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

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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

Enrollment and Penetration, by Plan Type	Current Month: December 2008	Change From Previous Month*	Same Month Last Year	
			December 2007	Change From December 2007- 2008
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	17,484,612	+14,949	17,239,108	+245,504
Individual	16,587,224	+13,672	Not Available	Not Available
Group**	897,388	+1,277	Not Available	Not Available
Total Medicare Advantage (MA)	10,283,076	+25,514	9,007,800	+1,275,276
Individual	8,484,926	+19,962	Not Available	Not Available
Group	1,798,150	+5,552	Not Available	Not Available
Medicare Advantage-Prescription Drug (MA-PD)	8,618,617	+27,986	7,529,773	+1,088,844
Medicare Advantage (MA) only	1,664,459	-2,472	1,478,027	+186,432
Medicare Advantage (MA) by Type				
MA Local Coordinated Care Plans** *	7,261,299	+20,705	6,339,642	+921,657
Health Maintenance Organizations (HMOs)	6,539,754	+14,085	5,821,214	+718,540
Provider Sponsored Organizations (PSOs)	19,860	+432	78,419	-58,559
Preferred Provider Organizations (PPOs)	701,653	+6,192	439,981	+261,672
Regional Preferred Provider Organizations (PPO)	313,755	+2,228	235,503	+78,252
Medical Savings Account (MSA)	3,613	-23	2,271	+1,342
Private Fee For Service (PFFS)	2,308,012	+2,668	1,703,912	+604,100
Individual	1,689,063	+520	Not Available	Not Available
Group****	618,949	+2,148	Not Available	Not Available
Cost	277,245	+420	309,658	-32,413
Pilot*****	26,644	-509	109,511	-82,867
Other******	92,508	+25	307,303	-214,795
General vs Special Needs Plans***** **				
Special Needs Plan Enrollees	1,323,132	+13,739	1,098,754	+224,378
Dual-Eligibles	911,950	+6,249	760,561	+151,389
Institutional	127,776	-755	145,583	-17,807
Chronic or Disabling	283,406	+8,245	192,610	+90,796
Other Medicare Advantage Plan Enrollees	8,959,944	+11,775	7,909,046	+1,050,898
Penetration (as percent beneficiaries)********				
Prescription Drug Plans (PDPs)	39.9%	No Change	39.1%	+0.8% points
Medicare Advantage Plans (MA)	22.8%	No Change	20.4%	+2.4% points
Medicare Advantage-Prescription Drug Plans (MA-PDs)	19.1%	+0.1% points	17.1%	+2.0% points
Local Health Maintenance Organizations (HMOs),	14.5%	No Change	13.2%	+1.3% points
Local Preferred Provider Organizations (PPOs)	1.6%	+0.1% points	1.0%	+0.6% points
Private Fee For Service (PFFS)	5.1%	No Change	3.9%	+1.2% points

December 2008 data is from the 12.08.08 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 November 2008 data is from data released by CMS on 11.03.08 also on its website

**The breakdown by Group includes Employer/Union Only Direct Contract PDP (125,330)

***The data for the breakdown of MA Local Coordinated Care Plans is from the 11.03.08 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 (13,264)

*****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 December is from the SNP Enrollment Comprehensive Monthly Report released by CMS on 12.08.08 and includes counts of 10 or less. (See: (**http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**).

*******Penetration for December and November 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 December:

Plan Participation, by type	CURRENT MONTH: DECEMBER 2008*	SAME MONTH LAST YEAR	
		DECEMBER 2007	CHANGE FROM DECEMBER 2007– 2008
MA Contracts			
Total	735	605	+130
Local Coordinated Care Plan	509	408	+101
Health Maintenance Organizations (HMOs)	368	289	+79
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	441 269 65 107	312 204 65 43	+129 +65 No Change +64
Other**	93	93	No Change

*Contract counts for December 2008 are from the 12.08.08 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 December 29, 2008, CMS released a press release titled "Medicare Reminds Beneficiaries to Review Their Prescription Drug Coverage and Health Plan Needs for 2009." The press release provides a reminder that the annual enrollment period for prescription drug plans ends on December 31, 2008. However, beneficiaries can make changes in enrollment for Medicare Advantage only plans between January 1 and March 31, 2009. In the press release, CMS also reminds beneficiaries that the MA only plan enrollment period cannot be used to stop or start drug coverage or to enroll/disenroll in a Medicare Medical Savings Account (MSA) plan. The press release is available on CMS's website at: http://www.cms.hhs.gov/apps/media/press_releases.asp

Relevant to Medicare Advantage

- None

Relevant to Prescription Drug Plans

- None

Of General Interest

- None

Relevant to Special Needs Plans Specifically

- This month, CMS posted data results from the SNP Quality Measures collected for 2008. In the memo titled "SNP Quality Measures for 2008," CMS provided an overview of the SNP quality measures collected as well as the measurement selection process and an overview of the SNP data publicly reported. The Geriatric Measurement Panel (GMAP) of NCQA provided guidance on the development and maintenance of the measures. For this first year (2008), CMS selected SNP performance measures from thirteen existing HEDIS measures and for assessment of structure and process measures, CMS selected three measures from current NCQA accreditation standards. CMS stated that in many cases, plans were either too new or too small to collect the information for 2008 and there are substantial variations between organizations. From the initial set of 13 HEDIS measures, 4 were chosen for initial public reporting: 1) colorectal cancer screening (with 39% of SNPs reporting); 2) controlling high blood pressure (with 39% of SNPs reporting); 3) appropriate monitoring of patients taking long term medications (with 85% of SNPs reporting) and 4) board certified physicians (with 50% of SNPs reporting). Details of the SNPs reporting measures are displayed in the "SNP Quality Measures Plan Scores for

2008" pdf also on CMS's website. CMS states that these scores reported in 2008 may reflect inexperience of SNPs with HEDIS reporting and CMS expects improvement overtime. These data are not risk-adjusted. The information is on CMS's SNP web page at: http://www.cms.hhs.gov/specialneedsplans/

OTHER ITEMS OF RELEVANCE

Briefings and Hearings:

- None

Other

- The Kaiser Family Foundation released two reports this month relevant to Medicare Advantage and prescription drug plan program:
    - An updated Medicare Primer provides general information on the Medicare program (including characteristics of people with Medicare) as well as the specific information on the Part D drug benefit, Medicare Advantage and cost-sharing requirements. The Medicare Primer is available at: http://www.kff.org/medicare/7615.cfm
    - An issue brief titled: "The Emerging Role of Group Medicare Private Fee-for-Service Plans" prepared by Avalere Health. The issue brief focuses on changes in regulations and statutes that appear to have influenced employers' interest in Medicare Advantage group plans since 2006. The issue brief reports that since 2006, the number of Medicare beneficiaries enrolled in group plans has increased from 900,000 to nearly 1.7 million. The issue brief states that group PFFS plans have the potential to reduce employers' retiree health costs, for example, because PFFS allow employers to offer uniform benefits nationwide to Medicare-eligible retires, with minimal burden (i.e. no network issues). However, the issue brief goes on to state that despite rapid enrollment growth, continued growth in the group PFFS market is uncertain. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA of 2008) will require group PFFS plans to create provider networks as of 2011 and the non-network nature of PFFS plans is a key reason why employers have chosen PFFS products in the past few years. The issue brief is available at: http://www.kff.org/medicare/7841.cfm.
- The GAO released three reports this month relevant to Medicare Advantage and the prescription drug program. The full reports are at: www.gao.gov.
    - "Medicare Advantage: Characteristics, Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for-Service Plans." This report compares PFFS plans to other MA plans as well as Medicare FFS by

reviewing materials from a sample of 9 PFFS plan sponsors, analyzing Medicare data, and interviewing officials from CMS involved in administering the Medicare program. Specifically, the report compares: 1) the characteristics of beneficiaries in each (with beneficiaries in PFFS plans generally healthier and younger than in other MA plans and Medicare FFS as well as more likely to reside in rural areas where fewer other MA plans available as of April 2007); 2) financial risk for beneficiaries who do not contact their plans before receiving services (i.e. PFFS enrollees (or their providers) that did not contact their PFFS plans before obtaining a service to make sure it would be covered might have to pay for the entire cost of the service if coverage was later denied by the plan or experience higher out of pocket costs for a covered service; this differs from other MA plans and Medicare FFS) and 3) disenrollment rates (From January through April 2007, beneficiaries in PFFS plans disenrolled at an average rate of 21 percent compared to 9 percent for other MA plans). The GAO made three main recommendations for CMS: 1) investigate the extent to which PFFS beneficiaries face unexpected costs for not contacting their plan before receiving care; 2) ensure CMS guidance on prior authorization reflects CMS policy (as the GAO found that some plans were inappropriately using this term on their informational materials); and 3) mail MA plan disenrollment rates to beneficiaries as required by statute and update rates on Medicare's website. (Although disenrollment rates often reflect such factors as beneficiary satisfaction and CMS is required by law to mail this information to beneficiaries to help them compare plans in their area, CMS has not mailed this information to beneficiaries since 2000 and has not updated this information online since 2005).

- "Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2006." This report compares MA organizations 2006 actual medical expenses, non-medical expenses and profits to projections for the same year and compares 2006 results to 2005 results (from GAO's earlier report of 2005 results in June of 2008). GAO found, on average, for 2006, MA organizations reported profits that were 2.5 percentage points higher than projected (actual profits of 6.6 percent of total revenue compared to projected profits of 4.1 percent). In 2005, the difference between reported earning profits and projected profits was larger (3.2 percentage point difference). However, due to an a increase in enrollment of about 40 percent between the two years, the actual dollar amount of difference between actual and projected profits increased from $1.1 billion in 2005 to $1.3 billion in 2006.

- Medicare Part D: Opportunities Exist for Improving Information Sent to Enrollees and Scheduling the Annual Election Period." In this report the GAO examined: 1) stakeholders' views of the model Annual Notice of Change (ANOC), which plan sponsors are required to use to send to beneficiaries prior to the Annual Election Period (AEP) and CMS's efforts to ensure its effectiveness and 2) how the scheduling of the AEP affects the enrollment process for beneficiaries switching PDPs. The GAO selected 8 PDP sponsors to interview along with other stakeholders involved in the

Annual Election Process (AEP) and also obtained data from CMS in order to conduct its analysis. The GAO found that many stakeholders are concerned that the ANOC model form for 2008 did not effectively communicate drug plan changes to beneficiaries prior to AEP (e.g. the language was too difficult for some beneficiaries to understand as well as often contained too much and often irrelevant information). The GAO found that CMS did not conduct a systematic evaluation of the ANOC process. In addition, the GAO found that about 15 percent of beneficiaries that chose to switch plans during the AEP were not fully enrolled in their new plan by January 1st. The GAO made the following recommendations: 1) CMS should strengthen its evaluation of its ANOC materials by reviewing alternative formats to communicate plan changes and 2) Congress should consider authorizing the DHHS Secretary the ability to amend the AEP schedule to include a processing interval between the end of the AEP and the effective date of new coverage.

- MedPAC held a public meeting on December 4 and 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:

    - "The Medicare Advantage Program." In this session, MedPAC staff members Scott Harrison and Carlos Zarabozo discussed the continued growth in enrollment in MA plans as well as the level of MA payments and benchmarks in relation to fee-for-service expenditure levels. They also discussed the value of extra benefits offered by MA plans. Specifically, they presented an analysis showing continued growth in MA between November 2007 and November 2008, with continued high access to MA in 2009. In 2009, MA bids were 102 percent of FFS costs for Part A/B, with average MA payments at 114 percent because of the structure of MA benchmarks. HMO bids for regular A/B services were 98 percent of FFS Medicare whereas PFFS bids were 113 percent. Bids for group plans were 109 percent of FFS and higher than individual plan bids within each plan type. Staff noted that the benchmark in Dade County (Miami) increased 13 percent in 2009, which was troubling given the already high benchmarks and also the recent reports of fraudulent claims that likely contributed to the rise. Staff analysis indicated that because of overpayments it cost Medicare $1.30 for each additional dollar of enhanced benefits beneficiaries received through MA. It costs CMS $0.97 for HMOs but $3.26 for PFFS. In 2009, MedPAC will be responding to the annual March reporting requirements and also providing additional input in response to questions posed by Congress in MIPPA on MA payment. Chairman Hackbarth indicated that MedPAC's March report in 2009 would include the enrollment and payment analysis information and reiterate past MedPAC recommendations. The June repot will address the MIPPA questions, with the Commission beginning to discuss this in January 2009.

    - "Analysis of Part D formularies for 2009" In this session, Jack Hoadley of Georgetown and colleagues reviewed information on the 2009 Part D

benefit. Hoadley indicated that a dominant tier structure for Part D seems to be emerging involving one generic tier, two brand tiers (one preferred brand name drugs and one non-preferred) and usually a specialty tier. Also a few plans (7 percent of PDPs and 1 percent of MA) use the defined standard coinsurance (25 percent). Among PDPs, there is a gradual increase in cost sharing for Part D in 2009 whereas MA seems more constant. More drugs are subject to utilization management. Enhanced benefits generally refer to reduced cost sharing rather than larger formularies. This year, for the first time, his team also examined SNPs. These on average cover fewer drugs though the same number of unrestricted drugs. The distinction refers to a difference in dual eligible SNPS rather than other SNPs.