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

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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

Enrollment and Penetration, by Plan Type	Current Month: October 2008	Change From Previous Month*	Same Month Last Year	
			October 2007	Change From October 2007- 2008
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	17,438,716	+20,326	17,179,743	+258,973
Individual	16,544,011	+18,165	Not Available	Not Available
Group**	894,705	+2,161	Not Available	Not Available
Total Medicare Advantage (MA)	10,224,066	+50,761	8,949,143	+1,274,923
Individual	8,437,700	+41,004	Not Available	Not Available
Group	1,786,366	+9,757	Not Available	Not Available
Medicare Advantage-Prescription Drug (MA-PD)	8,555,016	+53,481	7,454,358	+1,100,658
Medicare Advantage (MA) only	1,669,050	-2,720	1,494,377	+174,673
Medicare Advantage (MA) by Type				
MA Local Coordinated Care Plans** *	7,220,849	+36,701	6,296,444	+924,405
Health Maintenance Organizations (HMOs)	6,513,662	+27,179	5,789,844	+723,818
Provider Sponsored Organizations (PSOs)	18,963	+278	78,757	-59,794
Preferred Provider Organizations (PPOs)	688,180	+9,243	419,952	+268,228
Regional Preferred Provider Organizations (PPO)	303,064	+5,376	216,660	+86,404
Medical Savings Account (MSA)	3,610	+26	2,260	+1,350
Private Fee For Service (PFFS)	2,299,745	+9,790	1,703,980	+595,765
Individual	1,685,268	+4,774	Not Available	Not Available
Group****	614,477	+4,016	Not Available	Not Available
Cost	276,206	+1,685	309,860	-33,654
Pilot*****	28,096	-1,796	113,050	-84,954
Other******	92,496	-21	306,889	-214,393
General vs Special Needs Plans***** **				
Special Needs Plan Enrollees	1,295,463	+28,438	1,050,635	+244,828
Dual-Eligibles	901,887	+12,078	737,125	+164,762
Institutional	130,820	-648	144,748	-13,928
Chronic or Disabling	262,756	+17,008	168,762	+93,994
Other Medicare Advantage Plan Enrollees	8,928,603	+22,232	7,898,508	+1,030,095
Penetration (as percent beneficiaries)********				
Prescription Drug Plans (PDPs)	39.9%	No Change	39.0%	+0.9% points
Medicare Advantage Plans (MA)	22.7%	+0.2% points	20.3%	+2.4% points
Medicare Advantage-Prescription Drug Plans (MA-PDs)	18.9%	+0.2% points	16.9%	+2.0% points
Local Health Maintenance Organizations (HMOs),	14.5%	No Change	13.1%	+1.4% points
Local Preferred Provider Organizations (PPOs)	1.5%	No Change	1.0%	+0.5% points
Private Fee For Service (PFFS)	5.1%	No Change	3.9%	+1.2% points

October 2008 data is from the 10.13.08 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 September 2008 data is from data released by CMS on 9.2.08 also on its website
**The breakdown by Group includes Employer/Union Only Direct Contract PDP (125,118)
***The data for the breakdown of MA Local Coordinated Care Plans is from the 10.13.08 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 (13,239)
*****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 October is from the SNP Enrollment Comprehensive Monthly Report released by CMS on 10.13.08 and includes counts of 10 or less. (See: **(http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**).
*******Penetration for October and September 2008 is calculated using the number of eligible beneficiaries reported in the August 2008 MA State/County Penetration file. September 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 October:

Plan Participation, by type	CURRENT MONTH: OCTOBER 2008*	SAME MONTH LAST YEAR	
		OCTOBER 2007	CHANGE FROM OCTOBER 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 October 2008 are from the 10.13.08 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 October 10, 2008, CMS released the 2009 Medicare Prescription Drug Plan Finder and Medicare Options Compare (www.medicare.gov/MPDPF). The 2009 Plan Finder provides beneficiaries with information on 2009 MA and PDP health plan options and allows beneficiaries to make comparison on premiums, formularies and availability of coverage in the gap. The 2009 Plan Finder provides additional detail at the health plan level (i.e. allowing beneficiaries to compare HMOs and PPOs) as well as on estimated monthly mail order drug costs. CMS made the announcement of the 2009 Plan Finder availability through a press release titled "Medicare's Online Tools will Help Beneficiaries with Prescription Drug and Health Plan Choices for 2009." In the press release, CMS stated that this information is also available for beneficiaries without Web access through the 1-800-MEDICARE line and through the 2009 *Medicare & You* handbook to be sent to beneficiaries shortly. The press release is available at: http://www.cms.hhs.gov/apps/media/press_releases.asp

- CMS also released information this month on its low income subsidy (LIS) outreach efforts designed to help LIS eligible beneficiaries with annual enrollment (which begins November 15, 2008). This includes CMS currently sending out notices on orange paper to all LIS beneficiaries who continue to qualify for the benefit but will receive a change in their copayment. Last month, CMS sent out a notice to those no longer automatically qualifying for the benefit encouraging them to reapply. CMS provides a LIS 'toolkit' on their website which includes a summary of frequently asked questions/answers on reassignment issues as well as other information. See: http://www.cms.hhs.gov/limitedincomeandresources/

- This month, CMS released two memorandums to further clarify the two regulations (one final rule, CMS 4131-F and one an interim final rule, CMS 4138-IFC) released last month which provided guidance on changes in the Medicare Advantage and Prescription drug benefit program as required by the Medicare Improvements for Patients and Providers Act (MIPPA) enacted in July of 2008 (see also the September Monitoring report for a more detailed description on these regulations). In particular, the memorandums sent from Abby Block to all MA, MA-PD and PDP organizations; cost-based contractors and employer/union health plans provides more detailed information on the provisions of the marketing regulations. For example, the clarification memorandums include information on which of the provisions apply to employer/union group plans (CMS also provided a table to detail this). CMS also provided addition clarification on the section of the guidance that requires agents and brokers to document the scope of an individual marketing appointment in writing. Since the format or elements necessary for documentation was not clear in the guidance released last month, CMS provided as an attachment to the memorandum: a "Model Sales Appointment Confirmation Form," which CMS strongly encourages plans to use. The memorandum also provides additional definitions for educational vs. marketing events. The two memorandums as well as the

regulations and the other information released is available on CMS's website at: http://www.cms.hhs.gov/HealthPlansGenInfo/

Relevant to Medicare Advantage

- None

Relevant to Prescription Drug Plans

- On October 30, 2008, CMS held an all day Prescription Drug Event (PDE) symposium in Baltimore, Maryland. Kerry Weems, CMS Acting Director and Abby Block, CMS Director for the Center for Drug and Health Plan Choice (CPC) provided an overview of the symposium. CMS speakers at the event included: 1) Cynthia Tudor, CPC, who discussed consumer preferences in Part D (i.e. what type of plan beneficiaries are choosing and what design features tend to be the most important in selection); 2) next Dan Waldo (CMS-ORDI) provided an overview of the PDE data; 3) Michelle Ketcham and Anita Varghese (CPC) presented information on drug use (including the top 100 drugs by utilization and class variations in generic dispensing rates); 4) Christopher Powers (CPC) provided information on beneficiary experience including the average drug cost for beneficiaries as well as an analysis on coverage limits; 5) Kathleen Flannery (CPC) and Paul Spitalnic (CMS-OACT) discussed prescription drug plan specialty tiers and 6) Gregory Dill (CPC) presented information on what CMS as well as plans are currently doing to control drug costs. The agenda as well as other information on the PDE symposium is available on CMS's website at:http://www.cms.hhs.gov/apps/events/event.asp?id=515&Kw=&Mh=NoMonth&cboOrder=date&Yr=NoYear&type=2

Of General Interest

- None

Relevant to Special Needs Plans Specifically

- None

OTHER ITEMS OF RELEVANCE

Briefings and Hearings:

- None

Other

- The Kaiser Family Foundation updated its Medicare Health Plan Tracker with 2009 Medicare Advantage and prescription drug data this month. The Tracker provides detailed information on prescription drug plans nationally and by state as well as Medicare Advantage plans by region and county. The tracker is available at: http://www.kff.org/medicare/healthplantracker/

- This month the General Accountability Office (GAO) released two reports pertaining to Medicare Advantage and prescription drug plans:

  - "Medicare Part D Prescription Drug Coverage: Federal Oversight of Reported Price Concessions Data (GAO-08-1074R)." In this report, the GAO examined how CMS ensures the reliability of price concessions (such as rebates and discounts) data from prescription drug plans since this data is used to calculate final plan payments. The GAO specifically reviewed CMS's oversight on 2006 data. The GAO reported that CMS conducted data checks on the reported price concessions data prior to payment reconciliation to identify potential problems such as outliers and questionable data and if necessary CMS would follow up with sponsors' to resolve any problems. In conducting interviews with CMS officials, the GAO stated that CMS acknowledged that not all problems could be addressed through such checks and that CMS also performed more detailed financial audits in some cases. However, the GAO found that only about half of the 2006 audits were conducted as planned. CMS stated that the remaining audits have been delayed due to financial constraints but that CMS expects to begin these audits of program year 2006 data in October 2008, with results for those audits completed by October 2009. This report is available at: http://www.gao.gov/new.items/d081074r.pdf

  - "Medicare Part D Low-Income Subsidy (GAO-08-824)." To determine the importance of assets and income in LIS denials in 2006 and 2007, the GAO analyzed data from the SSA, reviewed information on state and drug manufacturer pharmaceutical programs, and interviewed SSA, CMS, state programs and pharmaceutical manufacturer program officials. The GAO found that in 2006 and 2007, while both the assets and income of an individual were important factors in determining whether or not an individual who applied for LIS benefits was denied, income was of greater importance in denial of LIS benefits. In 2006, over 60 percent of denials were due at least in part to income and in 2007 over 80 percent were due at least in part to income (in contrast about half of LIS denials in 2006 were based at least in part because of an applicants' assets exceeded the established threshold and in 2007 about 30 percent of denials were due to greater than allowed assets). The GAO also examined state and manufacturer programs that provide assistance to LIS Medicare beneficiaries in obtaining access to prescription drugs. The GAO found that such programs varied in their assistance with 23 states for example offering State Pharmaceutical Assistance Programs (SPAP), which supplement prescription drug benefits (while such benefits varied in assistance

provided, they generally covered some out-of-pocket prescription drug costs). This report is also available on the GAO's website at: http://www.gao.gov/new.items/d08824.pdf

- MedPAC held a public meeting on October 2 and 3, 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. Three sessions in particular were relevant to Medicare Advantage and Prescription Drug Plans:

    - MIPPA MA payment report work plan: In this session, MedPAC's Scott Harrison and Dan Zabinski discussed MedPAC's work plan for the MA payment report that is mandated by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA section 169). Specifically, MedPAC will be conducting three separate analyses: 1) the correlation between MA plan costs to deliver Parts A and B benefits and county level per capita spending under fee-for-service Medicare; 2) an evaluation of CMS's measurement of the county level spending; and 3) based on the findings of the first two analyses, MedPAC will also examine alternate approaches to MA payment other than the county fee-for-service approach and to make recommendations as appropriate.

    - MIPPA MA quality report work plan: MedPAC's Carlos Zarabozo and John Richardson discussed their proposed quality work plan for the report. This will include: 1) a study assessing how quality can be compared between fee-for-service and MA (including, for example, what the unit of measurement should be); 2) an assessment on the appropriate geographic unit of analysis for quality comparisons; and 3) how reporting on quality should be done (for example, whether benchmarks and results should be reported in specific ways that would allow subpopulations of beneficiaries to make comparisons for their particular needs). MedPAC also plans to assess the administrative burdens on the collection, analysis and reporting of both the current and any new quality measures that would be/are imposed on physicians and other providers, MA plans and on CMS (as well as evaluate the cost-benefits of these).

    - Use of drug data in risk adjustment: In this session, MedPAC's Shinobu Suzuki provided background information on the risk adjustors for Part D and then Dr. John Hsu, a physician scientist and internist at Kaiser Permanente, presented results of an analysis on risk adjustment under the Part D program. In particular, Dr. Hsu discussed how the LIS multiplier in the risk adjuster may benefit from some additional evaluation. Dr. Hsu proposed that there are a number of ways the current LIS multipliers could change stating that calculating an entirely separate risk adjustor for the LIS subsidy beneficiaries might be more appropriate.