plans let MA companies market more attractive plans to the employer market for their Medicare eligible retirees.
- Xerox offers MA plans to both their "grandfathered" retirees and to their "capped retirees" for whom the Xerox subsidy is fixed. They offer several MA HMOs and two MA national PFFS among others. Among capped retirees, half now elect an MA plan at 65. One advantage for MA that Xerox sees is the opportunity to develop a more integrated product. While Xerox offers multiple options, the American Federation of State, County and Municipal Employees (AFSCME) says that some of its members are moving to total replacement products built around PFFS as a way of gaining more predictability and lower costs in response to the GASB rules. Those that do so, AFSCME believe, generate savings by shifting costs from the private to public sector. (AFSCME, as an organization however, does not support PFFS as an MA option).

- This month, MedPAC held a public meeting on April 9 and 10th at the Ronald Reagan Building in Washington DC. One session titled "Employer group plans in Medicare Advantage" discussed the prevalence of employer-group plans, the history of their development and the recent growth in enrollment. They also discussed how these plans are different from plans offered to individual Medicare beneficiaries. Scott Harrison of MedPAC led the discussion. He stated that the employer group market can be an attractive market for insurers and health plans as well as employer groups. Currently about 17 percent of all enrollees in MA plans are employer group enrollees and private fee-for-service plans are especially attractive for employer groups (over 80 percent of the growth in employer groups over the past two years). The agenda as well as the transcript and other information on this session and meeting are available on MedPAC's website at: www.medpac.gov. The next public meeting will be held in September 2008.
- This month, the Kaiser Family Foundation released two new Medicare Part D data spotlights:

- "Low-Income Subsidy Plan Availability." This spotlight examines the drug plans that are available for low-income subsidy (LIS) beneficiaries in 2008 as compared to 2006. The spotlight also provides 2008 enrollment information estimates including that there are 12.5 million beneficiaries eligible for low-income subsidy with about 9.4 million enrolled in Part D plans, including 6.2 million full-benefit duals, 1.7 million deemed eligible through MSP or SSI and 1.5 million who actively applied for and are receiving the subsidy. The spotlight then discusses the availability of benchmark plans for LIS beneficiaries and annual variations (from 2006-2008) by plan, organization and region. It ends with policy issues related to benchmark plans including the recommendation that random assignment to enroll LIS beneficiaries in benchmark plans could be replaced by a beneficiary-centered approach that would assign beneficiaries in a similar way as other beneficiaries select plans using the Drug Plan Finder. In addition, the authors recommend that CMS revise the calculation of the regional benchmark to exclude premiums from MA plans, since few LIS beneficiaries enroll in these plans and they do not receive auto-enrollments. The authors suggest this would help provide a means in addressing the instability in benchmark plan availability. This spotlight is available online at: http://www.kff.org/medicare/7763.cfm

- "Ten Most Common Brand-Name Drugs." This spotlight examines coverage and utilization management of the top ten brand-name drugs among the 47 national PDP formularies. The ten most common brand-name drugs include cholesterol-lowing and other cardiovascular medications, two drugs for treating osteoporosis, three proton pump inhibitors (PPIs) used to treat gastrointestinal reflux and ulcers, and a medication used to treat dementia. The findings included that four of the top ten brands are listed on all 47 formularies (Actonel, Aricept, Plavix and Zetia); two are listed on all but one plan (Fosamax and Diovan); one is listed on all but four plans (Lipitar) and the three drugs to treat PPI are least likely to be included in national plan formularies (Prevacid, Nexium and Protonix). The authors found that quantity limits are the most common utilization management restriction for these drugs and step therapy is the second most common form of utilization management. The authors found that cost sharing varied across plans. The authors also noted that since their initial review of the PDP formulary coverage of the top brand-name drugs, four of the ten drugs have gone off patient. The authors state that with availability of generic versions most plans have either stopped covering the brand versions or put additional restrictions on them. The authors also state that additional top brand-name drugs are expected to go off patent in the next few years, which will create widespread opportunity for savings for both beneficiaries and the Part D program. This spotlight is also available at: http://www.kff.org/medicare/7749.cfm

- The Kaiser Family Foundation also released a report this month synthesizing key findings from all eight 2008 Medicare Part D Data Spotlights (including the two released this month). The synthesis include key information on plan availability; premiums; the coverage gap; benefit design and cost sharing; specialty tiers; and

formularies and utilization management. Findings from the synthesis include that there has been relatively minimal change in PDP formularies since 2006, however, the authors note that utilization management and cost sharing restrictions have increased, which could have important implications for beneficiaries' access to needed medications and out-of-pocket expenses. In addition, there are wide variations across Part D plans (including premium increases, benefit design and coverage changes). The authors state that it is therefore important for consumers to continue to compare plans each year to make informed decisions based on the medications they take. The authors also state it is also important to continue to monitor drug plans through research activities to ensure beneficiaries have access to needed and affordable medications in Part D. This synthesis is available at: http://www.kff.org/medicare/7762.cfm

- The Commonwealth Fund released an issue brief this month titled "Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice." In this issue brief, the authors discuss the difficulty consumers have with understanding the multitude of private plan choices available to them. The authors recommend greater standardization to help assure that consumers know what they are buying when they enroll. Specifically, the authors recommend three possible remedies: 1) requiring more standardized information and better tools to support beneficiaries' decision-making; 2) implementing a few standardized benefit and cost-sharing regimes to limit the numbers of dimensions along which plans may vary; and 3) requiring that plans put a cap on out-of-pocket costs. The authors state this would allow consumers to make more meaningful price comparisons across competing insurers, which is now virtually impossible. This issue brief is available online at: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=677729