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TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS
Monthly Report for June 2008

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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

Enrollment and Penetration, by Plan Type	Current Month: June 2008	Change From Previous Month*	Same Month Last Year	
			June 2007	Change From June 2007- 2008
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	17,335,048	+1,328	16,918,170	+416,878
Individual	16,457,218	+237	Not Available	Not Available
Group**	877,830	+1,091	Not Available	Not Available
Total Medicare Advantage (MA)	10,063,841	+45,679	8,678,244	+1,385,597
Individual	8,323,761	+39,495	Not Available	Not Available
Group	1,740,080	+6,184	Not Available	Not Available
Medicare Advantage-Prescription Drug (MA-PD)	8,345,171	+49,082	7,234,420	+1,110,751
Medicare Advantage (MA) only	1,718,670	-3,403	1,443,804	+274,866
Medicare Advantage (MA) by Type				
MA Local Coordinated Care Plans** *	7,068,824	+32,652	6,191,304	+877,520
Health Maintenance Organizations (HMOs)	6,402,842	+21,204	5,719,295	+683,547
Provider Sponsored Organizations (PSOs)	18,068	+188	77,382	-59,314
Preferred Provider Organizations (PPOs)	647,865	+11,260	394,601	+253,264
Regional Preferred Provider Organizations (PPO)	282,821	+ 4,329	156,645	+126,176
Medical Savings Account (MSA)	3,529	+26	2,249	+1,280
Private Fee For Service (PFFS)	2,263,271	+9,741	1,591,967	+671,304
Individual	1,662,728	+9,158	Not Available	Not Available
Group****	600,543	+583	Not Available	Not Available
Cost	271,788	+304	307,278	-35,490
Pilot*****	80,934	-1,310	122,300	-41,366
Other******	92,674	-63	306,481	-213,807
General vs Special Needs Plans***** **				
Special Needs Plan Enrollees	1,188,676	+22,005	930,013	258,663
Dual-Eligibles	854,877	+10,867	684,143	170,734
Institutional	133,581	-401	142,957	-9,376
Chronic or Disabling	200,218	+11,539	102,913	+97,305
Other Medicare Advantage Plan Enrollees	8,875,165	+23,674	7,748,231	+1,126,934
Penetration (as percent beneficiaries)********				
Prescription Drug Plans (PDPs)	39.9%	+0.5% points	38.4%	+1.5% points
Medicare Advantage Plans (MA)	22.7%	No Change	19.7%	+3.0% points
Medicare Advantage-Prescription Drug Plans (MA-PDs)	18.8%	No Change	16.4%	+2.4% points
Local Health Maintenance Organizations (HMOs),	14.4%	No Change	13.0%	+1.4% points
Local Preferred Provider Organizations (PPOs)	1.4%	No Change	0.9%	+0.5% points
Private Fee For Service (PFFS)	5.1%	No Change	3.6%	+1.5% points

June 2008 data is from the 6.03.08 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 May 2008 data is from data released by CMS on 5.08.08 also on its website
**The breakdown by Group includes Employer/Union Only Direct Contract PDP (123,578)
***The data for the breakdown of MA Local Coordinated Care Plans is from the 5.08.08 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/)
**** The breakdown by Group includes Employer Direct PFFS (12,944)
*****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 June is from the SNP Enrollment Comprehensive Monthly Report released by CMS on 6.03.08 and includes counts of 10 or less. (See: **(http://www.cms.hhs.gov/MCRAdvPartDEnrolData/)**.
*******Penetration for June 2008 is calculated using the number of eligible beneficiaries reported in the June 2008 MA State/County Penetration file. Penetration for May 2008 and June 2007 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 2008*	SAME MONTH LAST YEAR	
		JUNE 2007	CHANGE FROM JUNE 2007– 2008
MA Contracts			
Total	728	602	+126
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) General Employee Direct	79 77 2	48 47 1	+31 +30 +1
Cost	25	27	-2
Medicare Savings Account (MSA)	9	2	+7
Special Needs Plans Dual-Eligible Institutional Chronic or Disabling Condition	443 270 66 107	313 205 65 43	+130 +65 +1 +64
Other**	81	88	-7

*Contract counts for June 2008 are from the 6.03.08 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/)**
**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

- The summary table at the start of this report has been modified this month to take advantage of changes in CMS's monthly reporting. Specifically, the table has been revised to show better the breakdown between individual and group enrollment. We now show these separately for individual and group enrollment for PDPs and for MA plans overall, as well as within PFFS because of their recent growth. The new data also provide an updated and more current count of Medicare eligibles for the calculation of penetration rates.

- Changes made by CMS in monthly reporting include the following:

- An expanded Monthly Summary report that now includes a breakdown of employer plan (800 Series Plans) and Special Needs Plans (SNPs) enrollees by contract. http://www.cms.hhs.gov/MCRAdvPartDEnrolData/MCESR/list.asp#TopOfPage

- A Monthly MA and PDP State/County penetration file. http://www.cms.hhs.gov/MCRAdvPartDEnrolData/MASCPen/list.asp#TopOfPage

- A Monthly Enrollment by Plan report, which before May was released only annually in July: http://www.cms.hhs.gov/MCRAdvPartDEnrolData/EP/list.asp#TopOfPage;

- A Monthly Enrollment by Contract/Plan/State/County, which provides contract and plan level enrollment information at the county level. This information is also at: http://www.cms.hhs.gov/MCRAdvPartDEnrolData/MECPSC/list.asp#TopOfPage

Relevant to Medicare Advantage

- None

Relevant to Prescription Drug Plans

- The new Medicare Part D Data final regulation, which was published on May 28, 2008, went into effect on June 27, 2008. The data is expected to be available for release to researchers by December 2008. More information on this regulation is at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/08_PartDData.asp#TopOfPage

- On June 11, 2008, CMS held a Special Open Door Forum on the Medicare Part D Claims data final regulation. At the forum, CMS gave an overview of the rule as well as discussed the data release process. CMS noted that these data are now able to be used for oversight, research, demonstrations, evaluations and plan performance measures whereas before claims data could not be used for any other purpose than payment. CMS stated they plan to start reporting publicly information including: 1) the top 100 drugs that beneficiaries take; 2) how many beneficiaries reach the coverage gap and 3) how many reach catastrophic coverage among other information.

In addition, CMS provided detail on the data file: there are thirty-seven elements that are in the data file including age and sex of their beneficiary; date of service; date of payment and the coverage for the event (e.g. whether it is a covered drug, etc). The agenda, transcript and audiofile for this Special Open Door Forum are available at: http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp

Of General Interest

- CMS released a press release this month highlighting an expansion in funding to enhance beneficiary counseling (titled "Medicare Announces Additional Funding for Health Insurance Counseling Programs for 2008: $15 Million to Continue Helping Beneficiaries Learn about Medicare.") CMS stated that the $15 million is the second of three installments of State Health Insurance Assistance Programs (SHIP) funding in 2008 (with a total 52.5 million distributed in 2008). CMS's release emphasized the point that this year's funding should further the SHIPs' efforts to reach Medicare beneficiaries with limited income that are likely eligible for the Medicare PDP low income subsidy and assist them in applying for that help. This release is available at: http://www.cms.hhs.gov/apps/media/press_releases.asp

Relevant to Special Needs Plans Specifically

- As discussed above, CMS has now modified its monthly summary report to add data showing enrollment in Special Needs Plans (SNPs). The data includes aggregate numbers for SNP enrollees vs. non-SNP enrollees by contract type. CMS staff indicated that they still are resolving minor inconsistencies in total counts between SNP enrollees shown in the Monthly Summary Report and that included in the SNP comprehensive report (which also includes additional detail on SNPs). http://www.cms.hhs.gov/MCRAdvPartDEnrolData/MCESR/list.asp#TopOfPage.

OTHER ITEMS OF RELEVANCE

Briefings and Hearings:

- None

Other

- June 8-10, 2008, AcademyHealth held its Annual Research Meeting in Washington DC. Two sessions were particularly relevant to the future of Medicare and Medicare Advantage:
    - *Improving Medicare for the Long Haul: How Can we Improve Medicare's Performance for its Current and Future Beneficiaries? Marilyn Moon as chair.* Melinda Beeuwkes Buntin (RAND) described the spending challenges for the program with costs rising as baby boomers age and health care costs increase.

Michael Chernow (Harvard University) argued that Medicare's policy goals are to control expenditures, improve quality and expand choice, but the most pressing concern was with cost, including control not just of the level of costs but of its growth; he argued payment reform was key. Jack Hoadley (Georgetown) proposed five areas for "fixes" to Part D: (1) closing the coverage gap: (2) improving access for low income beneficiaries; (3) more price transparency; (4) making the benefit less confusing and easier for beneficiaries to understand; and (5) addressing access barriers related to exceptions and similar policies that make the benefit hard to negotiate. A more dramatic change would be to allow a government run option that would be available and the default for those not choosing. Patrica Neuman (Kaiser Family Foundation) highlighted ongoing issues for Medicare including the benefit gap and high cost sharing, the challenges for low income beneficiaries, disparities in coverage and care that persist, and the increasing complexity and lesser "user friendliness" of the program. In moderating a wide ranging discussion, Marilyn Moon highlighted 4 actions she would put high on her list for Presidential candidate advisors: (1) greater transparency on benefits and out of pocket costs; (2) creating a level payment field with MA; (3) improving the Medicare benefit by introducing stop loss on out of pocket costs as exists in large employer plans; and (4) having a public "default option" for Part D with a model evidence-based formulary. Melinda Buntin suggested use of a federal reserve or commission system to buffer Medicare from provider politics, and more experimentation. Mike Chernow stressed more need to for benefits that reflected clinical effectiveness. Jack Hodley argued for countering the current segmentation of Medicare into Parts A, B, C, and D, including understanding if the outcomes of pharmacy benefits differ in MA-PDs versus PDPs. Patricia Neuman urged a need to "get started", since issues would become more difficult with delay, noting that MA payments have been on the table and that policy decisions were required that were unlikely to be addressed by substituting a commission. Low-income protections also were important she noted.

- *Choice, Consumerism, and the Role of Private Plans in Medicare, Trish Neuman as chair.* This session included four presentations of research and policy proposals. Brian Biles (GWU) reviewed the MA payment issue as he saw it. He argued that overpayments led to a large number of plans that were confusing to beneficiaries and expensive for the program. His analysis indicates that Medicare is paying 12.4 percent more per enrollee, $986 per enrollee per year and 8.5 billion more overall than Medicare would if beneficiaries remained in the traditional program. Only 17 percent of the extra payments he said are in rural floor counties. He cited CBO's analysis showing that eliminating the extra payments would reduce the MA enrollment of 8.2 million to 5.5 million, with reduction against future growth even higher. Juliette Cubanski (Kaiser Family Foundation) presented analysis from the 2006 Medicare Current Beneficiary Survey involving the 8,000 community based sample members with Part D. She highlighted the high percentage (44 percent) saying they know little or nothing about Part D. Those with the benefit have higher knowledge and vulnerable subgroups tend to have less knowledge. Her analysis also provided insight into

the substantive areas where knowledge was strongest and weaker. Brian Elbel (NYU) described a hypothetical choice experiment conducted selectively with aged beneficiaries in selected high MA penetration communities. The analysis illustrated how increasing choice did not necessarily lead to "better" decisions and that the reasons for this and kinds of errors varied with the number of plans described as part of the experiment. Michelle Kitchman Strollo (Kaiser Family Foundation) described preliminary results of a review of TV, print, and radio adds nationwide and in three communities during the 2008 open enrollment season (Fall 2007). The top messages included low cost, predictable costs, less confusion/simplified choice, extra benefits, and brand recognition. MA ads, she noted, tended to emphasize somewhat different messages than those for PDP though both emphasized simplicity and less confusion. Tom Rice (UCLA) presented a policy proposal for reducing the number of choices made available to beneficiaries in what he characterized as "Libertarian Paternalism". He reviewed case studies involving similar approaches to manage choice in state government pensions, Arizona Medicaid, and California Medi-Cal selective contracting in terms of the insights they generated for his proposal.

- This month, the Kaiser Family Foundation released an issue brief by Marsha Gold of MPR titled "Medicare Advantage in 2008." The issue brief reviews trends in the Medicare Advantage program in the past several years. Key findings included information on: 1) Enrollment: There has been a rapid increase in MA enrollment in recent years with 8.2 million beneficiaries enrolled in MA at the end of 2007, up from 5.4 million in March 2005; 2) Firm Participation and Market Share: A small number of firms (UnitedHealthcare, Humana, and Kaiser, plus firms affiliated with BCBS) account for more than half of MA enrollment at the end of 2007; 3) Beneficiary Choice: The major source of variation across the country, and particularly between urban and rural areas, rests in the available choice of local CCPs; and 4) Role of MA plans for Employers: There is an increasing employer interest in PFFS plans. Unlike other MA plans, PFFS plans have no network restrictions and are able to serve retirees living throughout the country, which may be appealing to employers with broadly dispersed retirees. The issue brief concludes with a short summary of these trends, highlighting implications for beneficiaries and describing critical issues for policymakers. The issue brief is available at: http://www.kff.org/medicare/7775.cfm

- The GAO has released a report this month titled: "Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2005." The GAO analyzed MA organizations' projections and actual medical expenses for 2005. The GAO found that, on average, MA organizations' self-reported actual medical expenditures as a percentage of revenue were lower in 2005 than they had projected. MA organizations on average reported spending 85.7 percent of total revenue on medical expenses in 2005 but projected spending 90.2 percent of total revenue on medical expenditures (thus earning higher average profits). The GAO found that there were several outlier contracts with large differences between actual and projected profits and that inaccuracies of projections likely affected the bidding process that began in 2006. In commenting on the report, CMS stated that the GAO report should more clearly recognize changes to the program that have occurred since 2005 and should mention that differences between projected and actual expenses and

profits did not affect Medicare payments to MA organizations or the benefits they would have provided. This report is available at: www.gao.gov.

- On June 5, 2008, the Office of Inspector General released a report titled "Availability of Medicare Part D Drugs to Dual-Eligible Nursing Home Residents." (OEI-02-06-00190). From their analysis, the OIG found that most nursing home administrators report that dual-eligible residents in their nursing homes are receiving all necessary Part D drugs, however, OIG also found that nursing homes and long-term care pharmacies sometimes pay for Part D drugs that are not covered by plans. In addition, administrators as well as medical directors and pharmacy directors interviewed by the OIG expressed concerns that 1) formularies, the prior authorization process, and copayments may pose problems for dual-eligible nursing home residents and 2) long-term care pharmacies generally do not disclose to physicians the rebates that they receive from drug manufacturers. The OIG made several recommendations to CMS: 1) Work with plans to ensure that formularies meet the needs of dual-eligible nursing home residents; 2) Continue to work with plans to improve the prior authorization process; 3) Ensure that copayments for dual-eligible nursing home residents are fully subsidized, as appropriate; and 4) Consider methods to encourage long-term care pharmacies to disclose to physicians information about rebates that they receive from drug manufacturers (http://oig.hhs.gov/w-new.html).