TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS
Monthly Report for August 2009

Prepared by Stephanie Peterson and Marsha Gold, Mathematica Policy Research Inc.
as part of work commissioned by the Kaiser Family Foundation

PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

Enrollment and Penetration, by Plan Type	Current Month: August 2009	Change From Previous Month*	Same Month Last Year	
			August 2008	Change From August 2008- 2009
Enrollment				
Total Stand-Alone Prescription Drug Plans (PDPs):	17,507,036	+44,671	17,390,836	+116,200
Individual	16,552,227	+41,885	16,502,500	+49,727
Group**	954,809	+2,786	888,336	+66,473
Total Medicare Advantage (MA)	11,191,237	+49,847	10,152,845	+1,038,392
Individual	9,211,234	+43,779	8,383,761	+827,473
Group	1,980,003	+15,068	1,769,084	+210,919
Medicare Advantage-Prescription Drug (MA-PD)	9,531,551	+57,142	8,457,712	+1,073,839
Medicare Advantage (MA) only	1,659,686	-7,295	1,695,133	-35,447
Medicare Advantage (MA) by Type				
MA Local Coordinated Care Plans** *	7,908,012	+34,180	7,150,777	+757,235
Health Maintenance Organizations (HMOs)	6,931,349	+23,245	6,461,776	+469,573
Provider Sponsored Organizations (PSOs)	16,243	+167	18,419	-2,176
Preferred Provider Organizations (PPOs)	960,378	+10,765	670,537	+289,841
Regional Preferred Provider Organizations (PPO)	430,962	+4,171	293,234	-137,728
Medical Savings Account (MSA)	3,477	+41	3,563	-86
Private Fee For Service (PFFS)	2,451,434	+11,918	2,284,639	+166,795
Individual	1,705,235	+4,396	1,674,554	+30,681
Group and RFB****	746,199	+7,522	610,085	+136,114
Cost	290,248	+1,147	272,429	+17,819
Pilot*****	18,650	-1,710	55,747	-37,097
Other******	88,454	+100	92,456	-4,002
General vs Special Needs Plans***** **				
Special Needs Plan Enrollees	1,346,877	+12,888	1,244,425	+102,452
Dual-Eligibles	944,587	+6,990	880,039	+64,548
Institutional	116,400	-4,94	132,087	-15,687
Chronic or Disabling	285,890	+6,392	232,299	+53,591
Other Medicare Advantage Plan Enrollees	9,844,360	+36,959	8,908,420	+935,940
Penetration (as percent beneficiaries)********				
Prescription Drug Plans (PDPs)	39.8%	+0.1% point	39.7%	+0.1% point
Medicare Advantage Plans (MA)	24.8%	+0.1% point	22.7%	+2.1% points
Medicare Advantage-Prescription Drug Plans (MA-PDs)	21.1%	+0.1% point	18.8%	+2.3% points
Local Health Maintenance Organizations (HMOs),	15.4%	+0.1 % point	14.4%	+1.0% points
Local Preferred Provider Organizations (PPOs)	2.1%	No Change	1.4%	+0.7% points
Private Fee For Service (PFFS)	5.4%	No Change	5.1%	+0.3% points

August 2009 data is from the 8.21.09 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 July 2009 data is from data released by CMS on 7.14.09 also on its website
**The breakdown by Group includes Employer/Union Only Direct Contract PDP (123,044)
***The data for the breakdown of MA Local Coordinated Care Plans is from the 8.21.09 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.
****The breakdown by Group includes Employer Direct PFFS (13,609) and RFB-PFFS (154)
*****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 August is from the SNP Enrollment Comprehensive Monthly Report released by CMS on 8.21.09 and includes counts of 10 or less. (See: (**http://www.cms.hhs.gov/MCRAdvPartDEnrolData/**).
********Penetration for August and July 2009 is calculated using the number of eligible beneficiaries reported in the August 2008 MA State/County Penetration file. August 2008 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 August:

Plan Participation, by type	CURRENT MONTH: AUGUST 2009*	SAME MONTH LAST YEAR	
		AUGUST 2008	CHANGE FROM AUGUST 2008– 2009
MA Contracts			
Total	751	734	+17
Local Coordinated Care Plan	545	510	+35
Health Maintenance Organizations (HMOs)	375	369	+6
Preferred Provider Organizations (PPOs) (Includes Physician Sponsored Organizations (PSOs))	170	141	+29
Regional Preferred Provider Organizations (rPPOs)	14	14	0
Private Fee For Service (PFFS) General Employee Direct RFB	72 69 2 1	79 77 2 NA	-7 -8 0 NA
Cost	22	25	-3
Medicare Savings Account (MSA)	2	9	-7
Special Needs Plans Dual-Eligible Institutional Chronic or Disabling Condition	415 252 63 100	443 270 66 107	-28 -18 -3 -7
Other**	96	86	+10

*Contract counts for August 2009 are from the 8.21.09 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 August 13, 2009, CMS released the first set of estimates from the 2010 bids that will determine the prices paid for MA plans and premiums charged to beneficiaries.

    - The national average monthly bid for 2010 is $88.33. This calculation reflects an enrollment weighted average monthly amount for each PDP and each MA-PD that uses June 2009 as the reference month. (The calculation excludes MSAs, MA PFFS, SNPs, PACE, cost and selected other plans).

    - The Part D base beneficiary premium, reflecting legislated policy on the beneficiary contribution percent, will average $31.94 for 2010 though individual premiums will vary.

    - The regional low-income subsidy premium amount, which varies from a low of $24.75 in Arizona to $40.89 in Idaho/Utah, determines plans eligible to enroll LIS eligibile beneficiaries at no cost to the beneficiary. These calculations are based on LIS enrollment in PDPs and MA-PDs in 2009. For 2010, CMS modified the methods by using Part D premiums *before* Part A/B rebates were applied.

    - The Medicare Advantage regional preferred provider organization benchmarks, which represent a mix of statuatory and plan bid components. (Nationally the mix is $76.3 percent statuatory and 23.7 percent plan bid). In 2010, regional PPOs will be offered in 20 of the 26 regions, down one from prior years which appears to reflect a change in region 4 (New Jersey). This information is available at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmark2010.pdf

    - Along with the data, CMS released a press release titled "Medicare Prescription Drug Plan Premiums to Increase Slightly. Medicare Beneficiaries May Need to Enroll in New Plans," which provides a summary of the data that was released. The release, based on CMS's analysis, indicates that the average monthly premium a beneficiary will pay in 2010 will be $30, an increase of $2 over the average premiums of $28. These estimates differ from the average monthly bid because they take into account the influence of the low income subsidy and its affect on plan choice.(Those eligible for the LIS premium must enroll in a plan whose premium is below the LIS subsidy amount to avoid additional charges). CMS estimates that 800,000 current MA enrollees will need to switch plans or be reassigned because they are in plans whose premiums will exceed the LIS premium cap in 2010, a number half that of 2009. 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

- On August 19, 2009, CMS released final PDP enrollment and disenrollment guidance update for CY 2010. In addition to the updated manual, CMS also provides a shorter, tabular document summarizing the changes. These changes include a new section describing qualifications for PDPs to receive auto/facilitated enrollments. There are three criteria for qualifying: 1) basic coverage; 2) premium at or below LIS premium subsidy amount in region; 3) meets requirements critical for ensuring effective enrollment of dual eligibles in the 8/31/06 guidance. Other changes included general typos, added references as well as clarifications of certain sections (such as clarification that online enrollment is limited to sponsor's website and enrollment through broker enrollment websites is not allowed). The updated manual and summary document are both available on CMS's website at: http://www.cms.hhs.gov/MedicarePresDrugEligEnrol/

Of General Interest

- None

Relevant to Special Needs Plans Specifically

- CMS recently released a memorandum to all Medicare Advantage Organizations (MAOs) offering SNPs. The memorandum specifically provides contract guidance for all MAOs and State Medicaid agencies offering coverage to dual eligibles. The memorandum states that all organizations seeking to offer new dual eligible (DE) SNPs or those seeking a service area expansion have to have a contract with their State Medicaid agency in the 2010 contract year. (Existing CMS approved DE SNPs without State Medicaid agency contracts may continue to operate and enroll beneficiaries in 2010 and are not required to have a contract in place). The finalized State Medicaid/SNP contract is due to CMS by October 1, 2009. The contract must include information on 8 components, which are discussed in more detail in the memorandum. The 8 components include: 1)The MAOs responsibility to provide or arrange Medicaid benefits; 2) The eligibility category(ies) of the SNP; 3) The Medicaid benefits covered under the SNP; 4) The cost-sharing protections covered under the SNP; 5) The identification and sharing of information on Medicare provider information; 6) The verification process of enrollment for both Medicare and Medicaid; 7) The service area covered under the SNP, and 8) The contracting period. The memorandum is available on CMS's website at: http://www.cms.hhs.gov/SpecialNeedsPlans/Downloads/SNPs_HPMS_DE_ContractElemnts07-17-09.pdf