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

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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

Enrollment and Penetration, by Plan Type	Current Month: March 2008	Change From Previous Month*	Same Month Last Year	
			March 2007	Change From March 2007- 2008
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	17,412,675	+2,698	16,955,406	+457,269
General	17,289,128	+2,677	16,832,402	+456,726
Employer/Union Only Direct	123,547	+ 21	123,004	+543
Duals Auto Enrolled in PDPs**	Not Available	6,180,053	Not Available	Not Available
All others Enrolled in PDP		11,048,642		
Total Medicare Advantage (MA)	9,715,707	+106,255	8,350,765	+1,364,942
Medicare Advantage-Prescription Drug (MA-PD)	8,096,355	+84,045	7,040,909	+1,055,446
Medicare Advantage (MA) only	1,619,352	+22,210	1,309,856	+309,496
Medicare Advantage (MA) by Type				
MA Local Coordinated Care Plans** *	6,890,674	+60,871	6,090,735	+799,939
Health Maintenance Organizations (HMOs)	6,295,357	+40,107	5,644,883	+650,474
Provider Sponsored Organizations (PSOs)	16,483	+683	74,461	-57,978
Preferred Provider Organizations (PPOs)	578,772	+20,112	371,383	+207,389
Regional Preferred Provider Organizations (PPO)	261,962	+4,858	125,883	+136,079
Medical Savings Account (MSA)	3,328	-30	2,182	+1,146
Private Fee For Service (PFFS)	2,108,721	+38,494	1,379,277	+729,444
General	2,095,931	+38,459	1,368,792	+727,139
Employer Direct PFFS	12,790	+35	10,485	+2,305
Cost	270,850	-536	308,611	-37,761
Pilot****	86,826	+3,011	140,590	-53,764
Other*****	93,346	-413	303,487	-210,141
General vs Special Needs Plans******				
Special Needs Plan Enrollees	1,130,264	+12,203	842,840	+287,424
Dual-Eligibles	815,569	+11,402	Not Available	Not Available
Institutional	138,097	-987	Not Available	Not Available
Chronic or Disabling	176,598	+1,758	Not Available	Not Available
Other Medicare Advantage Plan Enrollees	8,585,443	+94,052	7,507,925	+1,077,518
Penetration (as percent beneficiaries)********				
Prescription Drug Plans (PDPs)	39.5%	No Change	38.5%	+1.0%
Medicare Advantage Plans (MA)	22.0%	+0.2%	18.9%	+3.1%
Medicare Advantage-Prescription Drug Plans (MA-PDs)	18.3%	+0.1%	15.9%	+2.4%
Local Health Maintenance Organizations (HMOs),	14.2%	No Change	12.8%	+1.4%
Preferred Provider Organizations (PPOs)	1.3%	+0.1%	0.8%	+0.5%
Provider Sponsored Organizations (PSO)	0.04%	No Change	0.2%	-0.16%
Private Fee For Service (PFFS)	4.7%	No Change	3.1%	+1.6%

March 2008 data is from the 3.04.08 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 February 2008 data is from data released by CMS on 2.13.08 also on its website
**The data for dual eligibles automatically enrolled in PDPs comes from CMS released data "2008 Enrollment-Final LIS by State"-January 2008 also on its website. (http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/01_Overview.asp)
***The data for the breakdown of MA Local Coordinated Care Plans is from the 3.04.08 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/)**
****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 SNP Enrollment Comprehensive Monthly Report released by CMS on 3.04.08 and includes counts of 10 or less. (See: **(http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**)
*******Penetration 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 March:

Plan Participation, by type	CURRENT MONTH: MARCH 2008*	SAME MONTH LAST YEAR	
		MARCH 2007	CHANGE FROM MARCH 2007– 2008
MA Contracts (excluding SNP only contracts)**			
Total	727	604	+123
Local Coordinated Care Plan	509	410	+99
Health Maintenance Organizations (HMOs)	368	291	+77
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	Not Available	Not Available
Other***	78	88	-14

*Contract counts for March 2008 are from the 3.04.08 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/**)
****Data for both March 2008 and March 2007 exclude SNP only contracts.
***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 March 17, 2008, CMS released the 2009 Medicare Advantage (MA), Medicare Advantage-Prescription Drug (MA-PD), and Stand Alone Prescription Drug Plan (PDP) Combined Call Letter. Section A of the letter provides MA and MA-PD cost guidance; Section B provides information for PDP sponsors; Section C contains marketing information for all plan types; Section D contains the 2009 MA, MA-PD Plan Calendar, which includes deadlines for renewal, enrollment, bidding and other provisions. The 2009 Combined Call Letter is available on CMS's website at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/

    - The discussion of benefit design (p.10+) indicates that CMS will continue to scrutinize cost sharing amounts for inpatient acute and psychiatric hospital, home health and DME services. CMS will give greater scrutiny to plans that do not limit beneficiary liability for Medicare benefits to an out of pocket maximum or have a limit that exceeds $3,350 or impose a cap on a subset of services. MA plans with cost sharing amounts greater than original Medicare for renal dialysis, Part B drugs, or skilled nursing facility may be considered discriminatory. Plans approved in CY 2008 will not automatically be considered acceptable for CY 2009.

    - The call letter also indicates that CMS will not be accepting new reward and incentives programs for CY 2009 and expect to develop new guidance for CY 2010 for these potentially valuable programs. PFFS plans that do not use at least a partial network of physicians (i.e. deemed versus network plans) may not include language indicating "There is no coverage for services obtained from providers who have opted out of the Medicare program". They must pay for emergency and urgently needed services by opt out physicians where there is no signed agreement with the patient.

    - The call also indicates that CMS will reconsider any changes in the current 1,000 enrollment threshold for 2009 HEDIS reporting, with an announcement by December 31, 2008. CMS also is developing reporting requirements for MA beginning 2009, most likely with web entry. Areas of interest include: administrative stability, network stability, claims payment, organizational determinations and denials of coverage, grievances, enrollment, disenrollment and call center customer service. CMS intends to rely on a more data driven approach to monitoring compliance of MA and MA-PD contractors.

    - New SNP applications will not be accepted for 2009. Previous policy allowing marketing of non SNP plans to a special needs population will not be allowed in 2009. CMS discusses the 2008 experience with models of care, indicating that for auditing purposes existing SNPs should update their SNP model of care to include at least eight elements: goals and objectives relevant to the targeted special needs beneficiaries;

comprehensive risk assessment (with a sample tool); specialized provider network; coordinated care and case management; service delivery system (including protocols and out-of-network specialists); communication and accountability system; SNP training for network resources; performance measurement and improvement activities. SNPs are encouraged but not required to post their models of care on the plan web site. Because chronic care SNPs have experienced difficulty obtaining timely physician verification of conditions, CMS has approved use of a Pre-enrollment Qualification Asessment tool that meets specified conditions. CMS lists the conditions covered in currently approved chronic care SNPs and notes that they intend to work with industry experts and beneficiary advocates to further define "severe and disabling chronic conditions" in the coming year.

- The call reiterates CMS's concerns with marketing of PFFS and reminds plans to meet CMS requirements and make sure agents/brokers are trained. PFFS plans are also strongly encouraged to develop a provider education and outreach program. CMS lists examples of desirable practices. PFFS plans are required to use prominently revised disclaimers built on the original May 25, 2007 guidance. PFFS plans are strongly encouraged to participate in HEDIS and HMO if they meet minimum requirements; such data will be posted on www.Medicare.gov.

- CMS will seek to strengthen its partnerships with employer and union sponsored group plans in 2009. To this end, CMS will (1) permit employer/union sponsors to enroll beneficiaries in both an "800 series" local MA only CCP and an "800 series" standalone PDP: (2) special procedures will be used to accommodate formulary changes in non-calendar year Part D EGWP plan packages; (3) network access submission requirements MA only plans that include both individual and 800 series plans will initially not be required to have networks in place for areas out of their individual plan service areas though they will once the plan enrolls members. Other network issues also are addressed.

- CMS also released two solicitations for applications for both new PDP plans and new MA-PD plans for the 2009 contract year. The solicitations include the application schedule as well as detailed information on the application review processes (specific for PDPs and MA-PDs respectively). The documents also provide information on technical support available as well as information on automatic enrollment and other background information. These documents are also available on CMS's website at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.asp#TopOfPage

Relevant to Medicare Advantage

- None

Relevant to Prescription Drug Plans

- None

Of General Interest

- The Department of Health and Human Services (DHHS) released this month the Medicare Trustees Report. The HI trust fund is projected to be exhausted in 2019; the same as last year's though at an earlier point in the year. The 75 year actuarial deficit is the same as last year. Future Part B costs will depend on what Congress does with physician payments and about premium and general revenue funding which under current statute are adjusted to cover expected costs. In its press release, HHS discusses Medicare's poor fiscal health, stating in comparison to the status of the Part A and Part B programs, expenditures for Part D have been lower than projected. The press release states that the 2007 report continues to project lower spending primarily due to a significant reduction in bids. However costs over time are still expected to increase at an average annual rate of about 11.1 percent through 2017. This press release is available on DHHS website at: http://www.hhs.gov/news/press/2008pres/2008.html

Relevant to Special Needs Plans Specifically

- This month, CMS released a document titled "Special Needs Plans: Structure and Process Measures." This document provides detailed information for the required measures SNP plans must report on beginning March 14, 2008. The quality measures were developed by the NCQA with the support of a Geriatric Measurement Panel; 13 measures were posted for public review in December-January 2008. The final list of measures includes complex case management (identifying members for case management, access to case management, case management systems, frequency of member identification, providing members with information, case management process, and informing and educating practitioners); improving member satisfaction (assessment of member satifaction, opportunities for improvement); and clinical quality improvements (relevance to members). The document includes information on the intent for each measure; the data source; the scope of review; an explanation for each measure as well as scoring information for each organization. This document is available on CMS's website at: http://www.cms.hhs.gov/SpecialNeedsPlans/

OTHER ITEMS OF RELEVANCE

Briefings and Hearings:

- On March 11, 2008, the Committee on Ways and Means Subcommittee on Health held a hearing on MedPAC's annual March report with MedPAC chairman, Glenn Hackbarth. In his testimony, Hackbarth discussed MedPAC's updated estimates of MA payments relative to traditional Medicare, stating that MA payments are projected to be 113 percent of expected FFS expenditures in 2008. Plan bids for the traditional Medicare benefit package are projected to be 101 percent of FFS, which means that MA plans, on average now, are less efficient than traditional Medicare program. He then discussed the seven recommendations on SNPs outlined in the report. In addition, Hackbarth discussed the Part D enrollment, benefit offerings, and plan payments, stating that MedPAC also recommends that Congress should direct DHHS to make Part D claims data available to CMS and other federal agencies on a regular and timely manner for purposes of program evaluation, public health, and safety. More information on this hearing including the full witness testimony is at: http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=618

Other

- This month, MedPAC released a report titled "Facilitating Access to Medicare Part D Drug Claims." This report was written under contract to MedPAC by Elizabeth Hargrave of NORC at the University of Chicago and Jack Hoadley at Georgetown University. In their report, the authors discuss how CMS is currently using drug claims data for plan payment only-the strict interpretation of the law for allowable uses of the data. The authors argue that it is imperative that the data be made available to CMS and other federal agencies in order to fully evaluate and oversee the Part D program. The authors cite MedPAC's March 2008 report to Congress in which MedPAC recommends this data be made available for purposes of program evaluation, public health and safety as well. The authors' state in their report that claims data is critical to understanding the successes and failures of the program. The report also addresses how potential data release can be done without compromising individuals privacy or secrecy of proprietary information. This document is available at: http://www.medpac.gov/documents/Mar08_PartD_CONTRACTOR_RS.pdf

- MedPAC also held a public meeting on March 5 and 6, 2008. One session was relevant to Medicare Advantage and PDPs: The session was titled, "Part D and Performance Measures." In this session, MedPAC presented ideas on how to evaluate the drug benefit stating that findings from their expert panel included that Part D needs performance measures to evaluate how well plans meet cost, access, quality and customer service goals. The expert panelists did not believe that the current measures adequately measure access or clinical care. In particular, one proposed measure for access would calculate whether beneficiaries received their prescribed drug or its alternative without delay. MedPAC also presented findings from recent focus groups with beneficiaries, pharmacists and providers on their

experience with the drug benefit. Physicians and pharmacists in the focus groups stressed that poor communication between plans; pharmacists and physicians could result in delays before beneficiaries received needed medication. They suggest more standardized messaging between plans and pharmacists as a way to improve beneficiary access and reduce administrative costs. (More information on this session as well as the full testimony of the hearing is also available on MedPAC's website).

- MedPAC's next public meeting will be held on April 9 and 10th at the Ronald Reagan Building in Washington DC. An agenda for the meeting is usually posted one week prior to the meeting and should be available soon at MedPAC's website: www.medpac.gov.