August 2, 2006

TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS
Monthly Report for July 2006

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: July 2006	Change From Previous Month*	Same Month Last Year	
			July 2005	Change From July 2005- 2006
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):**	16,213,157	-222,693	Not Applicable	Not Applicable
Duals Auto Enrolled in PDPs	Not available	Not Available***	Not Applicable	Not Applicable
All others Enrolled in PDP	Not available	Not Available		
Total Medicare Advantage (MA)**	7,274,299	Not Available****	5,793,667	Not Available
Medicare Advantage-Prescription Drug (MA-PD)	6,278,020	+238,377	Not Applicable	
Medicare Advantage (MA) only	996,279	Not Available	5,793,667	Not Available
Medicare Advantage (MA) by Type****				
MA Local Coordinated Care Plans	5,813,218	Not Available	4,943,668	+869,550
Health Maintenance Organizations (HMOs)	5,416,562	Not Available	Not Available	Not Available
Provider Sponsored Organizations (PSOs)	87,789	Not Available	Not Available	Not Available
Preferred Provider Organizations (PPOs)	308,858	Not Available	Not Available	Not Available
Regional Preferred Provider Organizations (PPO)	83,294	Not Available	Not Applicable	Not Applicable
Private Fee For Service (PFFS)	763,559	Not Available	119,723	+643,836
Cost	313,510	Not Available	322,341	-8,831
Other****	307,718	Not Available	284,517	-70,678
General vs Special Needs Plans	Not Available	Not Available	Not Available	Not Available
Special Needs Plan Enrollees				
Other Medicare Advantage Plan Enrollees				
Penetration (as percent beneficiaries)******				
Prescription Drug Plans (PDPs)	37.3%	0%	Not Applicable	Not Applicable
Medicare Advantage Plans (MA)	16.3%	Not Available	13.4%	+2.9%
Medicare Advantage-Prescription Drug Plans (MA-PDs)	14.2%	+0.5%	Not Applicable	Not Applicable
Local Health Maintenance Organizations (HMOs),	12.3%	Not Available	Not Available	Not Available
Preferred Provider Organizations (PPOs) or	0.7%	Not Available		
Provider Sponsored Organizations (PSO)	0.2%	Not Available		
Private Fee For Service (PFFS)	1.3%	0%	0.3%	+1.0%

July data is from the 7.26.06 data release by CMS on its website at:
(**http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp**)

* The June 2006 PDP and MA-PD data is based on data from CMS with a cited date of June 11, 2006. (CMS 6/14/06 press release).

**The total PDP and MA enrollment includes employer groups because CMS has historically included employer group enrollees in the Monthly Managed Care Contract Report pre-2006. (The total PDP without employer groups is 15,515,433 and the total MA without employer groups is 6,293,676).
***CMS reported in April 2006 that of the 16,435,850 enrolled in stand-alone prescription drug plans (PDPs), 6,066,938 were duals auto enrolled (CMS 4/20/06 press release).
**** MA only and MA by type data were not reported by CMS in June 2006. Tabular information from CMS with a cited date of April 2006 reported 910,475 MA only enrollees. The information also included MA enrollment by type: Total MA Local CCPs: 5,679,600; HMOs: 5,335,225; PSOs: 76,946; PPOs: 267,429; rPPOs: 54,378; PFFS: 579,041; Cost: 313,312; Other 205,295.
*****Other includes Demo contracts, HCPP, and PACE contracts.
******Penetration rates for July and June 2006 are calculated using the number of eligible beneficiaries reported in the December 2005 State/County File. Penetration rates for June 2005 are calculated using the number of eligible beneficiaries reported in the December 2004 State/County File.

DEFINITIONS: Coordinated Care Plans, or CCPs, include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs) and preferred provider organizations (PPOs). The 2005 data include the PPO demonstration. 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 Plans refers to Medicare Advantage coordinated care plans focused on individuals with special needs. "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 (excluding SNPs) in July:

Plan Participation, by type	CURRENT MONTH: JULY 2006*	SAME MONTH LAST YEAR	
		JULY 2005	CHANGE FROM JULY 2005– 2006
MA Contracts (excluding SNPs)**			
Total	512	292	+220
Local Coordinated Care Plan	367	149	+218
Health Maintenance Organizations (HMOs)	Not Available	Not Available	Not Available
Preferred Provider Organizations (PPOs) (Includes Physician Sponsored Organizations (PSOs))	Not Available	Not Available	Not Available
Regional Preferred Provider Organizations (rPPOs)	11	Not Applicable	Not Applicable
Private Fee For Service (PFFS)	25	5	+20
Cost	28	29	-1
Other**	81	74	+7

*Contract counts for July 2006 are based on the 7.26.06 data release by CMS on its website at: (**http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp**)
** Contracts that only include SNPs maybe included in the total.
*** Other includes Demo contracts, Health Care Prepayment Plans (HCPP) and Program for all-inclusive care of Elderly (PACE) contracts

Pending Applications

- None Available

Summary of new MA contracts announced in June:

- None

NEW ON THE WEB FROM CMS

Relevant to Both Medicare Advantage and Prescription Drug Plans

- On July 26, 2006, CMS posted a new report: "Medicare Advantage, Cost, PACE, Demo and Prescription Drug Organizations—Annual Report by Plan, July 2006." The 506-page Excel spreadsheet is organized by contract number within plan type (Local Medicare Advantage, Cost, PACE and Demo Plans; Regional MA plans; and PDPs). The spread sheet shows for each contract/plan combination the: organization and plan type, whether the plan includes Part D, the organization name (including also marketing name and plan name and parent organization), the contract effective data, and the enrollment as of July 1, 2006. Enrollment is not reported when the count is less than 10 (in total, this excludes only about 1,200 people according to CMS.) While this is the most detailed data CMS has reported to date, it only supports national estimates because it excludes information on the counties served and enrollment in each county (This information historically has been provided monthly at the contract level for MA). The data is available to download on CMS's website at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp

- This month CMS released its 2007 marketing guidelines for Medicare Advantage (MA) plans; Medicare Advantage Prescription Drug plans (MA-PDs); stand-alone prescription drug plans (PDPs) as well as 1876 cost plans. The guidelines revise the original August 15, 2005 published guidelines as first revised on November 1, 2005. The document is available on CMS's website at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/07_RxContracting_Marketing.asp#TopOfPage

  Among other items, the revisions included:

  - **Co-brand relationships**. While organizations are allowed to continue this practice, organizations must not display the name or logo of the cobranded entity on the card and firms must let beneficiaries know that other pharmacies/physicians/providers are available in the network. (Exceptions apply to allow specifications of specific providers the member has selected and SPAPs.)

  - **Marketing Materials.** Materials marketed after October 10, 2006, if they reference 2006 benefits, must note that they may or will change in the upcoming contract year. PPOs that advertise potential savings acknowledge that added cost of out of network services. PDPs must state that if an enrollee is in an MA-PD they cannot enroll in a PDP without disenrolling from the MA-PD.

  - **Low Income Subsidy**. Organizations enrolling such individuals must send a low income subsidy rider to the evidence of coverage any LIS member receives. Enrollees newly qualifying for a rider during the year should receive the rider within 30 days. Riders must show the premium and cost sharing amounts the member will pay and note that the payments exclude the Part B premium.

- **Other Beneficiary Information.** Web sites are required to provide specific information on the plan's grievance, coverage determination (including exceptions) and appeals processes including instructions for filing grievances, links to various forms, contact information etc. Additional detail on the content for inbound telephone scripts must be provided.

The guidelines also have been expanded to include information on marketing and disclosure/dissemination waivers for employer/union groups. Marketing requirements for special needs plans (SNPs) also have been revised to convey better the fact that out of pocket costs may vary because of state payments and address other issues. They also have been expanded to provide more detail on call center requirements. The February 23, 2006 notice requirements apply until November 15, 2006. During open enrollment and 60 days therefore (November 15, 2006 through March 1, 2006, the call center must be open 7 days a week from 9 AM to 8 PM; after that until the next period alternative technologies may be used on Saturdays, Sundays and Holidays. Call centers are require to respond to inquires on at least a specified set of topics. They also must answer 80 percent of incoming calls within 30 seconds and the abandonment rate must not exceed 5 percent. Call centers for physicians and other business must operate during normal business hours and never less than 8 AM to 6 PM. Voice can be used for providers if it includes specific messages (including a way for immediate access in situations where an enrollee's life or health is in serious jeopardy).

- On July 10, 2006, CMS announced a new Medicare Advantage (MA) Medical Savings Account (MSA) plan demonstration project. The demonstration will allow organizations more flexibility to offer products similar to health savings accounts (HSAs). Specific features of the demonstration include: 1) a design that includes a minimum deductible and a separate limit on an enrollee's out-of-pocket expenditures; 2) Coverage of services after the deductible is met, prior to reaching the out-of-pocket expenditure cap; 3) reduced cost sharing for in-network services; and 4) coverage for preventive services. CMS does not have the authority to allow for demonstration participants to offer Medicare Advantage prescription drug products only stand-alone products. The 2007 MSA Demonstration Applications were due July 21, 2006 and the organization's bid and benefit submission are due on August 10, 2006. CMS also stated that organizations interested in participating in 2008 are requested to submit a Notice of Intent to Apply (NOI) as soon as possible. The announcement, guidelines, application and other information is available at: http://www.cms.hhs.gov/MedicareAdvantageApps/02_Final5202007%20Applications.asp

- This month, CMS released data on Medicare complaints about both Medicare Advantage drug plans and stand-alone prescription drug plans for the month of June. The tables provide each organization's name and total complaints per 1,000 enrollees as well as information on the various types of complaints (Benefit/access; enrollment/ disenrollment; pricing and co-insurance complaints and all other complaints) for both Medicare Advantage drug plans and stand-alone drug plans.

  - CMS compiles these data in a complaint tracking process to receive and resolve individual complaints about specific plan service. The data comes from three sources: 1) complaints from the 1-800-MEDICARE number; 2) complaints from CMS' regional offices; and 3) from Medicare Integrity Contractors. The complaints are from beneficiaries as well as family members, pharmacists or others who are assisting Medicare beneficiaries.

- Average complaints per month across plans were 2.6 complaints per 1,000 Medicare beneficiaries enrolled in prescription drug plans and 1.4 for those in MA plans). The most common type of complaints related to enrollment/disenrollment. The press release as well as the tabular information is available on CMS's website at: **http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1905**.

Relevant to Medicare Advantage

- None

Relevant to Prescription Drug Plans

- On July 11, 2006, CMS released a fact sheet titled "Medicare Part D Spending Projections Down Again, Part A and Part B Increases Highlight Need for Further Reforms." The fact sheet states that Medicare Part D expenditures are now projected to be lower over the next 5 years (2006-2010) than projections made in both the President's budget in February as well as the Mid-Session Review last year. (The new projections are $34 billion lower than February's projection and $110 billion lower than last year). CMS states there are several reasons why Part D spending projections are lower than expected: 1) The drug plans participating have been able to establish more savings due to aggressive price negotiations; 2) Beneficiaries have overwhelmingly chosen drug plans with low premiums; and 3) For the first time in over a decade there has been lower actual growth in drug costs, with a single digit percentage increase expected this year partly because of more generic drugs becoming available as well as other aggressive measures to keep drug costs down. The fact sheet also states that continued higher than expected expenditures for Medicare Part A and Part B highlight the need for reform in these areas as well. The fact sheet is available at **http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1895**.

Relevant to Special Needs Plans Specifically

- This month, CMS released a fact sheet on Special Needs Plans titled, "Improving Access to Integrated Care for Beneficiaries who are Dually Eligible for Medicare and Medicaid," (**http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1912**). The fact sheet describes how CMS is implementing an action plan to facilitate better care for dual eligibles through SNPs. The action plan is based on the lessons learned from various meetings over the past several months, which discussed current barriers to successfully integrating care for the dual eligibles through SNPS. CMS held meetings with states, other stakeholder groups as well as several outside groups such as the Center for Health Care Strategies (CHCS). The action plan includes several steps:

  - CMS is in the process of releasing "How To" Guides to help states work with both SNPs and Medicare with the goal of streamlining processes and reducing confusion for SNPs and beneficiaries about rules that apply. s. The 'How To" Guides address marketing, enrollment and quality issues and are considered "living documents" that CMS can update and expand as needed. See the CMS's website at: **http://www.cms.hhs.gov/DualEligible/04_IntegratedMedicareandMedicaidModels.asp#TopOfPage.**

  - CMS has implemented new policy that allows SNPs that has a relationship with a state to target subgroups of dual eligibles (versus all dual eligibles) when doing so allows SNPs to better take into account exclusions from state managed care programs. The fact sheet

stated that more details of this policy will be posted on CMS's website soon (as of press time it was not yet released).

- CMS is working with the Center for Health Care Strategies (CHCS) to develop a guide with a model agreement that SNPs, states and CMS can use to clarify roles and responsibilities of each party and facilitate care integration.

- CMS is also currently working with the National Committee for Quality Assurance (NCQA) to develop improved quality measures specific for SNP enrollees that will better reflect specific chronic conditions such as AIDS. These measures will be at the individual SNP plan level.

- CMS also will conduct, additional outreach efforts for beneficiaries will be conducted this fall and will include collaboration with various non-English speaking groups including Asian American, Hispanic and African-American communities.