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

Prepared by Stephanie Peterson and Marsha Gold, Mathematica Policy Research Inc.
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: June 2007	Change From Previous Month**	Same Month Last Year	
			June 2006***	Change From June 2006- 2007
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	16,918,170	+19,975	16,435,850	+482,320
General*	16,794,886	+19,877	Not Available	Not Available
Employer/Union Only Direct	123,284	+98	Not Available	Not Available
Duals Auto Enrolled in PDPs****	Not Available	(Total Enrollees) 6,270,154	6,066,938	Not Available
All others Enrolled in PDP		10,360,026	10,368,912	
Total Medicare Advantage (MA)	8,678,224	+55,248	6,831,626	+1,846,598
Medicare Advantage-Prescription Drug (MA-PD)	7,234,420	+26,549	5,919,562	+1,314,858
Medicare Advantage (MA) only	1,443,804	+28,699	910,475	+533,329
Medicare Advantage (MA) by Type				
MA Local Coordinated Care Plans** ** *	6,191,304	+14,988	5,679,600	+511,704
Health Maintenance Organizations (HMOs)	5,719,295	+11,426	5,335,225	+384,070
Provider Sponsored Organizations (PSOs)	77,382	+3,372	76,946	+436
Preferred Provider Organizations (PPOs)	394,601	+3,470	267,429	+127,172
Regional Preferred Provider Organizations (PPO)	156,645	+9,010	54,378	+102,267
Medical Savings Account (MSA)	2,249	-12	Not Applicable	Not Applicable
Private Fee For Service (PFFS)	1,591,967	+33,596	579,041	
General	1,581,393	+33,566	Not Available	Not Available
Employer Direct PFFS	10,574	+30	Not Available	Not Available
Cost	307,278	-101	313,312	
Pilot******	122,300	-1,620	Not Applicable	Not Applicable
Other*******	306,481	-613	Not Available	Not Available
General vs Special Needs Plans****** **	Not Available	(Total Enrollees) 842,840	Not Available	Not Available
Special Needs Plan Enrollees				
Other Medicare Advantage Plan Enrollees		7,665,704		
Penetration (as percent beneficiaries)**********				
Prescription Drug Plans (PDPs)	38.4%	No Change	37.3%	+1.1%
Medicare Advantage Plans (MA)	19.7%	+0.1%	15.5%	+4.1%
Medicare Advantage-Prescription Drug Plans (MA-PDs)	16.4%	No Change	13.4%	+3.0%
Local Health Maintenance Organizations (HMOs),	13.0%	No Change	12.2%	+0.8%
Preferred Provider Organizations (PPOs)	0.9%	No Change	0.6%	+0.3%
Provider Sponsored Organizations (PSO)	0.2%	No Change	0.2%	No Change
Private Fee For Service (PFFS)	3.6%	+0.1%	1.3%	+2.2%

June 2007 data is from the 6.5.07 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 May 2007 data is from data released by CMS on 5.10.07 also on its website
***CMS did not release data for the month of June 2006 (or May 2006) except for the PDP numbers. All other 2006 data reported for June were released in April 2006.
****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 5.10.07 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 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 June:

Plan Participation, by type	CURRENT MONTH: JUNE 2007*	SAME MONTH LAST YEAR	
		JUNE 2006**	CHANGE FROM JUNE 2006– 2007
MA Contracts (excluding SNP only contracts)			
Total	602	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 June 2007 are from the 6.5.07 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)

NEW ON THE WEB FROM CMS

Relevant to Both Medicare Advantage and Prescription Drug Plans

- On Friday, June 15, 2007, CMS released a press release titled: "Plans Suspend PFFS Marketing; Plans Adopt Strict Guidelines in Response to Deceptive Marketing Practices." The release said that seven plans had voluntarily agreed to stop marketing. They include most but not all of the major PFFS contractors and include: United Healthcare; Humana; Wellcare; Universal American Financial Corporation (Pyramid); Coventry; Sterling; and BCBS of Tennessee. The press release detailed primary provisions that all PFFS plans must meet beginning October 1, 2007. These provisions are from the 2008 Call Letter and the May 25, 2007 guidance issued by CMS. The provisions include: 1) all materials used at sales presentations and by representatives of the health insurance company will be required to include the model disclaimer language provided by CMS in its May 25, 2007 guidance; 2) All representatives selling their product to beneficiaries on behalf of the plan sponsor must pass a written test to demonstrate their familiarity with the Medicare program and the product they are selling; 3) Outreach and education programs must be in place for both providers and beneficiaries; 4) lists of planned marketing and sales events provided to CMS must include events sponsored by delegated brokers and agents in addition to those sponsored by the plan; 5) When asked by CMS, plan sponsors will provide a complete list of all representatives marketing a PFFS product and authorize CMS to make that list available to the State Insurance Departments on request. The press release also stated that the seven health care sponsors that already signed an agreement to voluntary suspend marketing of the PFFS plans will be reviewed by CMS shortly. Once CMS determines the provisions listed above have been met by each plan, their suspension will be lifted. This press release is available at: http://www.cms.hhs.gov/apps/media/press_releases.asp

Relevant to Medicare Advantage

- None

Relevant to Prescription Drug Plans

Of General Interest

- This month, the Department of Health and Human Services, Office of Inspector General released a report titled "Retail Pharmacy Participation in Medicare Part D Prescription Drug Plans in 2006" (OEI-05-06-00320. June 2007). The objectives of the report were to 1) determine the extent to which retail pharmacies participate in Medicare Part D stand-alone prescription drug plans and 2) determine how many Medicare Part D stand-alone PDPs are offered by these participating retail pharmacies. OIG found that nearly all pharmacies participate in Medicare Part D (ninety-seven percent) and that seventy percent of participating retail pharmacies offer beneficiaries the choice of all available PDPs in their region. The OIG conclude

that beneficiaries' access to retail pharmacies that dispense Part-D covered drugs does not appear to be limited by retail pharmacies' participation in PDPs. This report is available on the OIG website at: http://oig.hhs.gov/oei/reports/oei-05-06-00320.pdf

Relevant to Special Needs Plans Specifically

- None

OTHER ITEMS OF RELEVANCE

Briefings and Hearings:

- The Senate Budget Committee held a hearing on June 21, 2007 titled, "Health Care and the Budget: Issues and Challenges for Reform." Peter Orszag, Director, Congressional Budget Office, was a witness at the hearing. In his testimony, Orszag stated that there could be a fundamental change in the nature of the Medicare system that may be hard to reverse if over the next couple of years the rate of growth that we have recently experienced in Medicare Advantage continued. He provided recommendations to alleviate the spending growth. These include expanding research efforts as well as providing financial incentives to physicians and patients. Orszag's full testimony as well as other information on this hearing including the webcast of the hearing is available at http://budget.senate.gov.

- The House Committee on Ways and Means Subcommittee on Health also held a hearing on June 21, 2007 on beneficiary protections in Medicare Part D. Witnesses included Leslie Norwalk, Acting Administrator, Centers for Medicare and Medicaid Services; and Kathleen King, Director, Medicare Payment, Government Accountability Office. Panel members included: 1) Steve O'Brien, Medical Director, Alta Bates Summit East Bay AIDS Center, Oakland, California; 2) William Fleming, Vice President, Pharmacy and Clinical Integration, Humana, Louisville, Kentucky; 3) Paul Precht, Policy Director, Medicare Rights Center; 4) Tom Maher, Regional Director, Medicare Today, Concord, New Hampshire; and 5) Vicki Gottlich, Senior Policy Attorney, Center for Medicare Advocacy. More information on this hearing, including the testimony of each participant is available at: http://waysandmeans.house.gov/hearings.asp. In addition, some of the witness testimony included:

    - Leslie Norwalk, Acting Administrator, CMS: In her testimony, Norwalk began by discussing 1) how Part D has resulted in lower costs in 2007 than in 2006 (for example, the estimated average premiums in 2007 is now $22 a month, down from an average of $23 a month in 2006) and 2) that consumer satisfaction, as measured by a survey conducted for the Medicare Rx Education Network in January 2007 reported high satisfaction by beneficiaries (for example, 86 percent of the beneficiaries surveyed stated that the plan has good customer service). She also discussed lessons learned in 2007 such as the importance of working with states and SSA to help identify dual eligibles for a smoother transition. In speaking

specifically about beneficiary protections and CMS oversight of Part D Plans, she discussed the formulary requirements that MMA requires for Part D as well as the coverage determinations and the appeals process. She also discussed how CMS has strengthened its oversight of Part D plans in the last year. For example, CMS has established baseline measures for the performance data submitted by Part D plans from the data they have been collecting and analyzing. CMS has also conducted various compliance audits and is working to strengthen relationships with State regulators to oversee the market conduct of health insurers to help eliminate any of the various marketing schemes that have mislead or defrauded beneficiaries.

- Kathleen King, Director, GAO: In her testimony King discussed CMS's process for enrolling new dual eligibles into PDPs and provided recommendations for strengthening this process. Her testimony is based on the recently released GAO report, which can be accessed at http://www.gao.gov/new.items/d07272.pdf and was summarized in the May 2007 Tracking Medicare Health and Prescription Drug Plans Monthly report as well.

- On June 26, 2007, the House Committee on Energy and Commerce Subcommittee on Oversight and Investigations held a hearing titled "Predatory Sales Practices in Medicare Advantage." Witnesses included: Panel 1): David Lipschutz, California Health Advocates; Kathleen Healey, State Health Insurance Assistance Program, Alabama Department of Senior Services and Brenda Clegg-Boodram, Judiciary House. Panel 2): Francis Soistman, Coventry Health Care; Gary Bailey, WellCare Health Plans; and Peggy Olson, Healthwise Insurance Planning. Panel 3): Abby Block, CMS; Kim Holland, Oklahoma Insurance Department; Jim Poolman, North Dakota Insurance Department; and Lee Harrell, Mississippi Insurance Department. Full testimony as well as the hearing webcast is available at: http://energycommerce.house.gov/cmte_mtgs/110-oi-hrg. In addition, some of the witness testimony included:

    - Panel 1): David Lipschutz, California Health Advocates: In his testimony, Lipschutz stated that there has been an alarming epidemic of abuse surrounding the sale of Medicare Advantage with the majority from Private Fee-For-Service (PFFS) plans. He discussed that while CMS has taken some measures in response to reports of marketing misconduct, they have not gone far enough. He states that California Health Advocates urge Congress and CMS to address several underlying, structural issues at the root of the marketing misconduct including payments to MA plans and agent commission structures. He also provides several specific and broad recommendations, including standardizing MA benefits.

    - Panel 2): Francis Soistman, Coventry Health Care: In his testimony, Soistman discussed ways Coventry has responded to sales and marketing issues to help prevent inappropriate broker-agent marketing practices such as communicating regularly with brokers on the belief that dual eligible beneficiaries may not be suitable for dual eligibles. He stated Coventry has tried to take a proactive approach to this by eliminating upfront

commission payments for sales of PFFS to dual eligibles and instead Coventry pays for these sales only on the back-end, which can be up to a year later. He also discussed Coventry's work with CMS and State regulators, including Oklahoma, Mississippi, North Dakota, and Georgia among others.

- Panel 3): Abby Block, CMS: Block stated that CMS is building on lessons learned and information gathered during 2006 to help strengthen its oversight to PFFS plans as well as all MA plans in 2007. She stated that one way CMS has strengthened oversight is through expanded partnership with the States. She also discussed the recent guidance specifying more requirements around PFFS marketing and CMS's recent announcement of voluntary marketing suspensions for seven PFFS plans.

- On June 28, 2007, the House Budget Committee held a hearing on Medicare Advantage plans and their implications for beneficiaries. Speakers included: Panel 1: 1) Peter Orszag, CBO and 2) Mark Miller, MedPAC; Panel 2: 1) Mark McClellan, AEI-Brookings; 2) Barbara Kennelly, National Committee to Preserve Social Security and Medicare; 3) Patricia Neuman, Kaiser Family Foundation; 4) Robert Wah, American Medical Association and 5) Catherine Schmitt, Blue Cross Blue Shield of Michigan. Speaker testimony as well as the web cast are available at: http://budget.house.gov/hearings.htm: Speaker testimony included:

  - Panel 1: Peter Orszag, CBO: In his testimony, Orszag focused on several themes including that reducing the payment differential between MA and FFS program could result in substantial savings to the Medicare program but also a decline in the supplemental benefits and cash rebates that MA plans can offer to enrollees and reduced enrollment in those plans. He also provided recommendations for reducing growth spending.

  - Panel 2: Tricia Neuman, Vice President, Kaiser Family Foundation. In her testimony, she discussed 1) the characteristics of MA enrollees; 2) benefits and out-of-pocket costs for those enrolled in MA plans; and 3) key issues for beneficiaries and for Medicare's future. She stated that critical questions relate to whether the positive attributes of the MA program are balanced by the higher costs associated with the current payment structure. She also stated that future research is needed to monitor coverage, care and costs associated with the MA program, and to gain insights that may be used to strength and improve care for the majority of beneficiaries in traditional Medicare program.

Other

- On June 22, 2007, the National Health Policy Forum held a session titled: "Medicare Advantage in 2007: What are the Choices?" More information on this session is available at: http://www.nhpf.org/announcements/FS_06-22-07_MAin2007.pdf. Speakers at the event included:

- Mark Miller, Executive Director, MedPAC: Miller discussed MedPAC's position on private plans in Medicare stating that the Commission strongly supports them but the Medicare program should be "financially neutral," meaning the program should not pay more for one choice versus another. He provided recommendations for transition options for bringing benchmarks closer to FFS, which include: 1) freeze benchmark rates; 2) differentially reduce benchmark rates; or 3) use blend of FFS and MA rates.

- Marsha Gold, Senior Fellow, Mathematica Policy Research: In her presentation, Gold discussed firm strategies to balance resource demands to expand MA and PDP as well as firm perceptions on rPPOs vs. PFFS plans. She provided data on PFFS contracts (including contracts available to beneficiaries by county type in 2007 as well as the major PFFS firms in MA in 2007), MA enrollment and distribution of MA enrollment by type as well as distribution of enrollment by payment type. Other data Gold presented included estimated out-of-pocket costs per enrollee for hospital and physician services in MA-PD plans by type for 2006. Gold also presented information on SNPs; rural vs. urban area availability to MA plans; among other data.

- Cindy Polich, Senior Vice President, Secure Horizons: Polich provided an overview of UnitedHealth Group's senior business; factors in MA product design and characteristics of UHG MA members. She also provided a response to whether MA plans are overpaid, stating yes, but approximately one-third of the MA-FFS payment gap in 2007 is due to budget neutrality adjustments to help MA plans make the transition to the risk adjustment payment methodology and that these adjustments will be phased out completely by 2011.

- This month, the Kaiser Family Foundation released two updated fact sheets:

  - The Medicare Prescription Drug Benefit, which provides updated information from November 2006 on data about the Medicare Drug Benefit including 2007 enrollment information as well as data for each state on the number of drug plans available. (http://www.kff.org/medicare/7044.cfm

  - The Medicare Advantage Fact Sheet, which provides updated information from March 2007 on data on participation and enrollment as well as benefits and premiums. It also provides updated information on payments to plans. (http://www.kff.org/medicare/2052.cfm)

- The GAO released a report this month titled: "Medicare Part D Low-Income Subsidy: Additional Efforts Would Help Social Security Improve Outreach and Measure Program Effects" (GAO-07-555). In this report, the GAO reviewed SSA's progress in reviewing applications from individuals potentially eligible for the subsidy as well as their processes for making eligibility determinations and resolving appeals. The report also reviews how this subsidy has affected the SSA workload and operations. GAO made several recommendations as a result of this study including 1) that the SSA develop specific performance goals and measures for its outreach activities and

2) that the SSA and the IRS work together to assess the extent to which taxpayer data could help to better target individuals who might qualify for the subsidy. (www.gao.gov).