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

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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

Enrollment and Penetration, by Plan Type	Current Month: July 2008	Change From Previous Month*	Same Month Last Year	
			July 2007	Change From July 2007- 2008
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	17,359,456	+24,408	16,973,908	+385,548
Individual	16,476,608	+19,390	Not Available	Not Available
Group**	882,848	+5,018	Not Available	Not Available
Total Medicare Advantage (MA)	10,119,338	+55,497	8,790,422	+1,328,916
Individual	8,364,860	+41,099	Not Available	Not Available
Group	1,754,478	+14,398	Not Available	Not Available
Medicare Advantage-Prescription Drug (MA-PD)	8,401,402	+56,231	7,318,237	+1,083,165
Medicare Advantage (MA) only	1,717,936	-734	1,472,185	+245,751
Medicare Advantage (MA) by Type				
MA Local Coordinated Care Plans** *	7,109,358	+40,534	6,223,265	+886,093
Health Maintenance Organizations (HMOs)	6,431,529	+28,687	5,743,022	+688,507
Provider Sponsored Organizations (PSOs)	18,242	+174	78,058	-59,816
Preferred Provider Organizations (PPOs)	659,554	+11,689	402,165	+257,389
Regional Preferred Provider Organizations (PPO)	288,816	+5,995	167,481	+121,335
Medical Savings Account (MSA)	3,552	+23	2,252	+1,300
Private Fee For Service (PFFS)	2,273,374	+10,103	1,661,078	+599,288
Individual	1,668,849	+6,121	Not Available	Not Available
Group****	604,452	+3,909	Not Available	Not Available
Cost	271,974	+186	308,930	-36,956
Pilot*****	79,737	-1,197	120,779	-41,042
Other******	92,527	-147	306,637	-214,110
General vs Special Needs Plans***** **				
Special Needs Plan Enrollees	1,218,413	+29,737	958,566	+259,847
Dual-Eligibles	868,342	+13,465	697,796	+170,546
Institutional	133,790	+209	143,443	-9,653
Chronic or Disabling	217,281	+17,063	117,327	+99,954
Other Medicare Advantage Plan Enrollees	8,900,925	+25,760	7,831,856	+1,069,069
Penetration (as percent beneficiaries)********				
Prescription Drug Plans (PDPs)	39.9%	No Change	38.5%	+1.4% points
Medicare Advantage Plans (MA)	22.7%	No Change	20.7%	+2.0% points
Medicare Advantage-Prescription Drug Plans (MA-PDs)	18.8%	No Change	16.6%	+2.2% 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	3.8%	+1.3% points

July 2008 data is from the 7.07.08 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 June 2008 data is from data released by CMS on 6.03.08 also on its website
**The breakdown by Group includes Employer/Union Only Direct Contract PDP (123,970)
***The data for the breakdown of MA Local Coordinated Care Plans is from the 6.03.08 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 (13,008)
*****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 July is from the SNP Enrollment Comprehensive Monthly Report released by CMS on 7.07.08 and includes counts of 10 or less. (See: **(http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**).
********Penetration for July and June 2008 is calculated using the number of eligible beneficiaries reported in the July and June 2008 MA State/County Penetration file respectively. July 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 July:

Plan Participation, by type	CURRENT MONTH: JULY 2008*	SAME MONTH LAST YEAR	
		JULY 2007	CHANGE FROM JULY 2007– 2008
MA Contracts			
Total	731	602	+129
Local Coordinated Care Plan	510	410	+100
Health Maintenance Organizations (HMOs)	369	291	+78
Preferred Provider Organizations (PPOs) (Includes Physician Sponsored Organizations (PSOs))	141	118	+23
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**	83	88	-5

*Contract counts for July 2008 are from the 7.07.08 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

- On July 15, 2008, the Medicare Improvements for Patients and Providers Act (MIPPA) was enacted. MIPPA suspends the 10.6% reduction to Medicare physician fees with a rate freeze for 2008 and a 1.1% increase in 2009. The cost of this will be largely offset by reductions in payment to Medicare Advantage (MA) plans. MIPPA phases out payments to MA organizations for costs of indirect medical education (IME). It also introduces other requirements, especially for PFFS, that the Congressional Budget Office estimated would generate savings starting in 2010 by slowing the rate of growth in MA enrollment. Under MIPPA, Private Fee For Service (PFFS) plans, starting in 2010, will no longer be able to structure access to providers through "deeming" and instead will need to establish provider networks for both individual and employer-group products. Only PFFS plans in areas with less than two local network plans will be exempt from this new requirement. MIPPA also extends authority for SNPs by one year, through December 31, 2010, and lifts the moratorium on most new SNPs and expansions, allowing them for 2010. SNPs will face additional requirements in 2010, however, some targeting new or expanded SNPs, and others, all SNPs (also discussed in more detail below). The statute also prohibits/puts further limits on certain marketing activities by MA and PDP plans (such as not allowing brokers to cross sell non-health related products, effective to plan years beginning on or after January 1, 2009; as well as limiting gifts to prospective beneficiaries and new broker training requirements, effective on a date specified by the Secretary but no later than November 15, 2008). The law also changes the low income subsidy including: increasing the amount of assets that eligible individuals may possess to qualify for the full LIS program in Part D; disregarding certain income and assets (such as life insurance policies) when determining eligibility; eliminating Part D late enrollment penalty for LIS beneficiaries; and providing additional funding to federal and state entities to increase outreach efforts. (Other MIPPA provisions specific to Part D are described in more detail below). CMS released a fact sheet on MIPPA on July 16, 2008, which available on their website at: http://www.cms.hhs.gov/apps/media/fact_sheets.asp. CMS stated in the fact sheet it intends to announce implementation of other provisions of the legislation in the coming months. The full Act is available at: http://frwebgate.access.gpo.gov/cgibin/getdoc.cgi?dbname=110_cong_bills&docid=f:h6331enr.txt.pdf

Relevant to Medicare Advantage

- CMS has released proposed new collection of Part C Medicare Advantage information (available for public comment through August 25, 2008). CMS is requesting a three year Office of Management and Budget (OMB) approval of reporting of twelve measures from Medicare Advantage Organizations (MAOs). The twelve measures (also laid out in CMS's 2009 Call Letter) include: 1) Benefit Utilization; 2) Procedure Frequency; 3) Serious Reportable Adverse Events; 4) Provider Network Adequacy; 5) Grievances; 6) Organization

Determinations/Reconsiderations; 7) Employer Group Plan Sponsors; 8) Plan Enrollment Verification Calls; 9) Provider Payment Dispute Resolution Process; 10) Agent Commission Structure; 11) Agent Training and Testing; and 12) Plan Oversight of Agents. The MAOs will be required to start collection on these data beginning on January 1, 2009. Reporting will vary by measure with some measures reported annually and others quarterly or semi-annually. CMS stated the goal of this collection is to better inform CMS on operations, costs, availability of services and other factors as listed above pertaining to the performance of MAOs in order to monitor and measure MAOs' compliance with federal regulations and to ensure that Medicare beneficiaries have access to necessary information and are provided with high quality care that is safe, effective and timely. More detailed information on each of the twelve proposed measures as well as other summary information including how to submit comments and recommendations is available on CMS's website at: http://www.cms.hhs.gov/PaperworkReductionActof1995/PRAL/list.asp#TopOfPage

Relevant to Prescription Drug Plans

- As mentioned above, the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 includes several provisions specific to Part D. Some of these provisions include: 1) coverage of two new drugs: barbiturates and benzodiazepines, beginning in 2013; 2) Clarification of the Secretary's authority to require Part D plans to cover certain drugs in categories or classes if determined that a) restricted access to the drugs would have major or life threatening consequences and b) there is significant clinical need for individuals to have access to multiple drugs in the class due to the unique effects of the particular drugs (e.g. for use in cancer treatment); 3) prompt payment by MA-PDs and PDP plans to reimburse pharmacies (e.g. within 14 days for claims submitted electronically). These provisions are in sections 171-183: http://frwebgate.access.gpo.gov/cgiin/getdoc.cgi?dbname=110_cong_bills&docid=f:h6331enr.txt.pdf

Of General Interest

- None

Relevant to Special Needs Plans Specifically

- Also as mentioned above, MIPPA extend SNP contract authority through December 31, 2010 (from 2009). It also lifts the ban on approving new contracts or expansions in 2010 for contracts that meet specific new requirements; an exception is *new* "disproportionate" SNPs. All SNPs must meet care management requirements including having in place an evidenced-based model of care, with appropriate networks of providers and specialists, and quality reporting. For each individual enrolled, the SNP must conduct an initial assessment and annual reassessment of the individual's physical, psychosocial and functional needs among other requirements. The MIPPA provisions also add requirements specific to individual types of SNPs.

Dual eligible SNPs must provide prospective enrollments with a written statement of Medicaid benefit and cost sharing protections and which the plan covers *prior to enrolling*; cost sharing cannot exceed amounts under traditional Medicare. *New* dual SNPs (but not existing ones) must have a contract with the state Medicaid agency to provide or arrange for the provision of Medicaid benefits, though it does not have to include LTC and states are not required to enter into such contracts. For institutional SNPs, each potential enrollee in the community must meet the institutional level of care determined by using either a State assessment tool of the State in which the individual resides or by an entity (e.g. physician) other than the organization offering the plan. In 2010, chronic SNP enrollment is limited to beneficiaries who meet criteria related to condition, risk of hospitalization, and need for specialized delivery systems. HHS is required to create a panel of clinical advisors to operationalize this definition. Sections 164 and 165 of the MIPPA pertain to SNPs: http://frwebgate.access.gpo.gov/cgiin/getdoc.cgi?dbname=110_cong_bills&docid=f:h6331enr.txt.pdf In addition, readers seeking a summary of these requirements can also find one online on the Community Catalyst's website at: http://www.communitycatalyst.org/doc_store/publications/medicare_ippa_2008_7.17.08.pdf

OTHER ITEMS OF RELEVANCE

Briefings and Hearings:

- The House Committee on Oversight and Government Reform held a hearing on July 24, 2008 titled "The Medicare Drug Benefit: Are Private Insurers Getting Good Discounts for the Taxpayer?" The purpose of the hearing was to examine whether Part D insurance sponsors are able to effectively obtain prescription drug discounts from drug manufacturers. Witnesses at the hearing included Kerry Weems, Acting Administrator at CMS. In his testimony, Weems stated that the Part D program has been a success to date. He stated that competition among private plans has contributed significantly to lowering both government and beneficiary costs to what was originally estimated; that there is high beneficiary satisfaction and that there is meaningful and affordable plan choices. Weems stated that CMS actuaries currently estimate that the Part D plans are achieving a savings of 29 percent off of Average Wholesale Price (AWP) through a combination of price discounts (22 percent) and rebates from manufactures (7 percent) and that prices for Part D-covered drugs have remained stable (with the majority of plans' price index not increasing more than 3 percent). Weems also discussed the potential impact of importing Medicaid's rebate structure into Part D. He stated that CMS is concerned with such efforts to adopt this structure or any form of government price-control for Part D as it would undermine the successes already achieved and it could have far-reaching impacts in the health care market beyond the Federal sector. Weems' full testimony as well as the other witness testimony is available on the Committee website at: http://oversight.house.gov/story.asp?ID=2103. The other witnesses at the hearing included: 1) Stephen Schondelmeyer, Professor and Head, Department of

Pharmaceutical Care and Health Systems, University of Michigan; 2) Gerard Anderson, Professor and Director, Center for Hospital Finance and Management, Bloomberg School of Public Health, Johns Hopkins University; 3) Fiona Scott Morton, Professor of Economics, Yale School of Management; 4) Mark Merritt, President and Chief Executive Officer, Pharmaceutical Care Management Association; 5) Rick Smith, Senior Vice President, Pharmaceutical Research and Manufacturers Association (PhRMA); 6) Paul Precht, Director, Medicare Rights Center; and 7) Judith Stein, Executive Director, Center for Medicare Advocacy.

- In addition to the hearing, the House Committee on Oversight and Government Reform released a report titled "Medicare Part D: Drug Pricing and Manufacturer Windfalls." The report's findings, which used confidential data on Medicare Part D and Medicaid drug prices, include that Part D insurers are paying significantly higher prices for drugs than the Medicaid program and that the discrepancy has produced a windfall worth over 3.7 billion dollars for drug manufacturers. This report is also on the Committee's website at: http://oversight.house.gov/story.asp?ID=2103.

Other

- The Government Accountability Office (GAO) released a report recently titled "Medicare Part D: Complaint Rates are Declining, but Operational and Oversight Challenges Remain." In this report, the GAO reports findings from their analysis of almost 630,000 complaints filed with CMS from Medicare beneficiaries about the prescription drug benefit during an 18-month period (from May 1, 2006 through October 31, 2007). The GAO found that overall complaints decreased during this time by 74 percent with the type of complaints that decreased mostly relating to problems in processing beneficiaries' enrollment and disenrollment requests. The GAO also noted that the average time needed to resolve complaints decreased from a peak of 33 days to 9 days. However, GAO found that many of the most critical complaints, such as resolving complaints from beneficiaries at risk of depleting their medications (sometimes within two days), remained a challenge for CMS to respond to in a timely manner. This report is located on the GAO website at: http://www.gao.gov/new.items/d08719.pdf.

- On July 29, 2008, the Department of Health and Human Services Office of Inspector General (OIG) released a report titled "Review of Medicare Part D Contracting for Contract Year 2006." The report provides results of OIG's review of contracting in 2006 between 40 PDP sponsors and 100 randomly selected pharmacies. The OIG found that 78 of the 100 local, community pharmacies in their sample relied on third-party contractors known as pharmacy services administrative organizations (PSAOs) to negotiate with PDP sponsors. The OIG found that almost all of the 100 sampled pharmacies and all of their PSAOs reported concerns about contracting with PDP sponsors including networking development methods, standard terms and conditions, extended-day supply terms, negotiations, and network requirements and contracting requirement concerns. The OIG recommended that Congress and CMS take these concerns into consideration with future deliberations regarding Part D contracting. The OIG also stated that while law prohibits Government interference in price

negotiations, CMS should still focus on increasing transparency and disclosure in contracting. http://oig.hhs.gov/oas/reports/region6/60700082.htm