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TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS
Monthly Report for December 2005

A Brief Summary of Selected Significant Facts and Activities This Month to Provide Background for Those Involved in Monitoring and Researching Medicare Advantage and Prescription Drug Plans

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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

From the CMS Medicare Managed Care Contract Report (http://cms.hhs.gov/healthplans/reportfilesdata/):

Plan Participation, Enrollment, and Penetration by type	Current Month: Dec 2005	Change From Previous Month	Same Month Last Year	
			Dec 2004	Change From Dec 2004 – 2005
Contracts				
Total	459	0	300	159
CCP	302	0	154	148
PPO Demo	34	0	35	-1
PFFS	17	0	6	11
Cost	29	0	29	0
Other*	77	0	76	1
Enrollment				
Total	6,121,678	+63,011	5,498,494	+623,184
CCP	5,157,627	+36,922	4,720,532	+437,095
PPO Demo	163,787	+37,300	111,316	+52,471
PFFS	208,990	+19,488	51,214	+157,776
Cost	321,555	+276	330,665	-9,110
Other*	269,719	-30,975	284,767	-15,048
Penetration**				
Total Private Plan Penetration	14.0%	+0.2%	12.8%	+1.2%
CCP + PPO Only	12.1%	+0.1%	11.0%	+1.1%

*Other includes Other Demo contracts, HCPP and PACE contracts.
** Penetration rates for December and November 2005 are calculated using the number of eligible beneficiaries reported in the September 2005 State/County File. Penetration rates for December 2004 are calculated using the number of eligible beneficiaries reported in the September 2004 State/County File.

DEFINITIONS: Coordinated Care Plans, or CCPs, include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs) and preferred provider organizations (PPOs). Data from the September 2005 Geographic

Service Area File show that HMOs account for 80 percent of CCP contracts and 99 percent of CCP enrollment. 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.

Pending Applications

- According to the December 1, 2005 Medicare Managed Care Contract Report, there are pending applications for 3 PACE contracts. There are no pending service area expansions this month.

Summary of new MA contracts announced in December:

CMS's Monthly Medicare Managed Care Contracts Report (MMCC) for December 1, 2005 indicates that no new contracts were signed since the September 1, 2005 MMCC Report. This report covers only approval of contracts for 2005. CMS had previously indicated that all new MA contracts for 2005 had to be approved by September 1, 2005. CMS has released information on contracts to be available in 2006 (www.cms.hhs.gov, see Landscape of Local Plans). This report (covering enrollment in December 2005) represents the last one before the 2006 expansion in offerings as drug benefits are introduced. At this point in time, private plan penetration is 14.0 percent, with 12.1 percent of Medicare beneficiaries in a CCP or PPO demonstration. Though the latter continues to dominate the MA program, the number of PFFS contracts has almost tripled (from 6 to 17). Enrollment now stands at almost 209,000, about four times more than a year ago. Enrollment in PPO plans also is increasing at a more rapid rate than in the past.

NEW ON THE WEB FROM CMS

Relevant to Both Medicare Advantage and Prescription Drug Plans

- On December 16, 2005, CMS announced the launch of its newly designed website (http://www.cms.hhs.gov/AboutWebsite/12_Aboutthiswebsite.asp). CMS has changed the web address of some of the information usually referenced in the Monthly Report. Users should anticipate potential problems, at least in the short run, in referencing materials they usually find on the web as CMS offices accommodate their postings to the new format. Readers might want to note the following new web address for:
    - The Managed Care and Medicare Advantage Reports, Files and Data, now available at https://63.240.208.147/HealthPlans/ReportFilesData/. However, the December 2005 updates have not yet been posted on the website. The MA Penetration file, which is usually released in December, will not be available until at least January 31, 2006.

- On December 7, 2005, CMS posted on its website information on 2007 applications for all Medicare Advantage Organizations (MAOs), Prescription Drug Plan Sponsors (PDPs) and Direct Employer/Union-Only Group Waiver Plan (Direct EGWP) sponsors, including New Special Need Plans (SNPs). The instructions apply to organizations that intend to apply for a new initial contract or service area expansion of a current contract for the contract year 2007. The information includes draft solicitations for applications with public comment available through December 14, 2005. CMS also posted a memorandum stating that both CMS-approved contractors wishing to extend service areas and new applicants for the contract year 2007 should send a "Notice of Intent to Apply" on or before January 17, 2006. This information is available at http://www.cms.hhs.gov/MedicareAdvantageApps

- On December 22, 2005, HHS issued a press release that provides the first official reports of enrollment in Medicare's new prescription drug benefit. The headline (that 21 million will be covered for prescription drugs as of January 1, 2006) is misleading because that figure is a composite of those with coverage from a variety of sources. The release does not clarify actual enrollment in drug plans offered by free-standing PDPs and MA plans. In terms of the Medicare drug benefit itself, the release indicates that as of December, 13, 2005:

    - Over one million have signed up for the new stand-alone PDP coverage and that CMS expects another 500,000 to be enrolled by the end of January 2006. (Lehman Brothers, which analyzes the industry for investors, reports industry sources as saying there could be more applicants in the pipeline that had not yet been approved.)

    - 6.2 million dual eligibles have been automatically enrolled in the program. Most (5.4 million) are in PDPs, but 600,000 will be in MA plans.

    - 4.4 million (in addition to the 600,000 dual eligibles noted above) are in MA plans. (The release does not indicate whether these individuals have elected the PD benefit through their MA plan, been passively enrolled in it, or are eligible for such an election.) Additional data on these plans is included in the release.

    - 1 million are in employer plans that incorporate or wrap around Medicare's Part D benefits. These include direct contract plans where the employer or union becomes the Part D plan for its retirees, "employer group waiver" plans with a single plan created just for that organization, or plans that wrap around Medicare benefits. (Presumably the first two categories of retirees reflect additional Medicare prescription drug enrollees whereas the latter counts individuals who enroll independently in PDPs).

  The release also indicates that CMS has approved Medicare retiree subsidy payments to employers covering 5.9 million retirees, with an addition of 600,00 in process. Another 500,000 more are continuing in coverage that is as good as Medicare (presumably through employers who will not receive a subsidy, perhaps because the beneficiary pays all/most of the premium). Another 3.1 million Medicare beneficiaries are covered by the federal retirement program (FEHB or TRICARE). The press release is available on line at: http://www.hhs.gov/news/press/2005pres/20051222.html.

Relevant to Medicare Advantage

- On December 6, 2005, CMS convened an MA technical user group training call for all Medicare managed care health plan providers. The call's focus was on planned posting of Medicare Advantage applications and included a question and answer session. The agenda for the call is available at http://www.cms.hhs.gov.

Relevant to Prescription Drug Plans

- On December 1, 2005, CMS released a fact sheet titled "Ensuring an effective transition of dual eligibles from Medicaid to Medicare Part D." This fact sheet discusses the steps CMS is taking to ensure a smooth transition for the over 6 million low-income Medicare beneficiaries who are currently receiving prescription drug coverage from Medicaid as their coverage shifts to Medicare

prescription drug plans starting January 1, 2005. CMS states that it has two key objectives:

- o Addressing concerns that the transition of dual eligibles to Part D could result in discontinuities, CMS stated its first objective is to provide comprehensive and high quality drug coverage. CMS announced it is requiring plan formularies to have at least two drugs in each approved category and class (unless only one is available). In addition, it is requiring each plan's formulary to include all or almost all drugs in key categories (including antidepressants, antipsychotics, and anticancer drugs). It is also including transitional guidance in which plans must include at least a one-time fill of prescription drugs excluded from the plan's formulary in order to accommodate situations where beneficiaries had a previously filled prescription no longer covered by their new plan.

- o CMS also stated that its second key objective is ensuring continuity of prescription drug coverage and care for dual eligibles. The fact sheet discusses the activities CMS has done such as outreach and its collaboration with States to ensure a smooth transition. In addition, CMS announced that it will contract with WellPoint (which has a nationwide pharmacy network) to enroll those dually eligible beneficiaries who come into pharmacies starting on January 1, 2005 but are not yet enrolled in a prescription drug plan. CMS indicated that this will allow those beneficiaries to leave the pharmacy with necessary prescriptions the same day. The fact sheet is available at http://www.cms.hhs.gov/media/?media=facts

- On December 29, 2005, CMS released two documents for employer and union plan sponsors that have decided not to continue coverage for any of their beneficiaries who enroll in a stand-alone Medicare Part D drug plan. The two documents notify the sponsors of the issues affecting dually eligible beneficiaries with retiree drug coverage that will be automatically enrolled in a Medicare Part D drug plan. The first document, a tip sheet, provides general information on dual eligibles and the automated enrollment process as well as why plan sponsors should be especially concerned about auto-enrollees. The tip sheet notes that many of these retirees may be confused about the auto-enrollment process and their choices and that many may wish to keep their current coverage. The second document is an issue paper and provides additional information on this topic including more background information and best practices employer and union plan sponsors can take to reduce confusion and/or adverse consequences facing retirees and their families. This information is available at CMS's Employer & Union Plan Sponsor Information website at http://www.cms.hhs.gov/EmplUnionPlanSponsorInfo/

Relevant to Special Needs Plans Specifically

- On December 7, 2005, CMS announced in a press release that an additional organization, Evercare of Georgia (United Healthcare product), will participate in the new managed care demonstration for Medicare beneficiaries with end stage renal disease (ESRD). Evercare of Georgia will partner with DaVita, a dialysis provider, to offer a Medicare SNP in two counties in Georgia. More information on this new SNP as well as other MA organizations that are partnering with dialysis facilities in this demonstration is available at http://www.cms.hhs.gov/media/?media=pressr

- Users should note CMS currently provides monthly lists of approved SNPs at http://www.cms.hhs.gov/SpecialNeedsPlans/. Tracking these contracts in the regular managed

care report is complicated because SNPs are not a mutually exclusive type of contract but rather may be offered through CCPs, etc. Some of the recent growth of CCPs reflects approval of contracts for SNPs.

ON THE CONGRESSIONAL FRONT

About Medicare Health and Drug Plans Specifically

- This month the General Accountability Office (GAO) released three reports with potential implications for the new Medicare prescription drug benefit. These reports can be accessed online at www.gao.gov.

    - On November 30, 2005, the GAO released a report titled "Medicare: CMS's Implementation and Oversight of the Medicare Prescription Drug Discount Card and Transitional Assistance Program (GAO-06-78R)." For this report, the GAO reviewed: 1) the processes that CMS used to solicit, evaluate, and approve drug card sponsors; and 2) the processes that CMS used to oversee drug card sponsors and the problems identified as a result of CMS oversight. The report focused on five areas of oversight: drug prices, sponsors' pharmacy networks, sponsor-provider beneficiary information, transitional assistance subsidy (TA), and beneficiary complaints and grievances. The report concluded that any potential savings from the Medicare prescription drug discount card program cannot be documented because of a lack of reliable data. The GAO report found that the data received from pharmaceutical companies and pharmacies was often incomplete and/or inaccurate. In addition, the report found that CMS provided inadequate guidance to drug card sponsors because of the short time frame in which the program had to be implemented (for example, final guidance on how drug card sponsors should report data on drug prices came about 5 months after the program had begun).

    - On November 30, 2005, the GAO also released a report titled, "Medicare: CMS's Beneficiary Education and Outreach Efforts for the Medicare Prescription Drug Discount Card and Transitional Program (GAO-060-139R)." The GAO report described how CMS's outreach effort raised public awareness of the prescription drug card program but CMS was less effective in its efforts to inform and assist beneficiaries in the enrollment process. The report concludes that in general CMS's efforts did not consistently provide information to beneficiaries that was clear, accurate, and accessible. The report notes that the drug program's unfamiliarity and uncertainty may have discouraged potential beneficiaries from enrolling. However, the report also notes that CMS has taken action to address some of these problems and CMS administrator, Mark McClellan, commented that the lessons CMS has learned with the drug card program have been applied to the new drug benefit.

    - On December 16, 2005, the GAO released a report titled, "Medicare: Contingency Plans to Address Potential Problems with the Transition of Dual-Eligible Beneficiaries from Medicaid to Medicare Drug Coverage (GAO-06-278R)." In the report, the GAO identifies three potential problems that may leave some dual-eligibles facing difficulties in obtaining necessary prescription drug coverage at the start of the new program benefit in January 2006. The three potential problems are: 1) some individuals may not be identified for automatic enrollment in a PDP due to potential inaccuracies in data (federal or state); 2) not all

beneficiaries who become dually eligible in late 2005 and beyond may be identified and automatically enrolled by the date they become dually eligible; 3) because dual-eligibles are randomly assigned, beneficiaries' prescription drugs may not be on the PDP formulary, or their customary pharmacy may not be in the PDP pharmacy network. The report also examines the various contingency plans put in place by CMS to address the potential problems with the transition. The report concludes that while these contingency plans may be useful in mitigating risks, their effectiveness is uncertain.

- The Medicare Payment Advisory Commission (MedPAC) held a meeting on December 8 and 9, 2005. In contrast to last month, this month's meeting did not have any sessions dedicated to discussing the new drug benefit or MA plans (www.medpac.gov).

- On December 9, 2005, MedPAC also released several *Medicare Payment Basics* documents. These documents are located on MedPAC's website at www.medpac.gov.

    - One of the documents, titled "Medicare Advantage Program Payment System," describes the two different payment categories of MA plans: local plans and regional plans. The document explains how in 2006, payment for each local plan is determined by the relationship of the plan's bid to the benchmark (which is defined in the MMA as county-level payment rates used to pay MA plans before 2006). If the plan bids above the benchmark then the plan receives a base rate equal to the benchmark (and the enrollees will have to pay an additional premium that equals the difference between the bid and the benchmark). If the plan bids below the benchmark, the plan receives a base rate equal to its bid plus 75 percent of the difference between its bid and the benchmark (with the Medicare program retaining the remaining 25 percent). For regional MA plans, the benchmark is more complicated and involves the weighted average of the average county rate and also takes into account the average plan bid. The document describes how CMS computes the average county rate and average plan bid.

    - Another of the *Medicare Payment Basics* documents, titled "Part D payment systems," provides general information on the drug benefit (the standard benefit and plans that offer alternative coverage structures), Medicare's subsidy amounts, Medicare's payments to plans, and how enrollee premiums are calculated.

- MedPAC will hold its next public meeting January 10-11, 2006. The meeting will be held at the Ronald Reagan Building in Washington, DC. An agenda will be available approximately one week before the meeting and transcripts will be available approximately 3-5 business days after the meeting ends. Both documents will be available online at www.medpac.gov.

Broader Medicare Program (in Brief)

- On December 12-14, 2005, the fifth White House Conference on Aging (WHCoA) was held in Washington DC. About 1,200 delegates (chosen by members of Congress, the Bush administration, and each governor) as well as policymakers and advocates for the elderly attended. Speakers included CMS Administrator, Mark McClellan, who discussed CMS's emphasis on preventative care. However, *USA Today* (Komblum, Janet, December 12, 2005) reported that President Bush did not attend the conference, which was the first time a president has not addressed the conference since it

began in 1961. The goal of the conference was to develop strategies and policy recommendations to guide aging policies for the next ten years and beyond and included various workshops and speaker presentation sessions. One of the top 50 resolutions (Resolution 29) the delegates voted for was to promote enrollment of seniors into the Medicare Prescription Drug program. The Delegates must deliver a final draft of policy recommendations to Congress and President Bush by June. More information on this conference (including McClellan's speech and the full list of resolutions the delegates voted on) is available at http://www.whcoa.gov/.

FROM THE PERSPECTIVE OF BENEFICIARIES

General

- On December 1, 2005, *USA Today* (Appleby) reported the computer data problem in the Medicare Prescription Drug Finder that was causing drug prices to be artificially inflated for some drug plans has been fixed. Appleby reported that the website incorrectly listed monthly co-payments for at least two drug plans (UniCare and CareFirst Blue Cross Blue Shield), causing the plans to look more expensive than they actually were. (The UniCare plan was incorrectly listed at almost $2,000 more a year than its actual price).

- On December 15, 2005, the *Wall Street Journal* (Harwood) reported results from a *Wall Street Journal*/NBC poll based on nationwide telephone interviews with 1,006 U.S. adults between December 9 and December 12, 2005. The poll found that 40 percent of those ages 65 and older view the new Medicare drug benefit unfavorably. In addition, the poll results also found that almost 73 percent of seniors feel the new prescription drug benefit is too complicated and too confusing.

- This month *Families USA*, a consumer health organization, reported results of a study on Medicare prescription drug benefit drug prices compared with Veteran Administration (VA) drug prices. The study was conducted using the top 20 drugs prescribed to seniors in 2004 in two regions (regions 5 and 14). The study used the lowest base drug price offered by any Medicare prescription drug plan to make the comparison to the VA base prices (lowest publicly reported price). However, Medicare Advantage prescription drug plans were not included in the analysis because these plans do not report the base prices for drugs they cover. The data from this analysis came from the Medicare Prescription Drug Plan Finder and the VA prices were drawn from price schedules that the VA negotiates such as the Federal Supply Schedule and the Big-4 Prices. The study concludes that for all 20 drugs, the lowest price negotiated by the VA was lower than the lowest price available through any Medicare prescription drug plan included in either of the two regions. The study also reported that the median percent price difference was 48.2 percent. The report and press release are available at http://www.familiesusa.org

- Kaiser Commission on Medicaid and the Uninsured (KCMU) released a document titled "Profiles of Medicare Beneficiaries with Medicaid Drug Coverage Prior to the Medicare Drug Benefit." The brief profiles four real people who are dual eligibles and is designed to provide more insight into the circumstances of this population as the new Medicare drug benefit goes into effect in January 2006. This brief is part of a larger study done by Lake Research Partners and American Viewpoint (commissioned by Kaiser Family Foundation) and involves two rounds of structured interviews with a diverse group of Medicare beneficiaries (ages ranging from 47 to 85 years). The goal of the interviews is to better understand beneficiaries' experiences with the new benefit throughout the first

year. The first round was conducted between October 27 and November 16, 2005 and the second round will be conducted between the spring through fall of 2006. The interviews will be conducted in four different cities, includes a total of 34 interviews and will be part of a broader forthcoming report next year. The brief of the four dual eligibles profiled from the first round of interviews is available online at http://www.kff.org/medicaid/kcmu121905pkg.cfm.

Special Populations

- None

FROM OTHER STAKEHOLDERS

- On December 8, 2005, Kaiser Family Foundation and Hewitt Associates reported results from an online survey of 300 large private-sector firms (1,000 or more employees) that offer retiree health benefits. The survey was conducted between June 21 and October 7, 2005 and focused on the firms' views of the new Medicare drug benefit and their plans for continuing drug coverage in the future. The survey results indicate that 79 percent of the firms that currently provide retiree health benefits will continue providing retiree drug coverage in 2006. Ten percent of employers say they will provide some drug coverage to supplement the new drug benefit and nine percent will stop coverage to Medicare-eligible retirees. Of those firms that are continuing coverage in 2006, 82 percent say they are 'very' or 'somewhat' likely to continue in 2007 and 50 percent say they are likely to continue coverage through 2010. The news release, report and chartpack are available at http://www.kff.org/medicare/med120705pkg.cfm

- On December 12, 2005, Kaiser Commission on Medicaid and the Uninsured (KCMU) sponsored a conference call to discuss findings from their state Medicaid officials' focus group study conducted in November 2005. The focus group discussion included representatives from 11 states and was designed to gain insight from the state perspective on the impact of the new Medicare drug program on states and Medicaid enrollees. The participants commented on five main areas: 1) transition issues; 2) evaluating Part D plan options; 3) states' role in the low-income subsidy program; 4) fiscal implications of Part D on states; and 5) longer term policy implications at both the state and federal levels of the Part D implementation. A number of the participants expressed concern that despite CMS's extensive efforts to ensure a successful transition, a significant number of dual eligibles could "fall through the cracks." Other comments included that the large number of plan options will likely complicate the Part D transition for the dual eligibles. In addition, most participants commented that their states had played little or no role in the process of determining eligibility for the Part D subsidy so far. A full listing of the comments as well as the entire report and the audio file of the briefing are available on the web at http://www.kff.org/medicaid/kcmu121905pkg.cfm.

- On December 21, 2005, America's Health Insurance Plans (AHIP) released results from a survey conducted by Ayres, McHenry & Associates on opinions of seniors who have signed up for the new prescription drug benefit. The sample of 400 randomly selected seniors was drawn from a list all adults age 65 or older and was conducted December 15-19, 2005. The margin of error is 4.9 percent. The survey found that 57 percent of the seniors who have signed up for the new drug benefit say that the time and effort they put into evaluating the many drug plans was worth it, given the benefits they will receive. In addition, 56 percent of seniors who have completed the enrollment process say they would recommend that other seniors sign up for the program. Twenty-four percent say it depends on the individual's particular circumstances and 9 percent say they would not recommend other seniors

sign up for the new benefit. The press release and the full report is available at http://www.ahip.org/content/pressrelease.aspx?docid=14070

- The *Baltimore Sun* (Salganik, William, December 21, 2005) reported that the Baltimore City Health Department is setting up a 24-hour system to help ensure dual eligibles are able to get needed prescriptions as their drug coverage transfers from state-run programs to the new Medicare drug benefit in January. The system involves a 24-hour phone line for pharmacists and a database to track problems. The City hopes the system will aid city officials in being notified of problems in order to resolve billing problems with the beneficiaries' prescription drug plans. In addition, Baltimore's health commissioner stated that in urgent cases, the city would pay for prescriptions to be filled to ensure uninterrupted supply.

NEWLY RELEASED RESEARCH STUDIES NOT PREVIOUSLY DESCRIBED

- **Merlis, Mark. "Eligibility Standards for Medicare/Medicaid Dual Eligibles: Issues and Options for Reforms." Washington DC: National Academy of Social Insurance (working paper).**

The author first provides a summary of the current eligibility standards that qualify Medicare beneficiaries for assistance with the new Medicare drug benefit and provides a detailed description of state differences, cliff effects, and asset rules. The author then uses data from the 2001 panel Survey of Income and Program Participation (SIPP) to illustrate four possible reform options he argues would make the application process simpler and the eligibility process more uniform with respect to income and resource limits that individuals must meet for assistance. In addition, all four of the author's reform options extend assistance to more individuals. This working paper is available online at: http://www.nasi.org/publications2763/publications_show.htm?doc_id=325220.

- **Sing, Merrile and Stevens, Beth. "The Value of Experience: Differences in Knowledge Among Medicare Beneficiaries."** ***Inquiry: Vol. 42, No. 3,*** **pp. 266-280**

In this article, the authors report results of a study they conducted on Medicare beneficiaries' awareness, knowledge and use of the National Medicare Education Program (NMEP). The authors conducted a national survey of Medicare beneficiaries six to 12 months after the nationwide mailing of the Medicare & You 2000 handbook. The sample came from CMS's enrollment database and included 3,125 interviews. The Medicare beneficiaries were divided into three groups: 1) "switchers"; 2) "new enrollees"; and 3) Medicare FFS beneficiaries. The first two groups included beneficiaries who recently had made a Medicare+Choice enrollment decision (i.e, "switchers" were enrolled in a Medicare HMO and had switched to a different HMO and "new enrollees" were either in Medicare FFS and had enrolled in an HMO or had become eligible for Medicare during the interview period and enrolled in an HMO). The authors report three key findings: 1) Seventy-three percent of beneficiaries say they were aware of at least one of the six NMEP information sources [the six sources included: 1) the Medicare & You handbook; 2) Medicare's toll-free number; 3) website; 4) health Fairs; 5) Medicare-sponsored meetings; 6) community based counseling from state and local agencies]; 2) after controlling for age, education, income, HMO enrollment before joining Medicare, and the other control variables in a regression equation, the study found that greater knowledge about Medicare and Medicare managed care was associated most often with beneficiary propensity to use information and beneficiary experience with Medicare managed care; 3) the subgroup "switchers" demonstrated greater knowledge about Medicare managed care than newly enrolled FFS beneficiaries.

OTHER SIGNIFICANT EVENTS

- None