October 7, 2008

TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS
Monthly Report for September 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: September 2008	Change From Previous Month*	Same Month Last Year	
			September 2007	Change From September 2007- 2008
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	17,418,390	+27,554	17,137,966	+280,424
Individual	16,525,846	+23,346	Not Available	Not Available
Group**	892,544	+4,208	Not Available	Not Available
Total Medicare Advantage (MA)	10,173,305	+20,460	8,919,710	+1,253,595
Individual	8,396,696	+12,935	Not Available	Not Available
Group	1,776,609	+7,525	Not Available	Not Available
Medicare Advantage-Prescription Drug (MA-PD)	8,501,535	+43,823	7,416,865	+1,084,670
Medicare Advantage (MA) only	1,671,770	-23,363	1,502,845	+168,925
Medicare Advantage (MA) by Type				
MA Local Coordinated Care Plans** *	7,184,148	+33,371	6,267,459	+916,689
Health Maintenance Organizations (HMOs)	6,486,483	+24,707	5,767,578	+718,905
Provider Sponsored Organizations (PSOs)	18,685	+266	78,701	-60,016
Preferred Provider Organizations (PPOs)	678,937	+8,400	421,151	+257,786
Regional Preferred Provider Organizations (PPO)	297,688	+4,454	209,542	+88,146
Medical Savings Account (MSA)	3,584	+21	2,267	+1,317
Private Fee For Service (PFFS)	2,290,955	+6,316	1,709,782	+581,173
Individual	1,680,494	+5,940	Not Available	Not Available
Group****	610,461	+376	Not Available	Not Available
Cost	274,521	2,092	310,084	-35,563
Pilot*****	29,892	-25,855	114,045	-84,153
Other******	92,517	+61	306,531	-214,014
General vs Special Needs Plans***** **				
Special Needs Plan Enrollees	1,267,025	+22,600	1,021,800	+245,225
Dual-Eligibles	889,809	+9,770	722,286	+167,523
Institutional	131,468	-619	143,905	-12,437
Chronic or Disabling	245,748	+13,449	155,609	+901,139
Other Medicare Advantage Plan Enrollees	8,906,280	-2,140	7,897,910	+1,008,370
Penetration (as percent beneficiaries)********				
Prescription Drug Plans (PDPs)	39.9%	No Change	38.9%	+1.0% points
Medicare Advantage Plans (MA)	22.6%	No Change	20.2%	+2.4% points
Medicare Advantage-Prescription Drug Plans (MA-PDs)	18.8%	No Change	16.8%	+2.0% points
Local Health Maintenance Organizations (HMOs),	14.4%	No Change	13.0%	+1.4% points
Local Preferred Provider Organizations (PPOs)	1.5%	+0.1% point	1.0%	+0.4% points
Private Fee For Service (PFFS)	5.1%	No Change	3.9%	+1.2% points

September 2008 data is from the 9.2.08 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 August 2008 data is from data released by CMS on 8.11.08 also on its website
**The breakdown by Group includes Employer/Union Only Direct Contract PDP (124,858)
***The data for the breakdown of MA Local Coordinated Care Plans is from the 9.2.08 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 (13,197)
*****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 September is from the SNP Enrollment Comprehensive Monthly Report released by CMS on 9.2.08 and includes counts of 10 or less. (See: (**http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**).
*******Penetration for September and August 2008 is calculated using the number of eligible beneficiaries reported in the August 2008 MA State/County Penetration file. August 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 September:

Plan Participation, by type	CURRENT MONTH: SEPTEMBER 2008*	SAME MONTH LAST YEAR	
		SEPTEMBER 2007	CHANGE FROM SEPTEMBER 2007– 2008
MA Contracts			
Total	735	601	+134
Local Coordinated Care Plan	510	408	+102
Health Maintenance Organizations (HMOs)	369	289	+80
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	312 204 65 43	+131 +66 +1 +64
Other**	87	89	-2

*Contract counts for September 2008 are from the 9.2.08 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 September 15, 2008, CMS released information regarding an interim final rule and a final rule on the Medicare Advantage and Prescription Drug Plan programs. These rules are based on the provisions of the Medicare Improvements for Patients and Providers Act (MIPPA) enacted in July 2008 which requires CMS to create a variety of new regulations. http://www.cms.hhs.gov/HealthPlansGenInfo/

    - CMS's final rule (CMS 4138-F) regarding standards for MA and PDP marketing becomes effective at the start of the 2009 marketing season on October 1, 2008. According to CMS, the purpose of the rule is to prevent insurance agents from pressuring beneficiaries into health plans for reasons other than to meet their best health care needs. Among other things, the new rule: 1) prohibits plans from contacting potential enrollees directly without the potential enrollee first initiating contact (such as telemarketing or approaching an individual in a parking lot); 2) requires plans to appoint and use only State licensed representatives to conduct marketing activities; 3) prohibits plans from cross-selling non-health care related products during Medicare sales or marketing activities. CMS also released a fact sheet on the final rule titled "Medicare Program; Medicare Advantage and Prescription Drug Benefit Programs: Final Marketing Provisions (CMS 4131-F)." The fact sheet is available on CMS's website at: http://www.cms.hhs.gov/apps/media/fact_sheets.asp

    - CMS issued an interim final rule (CMS 4138-IFC) which contains additional provisions on marketing; as well as new provisions on co-branding; agent and broker compensation; special needs plans; and contracts with states among others. As required by MIPPA, CMS codified, that beginning in 2010, MA organizations and PDP sponsors must include the plan type in the plan's name. In addition, CMS established a compensation structure to try to eliminate agents/brokers from trying to move a beneficiary from one plan to another based on financial incentives. Specifically, the new regulation establishes a six-year compensation structure limiting first-year compensation for an agent/broker to no more than 200 percent of the total compensation for each of the next five renewal years. Comments can be submitted until November 15, 2008. CMS also released a fact sheet on this interim final rule titled "CMS Issues Interim Final Rule: Changes to the Medicare Advantage and Prescription Drug Benefit Programs (CMS 4138-IFC)." The fact sheet is at: http://www.cms.hhs.gov/apps/media/fact_sheets.asp

- On September 25, 2008, CMS released a press release titled "CMS Reminds Medicare Beneficiaries to Review and Compare their Current Drug Coverage." In the press release, CMS stated that open enrollment for prescription drug coverage begins on November 15 and ends on December 31 and CMS announced the 2009 Medicare PD and MA plan options. CMS stated that each state will have access to at least one prescription drug plan with premiums of less than $20 (except Alaska, in

which beneficiaries will have access to one prescription drug plan at $23 a month). The press release also announces that marketing of the 2009 plans will begin October 1st and this will include many of the new marketing requirements (as discussed above): http://www.cms.hhs.gov/apps/media/fact_sheets.asp

- CMS also released several fact sheets providing additional detail on the 2009 Medicare prescription drug and Medicare Advantage plan options. CMS released fact sheets for each state and Washington DC, which include a limited amount of information (1-page each) in a consistent format on the number of PDPs available in the state; the number of PDPs offering enhanced benefits or services; the percentage of people with Medicare that could switch to a PDP with a lower premium in 2009; the total number of PDPs with $0 deductibles; the total PDPs with premiums under $25; the percentage of people with MA-PDs that will have access to a $0 premium; the percentage of MA-PDs with access to a plan with a $0 drug premium among other items. The fact sheets for each state and Washington DC are available at: http://www.cms.hhs.gov/center/openenrollment.asp.

- Along with these fact sheets, CMS released a list of the national stand-alone prescription drug plans. As with 2008, there will be 16 national stand-alone prescription plan sponsors as follows: 1) Aetna; 2) Cigna; 3) Coventry Health Care; 4) CVS Caremark Corporation; 5) Envision Insurance Company; 6) Health Net; 7) HealthSpring; 8) Humana; 9) Longs Drug Stores Corporation; 10) Medco Health Solutions; 11) Munich American Holding Corporation; 12) Torchmark Corporation; 13) UnitedHealth Group; 14) Universal American Corporation; 15) WellCare Health Plans; and 16) Wellpoint. This is the first year there are no new national plan sponsors. In addition, none of the listed organizations offer national Low Income Subsidy (LIS) plan (i.e. LIS plans across each region in the nation.). The list is available on CMS's website at: http://www.cms.hhs.gov/center/openenrollment.asp

- This month, CMS released new data pertaining to the 2009 offerings: 1) The 2009 PDP Landscape Source, an excel data file, which includes data fields at the state-plan level on benefit type; monthly drug premium; annual deductible among other fields and 2) the 2009 MA and SNP Landscape Source, also an excel file, which includes data fields at the state-plan level such as monthly premium and type of drug coverage. These data are available at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/

- CMS sent a letter this month to the over 16,000 beneficiaries in MD Medical Choice (MDMC) plan which was operating in 23 counties in Florida. (The letter follows the termination of CMS contract after a judge placed the company in receivership and sought to liquidate it). The letter explains to the plan enrollees that the MDMC plan will no longer be operational as of October 1, 2008 but ensures that the beneficiaries will continue to receive uninterrupted Medicare services and explains to the beneficiaries their options in enrolling in other plans or if they take no action, they will be re-enrolled in another plan that is comparable. The letter is at: http://www.cms.hhs.gov/HealthPlansGenInfo/Downloads/MDMCbeneltr092908.pdf

Relevant to Medicare Advantage

- None

Relevant to Prescription Drug Plans

None

Of General Interest

- On September 19, 2008, CMS released a fact sheet titled: "CMS announces Medicare Premiums, Deductibles for 2009." In the fact sheet, CMS provided an update on the standard Medicare Part B monthly premium for 2009, which will be the same as 2008 ($96.40). This means that the premium for Medicare beneficiaries will not increase for most beneficiaries (95 percent of beneficiaries), but may for others who pay an income related premium (single beneficiaries with annual incomes greater than $85,000 and couples with incomes greater than $170,000.) While Part B costs are expected to increase in 2008, various factors have added to Part B current assets and obviated the need for a premium increase in 2009. The fact sheet is at: http://www.cms.hhs.gov/apps/media/fact_sheets.asp

Relevant to Special Needs Plans Specifically

- CMS's interim final rule issued this month has several provisions on special needs plans as required by the MIPPA. CMS also released additional guidance with the interim final expanding on the requirements for SNPs, which are to go into effect January 2010. Beginning in 2010, SNPs are required to implement evidence-based Models of Care (MOC). CMS provides guidance that this can be accomplished in several different ways including that SNPs can contract with providers who are accredited by nationally recognized quality and healthcare safety accreditation organizations. In addition, further information on the SNP quality improvement plan was provided. This will be a three-tiered program involving mandatory collection of data including HEDIS measures among others. The interim final rule is available at: http://www.cms.hhs.gov/HealthPlansGenInfo/Downloads/2008-1686_PI.pdf and the general guidance, which includes the SNP provisions is at the following CMS link: http://www.cms.hhs.gov/HealthPlansGenInfo/Downloads/MIPPA_Imp_memo091208Final.pdf

- On September 10, 2008, CMS held a Special Open Door Forum to announce the convening of a special needs chronic condition panel. As required by MIPPA, the panel will determine the conditions that meet the definition of severe or disabling chronic conditions. The moderator for this forum was Natalie Highsmith and included statements from Michael Adelberg, Acting Director of CMS's Special Programs. The forum announced the panel members, which will include among others Caroyln Clancy

of AHRQ and George Mensah of the CDC. More information (including the announcement, agenda, transcript and audio file) is available on CMS's website at: http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp#TopOfPage

OTHER ITEMS OF RELEVANCE

Briefings and Hearings:

- None

Other

- The Kaiser Family Foundation released a report this month dealing with Medicare Advantage and stand-alone prescription drug plan advertisements during the 2008 open enrollment period. Specifically, the report provides findings from an analysis conducted on the content and frequency of television, print and radio advertisements for private Medicare plans that ran either nationally or in one of three local media markets in Florida, Arizona or North Carolina. Key findings included: 1) insurers used more resources to promote MA plans than stand-alone prescription drug plans ($30.1 million vs. $13.7 million); 2) the majority of ads did not convey basic, descriptive information such as the plan type; and 3) most ads promoted extra benefits such as low or no premiums. The report is available at: http://www.kff.org/medicare/med091508pkg.cfm

- In addition to the report, the Kaiser Family Foundation released a policy brief, by Vicki Gottlich of the Center for Medicare Advocacy, titled "The Federal Government's Authority to Regulate Advertising in Medicare." In the brief, Gottlich explains the legal authority of CMS to regulate advertising and information issued by private Medicare Advantage plans. The brief also provides recommendations for additional steps CMS could take to better protect beneficiaries given its authority including toughening requirements on the content and format of advertisements. This brief is available at: http://www.kff.org/medicare/7812.cfm

- On September 22 through September 24, 2008, America's Health Insurance Plans, AHIP, (www.ahip.com) held its annual Medicare and Medicaid Conferences. One session of relevance included the roles of government and private plans in Medicare prescription drug program. Other sessions included general perspectives on the future of Medicare. More information on these sessions as well as the full list of sessions, speakers and transcripts is available on the Kaiser Family Foundation website: http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=2968

- MedPAC held a public meeting on September 4-5, 2008 in the Ronald Reagan Building in Washington DC. The agenda as well as other information pertaining to the meeting is available at: www.medpac.gov. Two sessions in particular were relevant to Medicare Advantage and Prescription Drug Plans: On September 4th, a session summarized the Medicare Advantage sections of the Medicare Improvements

for Patients and Providers Act of 2008 (MIPPA) Under MIPPA, MedPAC is required to report on MA payments, with work on (1) the correlation between MA costs for Part A/B and county level per capita spending in traditional Medicare; (2) CMS's measurement of county level spending; and (3) alternative approaches to MA payment. The commissioners were asked to comment on the MA work plan. On September 5th a session on the work plan for Part D research for the upcoming year was presented by Rachel Schmidt and Shinobu Suzuki. They discussed how the recent change in the Medicare law that has now given MedPAC and others access to claims data will allow for them to significantly expand the types of analyses conducted. MePAC will be able to better analyze issues related to cost, quality and access. MedPAC stated they have just received 2006 claims data and hope to have 2007 claims data by the beginning of 2009. MedPAC's list of upcoming analyses include using the data to analyze basic questions such as: 1) how many enrollees are reaching the coverage gap?; 2) what is the average out-of-pocket spending?; and 3) what are the drug and drug classes that are used most widely by Medicare beneficiaries? In addition, MedPAC hopes to analyze geographic variation such as looking at Part D to determine whether there is as much variation in drug spending as in Part A and Part B spending.