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TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS
Monthly Report for May 2007

Prepared by Stephanie Peterson and Marsha Gold, Mathematica Policy Research Inc.
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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

Enrollment and Penetration, by Plan Type	Current Month: May 2007	Change From Previous Month**	Same Month Last Year	
			May 2006***	Change From May 2006- 2007
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	16,898,195	-27,412	13,898,083	+3,000,112
General*	16,775,009	-27,886	Not Available	Not Available
Employer/Union Only Direct	123,186	-126	Not Available	Not Available
	Not Available	(Total Enrollees)		Not Available
Duals Auto Enrolled in PDPs****		6,270,154	5,826,789	
All others Enrolled in PDP		10,360,026	8,071,294	
Total Medicare Advantage (MA)	8,622,976	+114,432	6,831,626	+1,791,350
Medicare Advantage-Prescription Drug (MA-PD)	7,207,871	+75,800	5,919,562	+1,288,309
Medicare Advantage (MA) only	1,415,105	+38,632	910,475	+504,630
Medicare Advantage (MA) by Type				
MA Local Coordinated Care Plans*** **	6,176,316	+51,032	5,679,600	+496,716
Health Maintenance Organizations (HMOs)	5,707,869	+39,089	5,335,225	+372,644
Provider Sponsored Organizations (PSOs)	74,010	-2,694	76,946	-2,936
Preferred Provider Organizations (PPOs)	391,131	+11,368	267,429	+123,702
Regional Preferred Provider Organizations (PPO)	147,635	+12,089	54,378	+93,257
Medical Savings Account (MSA)	2,261	-68	Not Applicable	Not Applicable
Private Fee For Service (PFFS)	1,558,371	+63,416	579,041	+979,330
General	1,547,827	+63,434	Not Available	Not Available
Employer Direct PFFS	10,544	-18	Not Available	Not Available
Cost	307,379	+244	313,312	-5,933
Pilot******	123,920	-14,608	Not Applicable	Not Applicable
Other*******	307,094	+2,327	Not Available	Not Available
General vs Special Needs Plans******	Not Available	(Total Enrollees)	Not Available	Not Available
Special Needs Plan Enrollees		842,840		
Other Medicare Advantage Plan Enrollees		7,665,704		
Penetration (as percent beneficiaries)**********				
Prescription Drug Plans (PDPs)	38.4%	No Change	31.6%	+6.8%
Medicare Advantage Plans (MA)	19.6%	+0.3%	15.5%	+4.1%
Medicare Advantage-Prescription Drug Plans (MA-PDs)	16.4%	+0.2%	13.4%	+3.0%
Local Health Maintenance Organizations (HMOs),	13.0%	+0.1%	12.2%	+0.8%
Preferred Provider Organizations (PPOs)	0.9%	No Change	0.6%	+0.3%
Provider Sponsored Organizations (PSO)	0.2%	No Change	0.2%	No Change
Private Fee For Service (PFFS)	3.5%	+.01%	1.3%	+2.2%

May 2007 data is from the 5.10.07 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/PrescriptionDrugCovGenIn/02_EnrollmentData.asp**)
*CMS did not provide a breakdown of general and employer/union only direct plans until July 2006.
** The April 2007 data is from data released by CMS on 4.10.07 also on its website
***CMS did not release data specifically for the month of May 2006. The 2006 data reported for May was released in April 2006.
****The data for dual eligibles automatically enrolled in PDPs comes from CMS released data "State Enrollment in Prescription Drug Plans-January 2007 also on its wesbite.
*****The data for the breakdown of MA Local Coordinated Care Plans is from the 5.10.07 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/PrescriptionDrugCovGenIn/02_EnrollmentData.asp).
****** 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 March is from the 2006 SNP Enrollment by Type PDF released by CMS on 3.21.07 and includes counts of 10 or less through March 2007. (See: http://www.cms.hhs.gov/SpecialNeedsPlans)
*********Penetration are 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 May:

Plan Participation, by type	CURRENT MONTH: MAY 2007*	SAME MONTH LAST YEAR	
		MAY 2006**	CHANGE FROM MAY 2006– 2007
MA Contracts (excluding SNP only contracts)			
Total	603	Not Available	Not Available
Local Coordinated Care Plan	410	314	+96
Health Maintenance Organizations (HMOs)	291	198	+93
Preferred Provider Organizations (PPOs) (Includes Physician Sponsored Organizations (PSOs))	119	116	+3
Regional Preferred Provider Organizations (rPPOs)	14	11	+3
Private Fee For Service (PFFS) General Employee Direct	48 47 1	21	+27
Cost	27	18	+9
Medicare Savings Account (MSA)	2	0	+2
Other***	88	Not Available	Not Available

*Contract counts for May 2007 are from the 5.10.07 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/PrescriptionDrugCovGenIn/02_EnrollmentData.asp**)
** 2006 data are based on contacts approved January 2006 and included in the November 2005 release of the Personal Plan Finder. Those data showed a total of 398 contracts, excluding HCPP, PACE and "other" which were not listed in the file.
***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

- This month CMS released several new or updated documents on MA concurrent with the increased Congressional focus on the program, particularly MA payment levels that exceed those in the traditional Medicare program as documented by the Medicare Payment Advisory Commission. In sum, these documents present CMS's perspective on the program, highlighting Administration's concerns that cutbacks in payments will hurt beneficiaries and that these effects will be felt in every area of the country. The documents are available on CMS's main web page (http://www.cms.hhs.gov/) and were the focus of a press briefing. This material included:

    - "Overview of the Medicare Advantage Program, May 2007." This document provides a brief overview on the history of legislation affecting the MA program; MA rebates; satisfaction rates; as well as CMS's view on the importance of chronic care management in the MA program.

    - "Medicare Advantage in 2007" (last updated April 2007): This report covers in more detail the topics in the overview and presents CMS's perspectives on the program. Points made include: how legislation has affected Medicare Advantage Plans; why MA plans are an important option for low-income and minority beneficiaries; how MA plan enrollees receive extra value; as well as information on what might happen if payment for MA were set at 100 percent of FFS. The report also provides information on the role of MA in the future.

    - State Summary Fact Sheets: These one-page fact sheets provide state specific information on how Medicare Advantage policy has affected each state. The fact sheets provide enrollment numbers as well as information on how the state would be impacted if MA payments were set to 100 percent of FFS as well as distribution tables of state counties and MA enrollees based on the impact of 100% of FFS limit.

    - State Press Releases: These press releases provide statements from each state on the effects of Medicare Advantage funding cuts to beneficiary access to services.

    - A power point presentation on MA payment type by state: This includes a color-coded map of each of the 50 states, the United States and the District of Columbia by payment type (2004 FFS; 2005 FFS; 2007 FFS; Blend; Minimum Update; Rural Floor and Urban Floor).

    - A power point presentation on MA penetration by state: This includes a color-coded map of each of the 50 states, the United States and the District of Columbia by penetration rate (the breakdown of penetration rates

includes: less than 1.0%; 1.0%-4.9%; 5.0%-9.9%; 10.0%-14.9%; 15.0%-24.9%; 25.0%-34.9%; 35.0% or more).

- On May 21, 2007, CMS issued proposed rules in the Federal Register that were also announced in a press release titled: "CMS Proposes Reforms of Compliance Requirements for Medicare Advantage Plans. Provisions Also Extend to Part D Prescription Drug Plans." The rules seek to clarify and strengthen its current oversight requirements and penalties for Medicare Advantage and Prescription drug plans. (See below for Congressional hearings that further discuss these issues and the problems that have arisen). The new provisions include 1) mandatory self-reporting and 2) streamlining intermediate level sanctions and contract determinations. This proposed rule is available for comment for 60 days and the final rule will be released later this year. The press release also briefly mentions two other proposed rules: 1) a proposed rule which makes technical changes to the regulations implementing the Part D prescription drug benefit and 2) a proposed rule that would also take effect in 2009 relating to reporting of prescription drug costs. See CMS's website at: http://www.cms.hhs.gov/apps/media/press_releases.asp

    - These proposed rules are available to view in the Federal Register. http://a257.g.akamaitech.net/7/257/2422/11dec20060800/edocket.access.gpo.gov/ua070430/pdf/ua070408.pdf

Relevant to Medicare Advantage

- None

Relevant to Prescription Drug Plans

Of General Interest

- None

Relevant to Special Needs Plans Specifically

- None

OTHER ITEMS OF RELEVANCE

Briefings and Hearings:

- The Senate Committee on Finance held a hearing on May 2, 2007 titled "The Medicare Prescription Drug Benefit: Monitoring Early Experiences." Witness testimony included 1) Kris Gross, Director, Senior Health Insurance Information Program, Iowa Insurance Division, Des Moines, IA; 2) Vicki Gottlich, Senior Policy Attorney, Center for Medicare Advocacy, Inc,. Washington, DC; 3) Tobey Schule,

Sykes Pharmacy, Kalispell, MT; and 4) Timothy Tucker, President-Elect, American Pharmacists Association, Washington, DC. Witness testimony, as well as more information on this hearing is available on the Senate Finance website at: http://www.senate.gov/~finance/sitepages/hearing050207.htm. In addition, witness testimony included:

- Timothy Tucker, President-Elect, American Pharmacists Association, stated that while the drug benefit has helped millions of beneficiaries, there have been delays in reimbursements from health insurers as well as other problems for pharmacies.
- Vicki Gottlich, Senior Policy Attorney, Center for Medicare Advocacy, Inc stated that choosing from so many plans creates a burden and increases the difficulty in making informed and meaningful decisions.
- Kris Gross, Director, Senior Health Insurance Information Program testified that a number of beneficiaries' premiums for the drug benefit have been withheld from them erroneously.

- On May 8, 2007, the Senate Finance Committee held another hearing on Medicare Part D titled, "Medicare Prescription Drug Benefit: Review and Oversight." Witness testimony included 1) Abby Block, Director, Center for Beneficiary Choices, CMS; 2) Beatrice Disman, Regional Commissioner of Social Security, New York Region, and Chair of the Medicare Planning and Implementation Task Force, Social Security Administration, New York, NY; and 3) Kathleen King, Director, Health Care, Government Accountability Office. More information on this hearing as well as testimony is available on the Senate Finance Committee website at: http://www.senate.gov/~finance/sitepages/hearing050807.htm

  - Abby Block, CMS, stated in her testimony that CMS has worked hard to ensure that once enrolled, people with Medicare are able to take advantage of their prescription drug coverage without difficulty. She discussed that Part D in 2007 has resulted in lower drug costs and that consumer satisfaction is high. She also discussed how CMS will be strengthening oversight in 2008 based on lessons learned to date.
  - In her testimony, Beatrice Disman, reinforced Block's statement that SSA is working hard to ensure beneficiaries receive coverage without difficulties. She discussed application improvement efforts as well as initial and ongoing outreach.
  - GAO Director of Health Care, Kathleen King discussed CMS's process for enrolling new dual eligibles into PDPs and provided recommendations for strengthening this process. Her testimony is based on the recently released GAO report (see below for more detail).

- On May 16, 2007, the U.S. Senate Special Committee on Aging held a hearing titled: "Medicare Advantage Marketing & Sales: Who Has the Advantage?" Witness included 1) Abby Block, Director, Center for Beneficiary Choices, CMS; 2) Commissioner Sean Dilweg, Wisconsin Office of the Commissioner of Insurance,

Madison, Wisconsin; 3) Commissioner Kim Holland, Oklahoma Insurance Department, Oklahoma City, Oklahoma; 4) Special Agent Sherry Mowell, Georgia Office of the Commissioners of Insurance, Atlanta, Georgia; 5) Albert Sochor, Vice President and Director of Marketing, Old Surety Life Insurance, Oklahoma City, Oklahoma; 6) Karen Ignagni, President and CEO, America's Health Insurance Plans; 7) Heidi Margulis, Senior Vice President, Humana Inc., Louisville, Kentucky; 8) Peter J. Clarkson, Senior Vice President, Distributions Operations, UnitedHealth Group, Minnetonka, Minnesota; and 9) Gary Bailey, Vice President, Medicare Operational Performance, WellCare, Tampa, Florida. More information on this hearing as well as statements from all witnesses are at: http://aging.senate.gov/hearing_detail.cfm?id=274320&. Below is a summary of some of the witnesses' testimonies:

- Abby Block, Director, Center for Beneficiary Choices, CMS: In her testimony, Block discussed CMS's various oversight activities of sales and marketing by Medicare health plans. She indicated that CMS has strengthened its oversight this year by working with a contractor to develop a risk assessment methodology tool that should be ready for implementation in January 2008. This tool will identify organizations and program areas that represent the greatest compliance risks to CMS so that CMS can focus its attention on those high-risk contracts. Block also discussed other oversight activities including working with state regulators in developing a Memorandum of Understanding (MOU) to share compliance related data; working with other contractors to conduct 'secret shopping' of Medicare plans to learn firsthand what is happening in the market; as well as collecting other performance data from plans to track trends in performance.

- Commissioner Sean Dilweg, Wisconsin Office of the Commissioner of Insurance, Madison, Wisconsin: Dilweg, although not testifying directly under his additional role as chairman of the Senior Issues Task Force of the National Association of Insurance Commissioners (NAIC), shared collective views of the nation's insurance commissioners in his testimony. He stated that consistent complaints from consumers about the marketing and sales of MA and Part D indicate troubling patterns. He also stated that the hands of state regulators are often tied, as states are largely preempted and marketing guidelines are established by CMS. He provided suggestions for improving this situation, such as CMS continuing to make the MOU a high priority.

- Commissioner Kim Holland, Oklahoma Insurance Department, Oklahoma City, Oklahoma: In her testimony, Holland discussed similar views to Dilweg. She stated that the Oklahoma Insurance Department is responding to an unacceptable number of complaints caused by the inappropriate and sometimes fraudulent marketing of Medicare Part D products to beneficiaries by certain insurance companies and their sales producers in which beneficiaries have been mislead or deceived during a sale. She also stressed the importance of the state regulators in having more of a role in

responding to such fraudulent activity through regulatory oversight that CMS currently controls.

- On May 22, 2007, the House Committee on Ways and Means, Subcommittee on Health held a hearing on Medicare Advantage private fee-for-service plans. Witnesses included 1) Abby Block, Director, Center for Beneficiary Choices, CMS; 2) Mark Miller, MedPAC; 3) Sean Dilweg, Commissioner of Insurance, State of Wisconsin, Madison, Wisconsin; 4) Patricia Neuman, Vice President, Henry J. Kaiser Family Foundation, Director, Medicare Policy Project; 5) David Lipschutz, California Health Advocates, Los Angeles, California; 6) Brock Slabach, Administrator, Field Memorial Community Hospital, Centereville, Mississippi, on behalf of the National Rural Health Association and 7) Catherine Schmitt, Vice President, Federal Government Programs, Blue Cross Blue Shield of Michigan, Detroit, Michigan. More information on the hearing as well as all witness testimony is available at: http://waysandmeans.house,gov/hearings.asp?formmode=detail&hearing=561 Also, summary of some of the witness testimony included the following:

    - Abby Block, Director, Center for Beneficiary Choice, CMS: Her testimony included background information on PFFS as well as current information on the benefit structure of PFFS plans, enrollment trends, and examples of the extra benefits that CMS believes PFFS plans provide. She also highlighted CMS's action to concerns over PFFS plans such as strengthening marketing oversight and beneficiary and provider education.

    - Patricia Neuman, Vice President, Henry J. Kaiser Family Foundation, Director, Medicare Policy Project. In her testimony, Neuman discussed why there is a need to focus on Medicare Private fee-for-service plans, stating that over the past two years PFFS has grown much faster than many expected and that recently has shown signs of growing pains. She discussed the role of PFFS under Medicare and how it differs from other plans as well as key issues for beneficiaries and long-term implications for Medicare.

Other

- This month the General Accountability Office (GAO) released a report titled, "Medicare Part D: Challenges in Enrolling New Dual Eligible Beneficiaries." In this report, the GAO analyzed 1) current challenges in identifying and enrolling new dual eligibles; 2) the CMS's effort to address the challenges and 3) federal and state approaches to assigning dual eligible beneficiaries to PDPs. The GAO also made six recommendations to CMS, such as notifying beneficiaries of their right to reimbursement and monitoring the number of individuals provided retroactive coverage. http://www.gao.gov/new.items/d07272.pdf