CHAPTER 4

Update on Medicare private plans

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Chapter summary

Private plans participate in Medicare through the Medicare Advantage (MA) program and as sponsors of prescription drug plans. In the past couple of years, plan participation in MA has grown substantially, with significant growth in enrollment. In delivering Medicare's outpatient prescription drug benefit, sponsoring organizations (both MA and stand-alone prescription drug plans) are offering a wide variety of plans and have many enrollees.

The Commission supports the private plan option offered through the MA program. Medicare beneficiaries should be able to choose between the fee-for-service (FFS) Medicare program and the alternative delivery systems that private plans can provide, so long as the choice is financially neutral to the program. The Commission's past recommendations about MA plans emphasize financial neutrality between payment rates in the FFS program and the MA program. However, our analyses of MA payments and plan participation show that benchmarks and program payments in MA are well above 100 percent of FFS levels. Specifically, in 2006, MA program payments

In this chapter

were 112 percent of FFS expenditure levels, and benchmarks were at 116 percent of FFS, a slight increase over earlier estimates, due primarily to growth in private fee-for-service (PFFS) plans.

The share of program payments used to fund extra benefits and reduced premiums varies by plan type. The highest level of extra benefits and reduced premiums in 2006 was among HMO plans; the lowest was among preferred provider organizations and PFFS plans.

Enrollment in MA grew substantially in 2006, with PFFS accounting for nearly half the growth. Medicare private plan penetration (the percent of beneficiaries enrolled in private plans of any type) reached 17 percent in 2006, approaching the historical high of 18 percent in 1999. All beneficiaries have access to at least one MA plan in 2007. Access to plans with no Part C (MA) premium for the coverage of Medicare Part A and Part B services, no premium for any additional services the plan may cover (e.g., dental or vision care not covered by Medicare), and no Part D premium increased in 2007, with 86 percent of Medicare beneficiaries residing in an area where at least one MA plan offered such coverage. About 31 percent of Medicare beneficiaries have access to an MA plan that eliminates or reduces their Part B premium obligation, with 16 percent of beneficiaries having access to a plan that covers the entire standard Part B premium ($93.50 per month in 2007).

Our analysis of Part D plan offerings for 2007 shows that more plans entered the market for 2007 than in 2006. The defined standard benefit structure and enhanced benefits (basic plus supplemental coverage) make up bigger shares of stand-alone prescription drug plans (PDPs) for 2007; plans with the same average value as the standard benefit but with alternative benefit designs (called actuarially equivalent basic benefits) make up a smaller share of PDPs. Coverage in the gap is more common than last year, usually in the form of generic drug coverage only.

The range of Part D premiums for basic benefits narrowed over the two years. The average premium offered by basic plans is lower but the average for enhanced plans is higher (both these averages are unweighted). If enrollees remain in the same plan for 2007, the premium (calculated across PDPs and Medicare Advantage–Prescription Drug plans) would be about $25 per month in 2007 compared with $23 in 2006 (these averages are weighted for enrollment).

The Medicare law called for weighting Part D plan bids for 2007 with plans' 2006 enrollment when calculating the national average bid (called enrollment weighting). Because enrollees tended to choose plans with lower premiums, enrollment weighting would have led to a lower government subsidy, which would mean lower Medicare program payments and higher enrollee premiums. CMS chose not to use enrollment weighting fully, which increases program payments, lowers enrollee premiums, and raises Medicare's Part D subsidies over those called for by law.

The Medicare law also calls for enrollment weighting in the formula for calculating each region's low-income premium subsidy amount for 2007. CMS also chose not to do this. Enrollment weighting would have led to fewer premium-free plans available for recipients of low-income subsidies (LIS), which meant that large numbers of LIS enrollees may have had to change plans or pay more to stay in the same plan. Using unweighted premiums avoids disruption but increases payments to plans from the program.

For both actions, CMS is using its general demonstration authority to transition to enrollment weighting over time. According to CMS's Office of the Actuary (OACT), the demonstrations will raise Medicare spending in 2007 by $1 billion relative to current law—$0.6 billion for higher program payments that limit the increase in enrollee premiums and $0.4 billion for the transition in setting LIS premium thresholds. OACT also estimates that the LIS premium threshold demonstration will reduce the number of LIS beneficiaries who must switch plans or pay a partial premium from 3.3 million (46 percent) to 0.5 million (7 percent). ■

Medicare Advantage benchmarks and payments compared with average Medicare fee-for-service spending

The Commission supports private plans in the Medicare program. Medicare beneficiaries should be able to have a choice between the fee-for-service (FFS) Medicare program and the alternative delivery systems that private plans can provide. Private plans have the flexibility to use care management techniques that FFS Medicare does not allow, and—if paid appropriately—they have greater incentive to innovate. The Commission supports financial neutrality between payment rates for the FFS program and the Medicare Advantage (MA) program. Financial neutrality means that the Medicare program should pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses. Our analysis of plan benchmarks and MA payment levels in relation to Medicare FFS expenditure levels shows that benchmarks and MA program payments continue to be well above FFS levels.

In June 2006, MedPAC released an issue brief, *Medicare Advantage Benchmarks and Payments Compared with Average Medicare Fee-for-Service Spending*, which found that program payments to MA plans in 2006 were 111 percent of spending on similar beneficiaries in Medicare's traditional FFS program. The issue brief also noted that MA benchmark levels were 115 percent of FFS expenditure levels. In this section, we update the earlier analysis using new enrollment data for 2006, and we refine it to present information by plan type and by geographic groupings. The new analysis shows similar results, with benchmarks at 116 percent of FFS rates and MA payments at 112 percent of FFS rates (Table 4-1, p. 244). Information about the methodology used is in the text box on p. 245.

The benchmark is a bidding target under the bidding system for MA plans that began in 2006. If a plan bid is below the benchmark, enrollees receive extra benefits or reduced out-of-pocket costs; for bids over the benchmark, enrollees pay a premium equal to the amount by which the bid exceeds the benchmark. The local MA benchmarks are based on the county-level payment rates used to pay MA plans before 2006. Those payment rates were at least as high as per capita FFS Medicare spending in each county, with some counties having rates significantly higher than FFS as a result of specific statutory changes, as explained on p. 245. Under the provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), from one year to the next, county benchmarks are updated in one of three ways—using whichever method results in the highest increased benchmark. Generally, the local benchmarks would be updated by the national growth rate in per capita Medicare spending. If the national growth rate is less than 2 percent, benchmarks are increased by 2 percent. The third possibility (if a higher benchmark is the result) is to set the benchmark of a given county at an amount equal to the FFS expenditure level for the county.[1] For purposes of implementing the latter provision, CMS is required to determine FFS rates for each county at least every three years. The county FFS rates used for our analysis are the 2007 county rates (deflated to 2006 levels) published by CMS, which form the basis of payment for counties where benchmarks are based on FFS rates.[2]

If a local plan is operating in multiple counties, the benchmark for the plan is the average of county benchmarks, weighted by the enrollment the plan expects from each county. The benchmarks of regional preferred provider organization (PPO) plans are computed differently. A statutory component (as it is termed in the law) is the primary determinant of regional benchmarks. It is the average of all the local county benchmarks in the region, weighted by the Medicare population in each county. The other component of the regional benchmarks that determines the final regional benchmark is the enrollment-weighted average of the regional PPO bids. The bid component of the final benchmark for each region is given a weight equal to the national level of MA penetration (the percent of Medicare beneficiaries enrolled in MA across the nation).

The detailed analysis of the benchmark and payment data presented here provides a clear understanding of what is happening in the MA program, bringing to light certain information that is not evident when dealing only with aggregate numbers. For example, the analysis of payments by different geographic classifications shows the extent to which the history of statutory payment changes has influenced the current landscape of the program. We specifically discuss the case of Puerto Rico, but other noteworthy geographic differences in benchmark and payment levels reflect statutory changes—the differences between floor and nonfloor counties and the differences between rural and urban counties. In the latter case, because MA enrollment is so heavily concentrated in urban areas, aggregate figures do not show the effect of the relatively higher benchmarks and higher payment rates

TABLE 4–1

Medicare Advantage benchmarks and payments are higher than average Medicare fee-for-service spending

	Enrollment as of July 2006 (in thousands)	Benchmark relative to FFS expenditures	Payments for MA enrollees relative to FFS expenditures
All MA plans with bids			
Including Puerto Rico	6,877	116%	112%
Excluding Puerto Rico	6,585	115	111
Floor status of counties			
Nonfloor	3,394	111	106
Large urban floor	2,683	121	117
Other floor	800	134	128
Urban/rural status			
Urban	6,244	116	112
Rural	633	121	117
Plan type			
HMO	5,195	115	110
Local PPO	285	120	117
Regional PPO	82	112	110
PFFS	774	122	119
SNP			
Including Puerto Rico	541	123	118
Excluding Puerto Rico	391	115	111
Beneficiary eligibility			
All in service areas	5,948	116	112
Employer groups only	929	116	114

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and fee-for-service expenditures.

for rural areas, where benchmarks are 121 percent of FFS compared with the urban benchmarks of 116 percent of FFS (which is the same as the overall benchmark level of 116 percent of all plans combined). However, rural enrollment is growing at a far faster rate than urban enrollment, and therefore aggregate numbers may change as a reflection of the changing geographic composition of MA enrollment.

Similarly, the analysis by plan type highlights major differences in benchmark levels, payments, and rebate dollars across plan types. Health maintenance organizations (HMOs), the plan type with the majority of enrollment, have so large a share of the total enrollment that by itself this category virtually determines the aggregate figure of benchmarks at 116 percent of FFS. The overall figure masks the significant variation between HMOs (with benchmarks at 115 percent of FFS) and plans with looser networks (PPOs, with benchmarks at 120 percent for local PPOs) or non-network plans (private fee-for-service (PFFS), with benchmarks at 122 percent). However, unlike the situation with regard to rural versus urban enrollment, the rapid, large growth in enrollment in PFFS plans has already affected the results of our analysis. The detailed information by plan type also shows that about 15 percent of MA enrollment is in employer group plans, a segment of the MA market we will look at more closely in the future.

The overall results reported in the June issue brief included data for Puerto Rico. For the updated analysis,

A note on the methodology for the benchmark and payment analysis

As discussed in the June 2006 issue brief regarding benchmarks and payment rates, the methodology used in this analysis is an improvement over that used for past analyses. In 2004, a similar MedPAC analysis did not consider the relative health status of enrollees in Medicare plans. Because enrollees were healthier than average, the 2004 estimate of Medicare Advantage (MA) program payments in relation to fee-for-service expenditures (computed as 107 percent) understated the difference. In 2004, a portion of program payments was risk adjusted, but we had no information to calculate the differences in health status between plan enrollees and Medicare beneficiaries not enrolled in plans.

CMS now publishes an estimate of the relative health status of plan enrollees, enabling us to consider health status when comparing benchmarks and MA payment rates with FFS expenditures. The CMS risk adjustment system applied to 75 percent of each enrollee's payment in 2006; 25 percent was adjusted solely by demographic and geographic factors. In 2007, 100 percent of the payment is adjusted by health status factors. However, a hold-harmless adjustment increased the benchmark rates in 2006 by the amount CMS expected payments to decrease because of risk adjustment due to the better average health status of plan enrollees. The data presented here include the effect of this hold-harmless provision. This hold-harmless adjustment is scheduled to decline over time because of the Deficit Reduction Act of 2005, but in 2006 the provision raised the benchmarks significantly. The impact of the decline in the hold-harmless effect on payments starting in 2007 cannot be estimated because payments depend strongly on future plan bids and the mix of enrollees that plans attract. ■

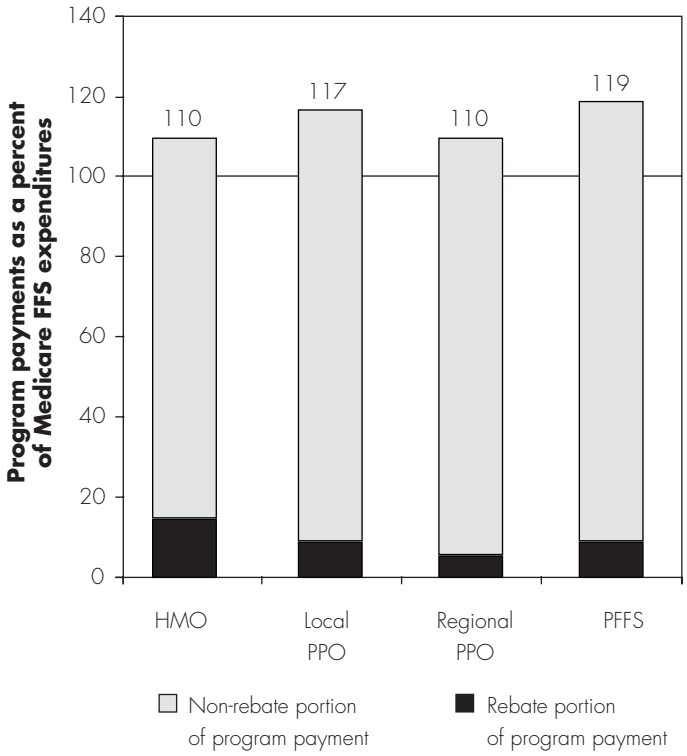
we examined some of the data with and without results for plans in Puerto Rico, where the MA market has some unusual characteristics. Benchmarks are 150 percent of FFS expenditure levels, and a very high proportion of beneficiaries are enrolled in special needs plans (SNPs) in Puerto Rico—150,000 beneficiaries, about one-quarter of all SNP enrollees in 2006.[3] Excluding Puerto Rico from the overall statistics in the updated analysis results in benchmarks being 115 percent rather than 116 percent of FFS and puts MA payments at 111 percent rather than 112 percent of FFS. Overall SNP benchmarks, without Puerto Rico, were 115 percent rather than 123 percent; SNP program payment levels would have been at 111 percent rather than 118 percent of FFS if Puerto Rico had been excluded (Table 4-1). Excluding Puerto Rico does not affect values for plan types other than SNPs.

With regard to the updated overall results of benchmarks at 116 percent and payments at 112 percent of FFS, the slight increases between the updated analysis and the June 2006 analysis are primarily due to the enrollment growth among MA PFFS plans. The earlier analysis was based on enrollment as of December 2005, when enrollment in PFFS plans stood at 209,000, compared with the July 2006 PFFS enrollment of 774,000 used for the update. Overall enrollment grew from about 5.5 million in December 2005 to nearly 7 million in July 2006, with PFFS plans accounting for about 46 percent of the growth.[4]

Benchmark differences by area and by type of plan

The updated analysis provides information on how the benchmarks vary by area and by type of plan. One source of the variation by area reflects statutory provisions that introduced minimum county payment rates, or floors, intended to attract or retain Medicare health plans in counties paid at a floor rate.[5] Floor rates as such are no longer a basis of plan payment, but what were historically floor counties generally continue to have higher payment rates than nonfloor counties in relation to FFS expenditure levels. The counties that had been floor counties have very high relative benchmark levels compared with other geographic areas—121 percent of FFS for the "large urban floor" and 134 percent, the highest benchmark level, for the "other floor." The latter floor was established in the Balanced Budget Act of 1997 (BBA). The "large urban floor" was enacted into law three years after the BBA floor was introduced and applies to counties within large metropolitan statistical areas. What we label as the "other floor" is often referred to as the rural floor because it applied mainly to rural counties and was intended to bring coordinated care plans (HMOs or PPOs) to rural areas.

FIGURE 4–1 **Program payments exceed FFS expenditures but vary by plan type**



Note: FFS (fee-for-service), PPO (preferred provider organization), PFFS (private fee-for-service). Rebate is the amount of program payments used to finance extra benefits or reduced out-of-pocket costs for enrollees.

Source: MedPAC based on bid and fee-for-service expenditure data from CMS.

What has transpired instead is that PFFS plans, which are not coordinated care plans, have become the predominant option in rural areas.

While we present the analysis by plan type, it has a geographic element because different plan types tend to be offered in different geographic areas. Except for regional PPOs, separate benchmarks are not established for each type of plan. Benchmarks for plans other than regional PPOs are established for each county and apply to each local (nonregional) plan type operating in the county. The analysis by plan type is a different way of examining the geographic distribution of enrollment with respect to benchmarks and payments. Looking at the data in this manner, among plan types, PFFS plans have the highest benchmark levels (other than SNPs, when Puerto Rico is included in the SNP data), reflecting their concentration in floor counties. Nearly 40 percent of PFFS enrollment came from rural counties in 2006. PFFS plans also draw substantial enrollment from the "large urban floor" counties. Only 13 percent of PFFS enrollment in 2006 was from nonfloor counties.

HMOs and local PPOs are more likely to be offered in urban than in rural areas. The benchmark level of HMOs, at 115 percent of FFS, is therefore similar to the urban area benchmark level of 116 percent. The benchmark level for regional PPOs is the lowest among plan types because regional plans cannot select which counties to include in their service area (i.e., they cannot choose to operate only in urban counties or only in rural counties) and because of the population-based formula used to determine regional benchmarks.[6]

Among the categories analyzed, the benchmarks for nonfloor counties are closest to FFS levels, at 111 percent. These counties are primarily urban areas, where the floor provision does not apply and payment rates are more likely to be based on Medicare FFS expenditures.

Payments and payment differences by area and by type of plan

The updated data show payments made to MA plans based on bids, by area and type of plan, and overall (Table 4-1, p. 244). All geographic areas and all plan types have program payments that exceed FFS expenditure levels. Among payment categories, the "other floor" counties have the highest program payments in relation to FFS, at 128 percent. Among plan types, PFFS plans, with enrollment concentrated in floor counties, have the highest program payments relative to FFS expenditures—at 119 percent. Local PPOs also have high program payments in relation to FFS, which is likely a reflection of less aggressive bidding on the part of such plans (reflecting the looser network structure and coverage of out-of-network care). The nonfloor counties have the lowest program payments in relation to FFS, at 106 percent. The nonfloor areas are likely to be those that historically had Medicare plans that offered rich benefit packages to enrollees.

By statute, if a plan bids below the benchmark, a portion of the Medicare payments that plans receive is used to fund extra benefits for enrollees or reduced Part B, C, or D premiums. When a bid is below the benchmark, 25 percent of the difference between the bid and the benchmark is retained in the Trust Funds, and 75 percent of the difference—referred to as the "rebate" amount—is paid to the plan to provide extra benefits and reduced premiums. Most plans are bidding below benchmark levels (and thereby can offer richer benefit packages), which explains

why program payments are at 112 percent of FFS overall while benchmarks are at 116 percent of FFS.

CMS calculates plan payments and enrollee premiums in the following manner. First, a plan submits a bid, which is the MA plan's statement of its revenue needs for providing the Medicare Part A and Part B benefit package to the population that it expects to enroll. CMS compares the bid to the appropriate benchmark amount for the plan, with the benchmark being the maximum possible plan payment from the Medicare program. When a plan bid is at or above the benchmark, there is no rebate amount, and the program payment would be the benchmark. The amount by which the bid exceeds the benchmark is a premium a beneficiary must pay to enroll in the plan. If a bid is below the benchmark, plans receive Medicare program dollars to finance the traditional Medicare Part A and Part B benefit package, as well as program dollars—the rebate amounts—that pay for extra benefits and reduced premiums.[7]

For each type of plan shown in Table 4-1 (p. 244), program payments include rebate dollars. Using the PFFS plans as an example, benchmarks are at 122 percent of Medicare FFS expenditure levels and program payments are 119 percent of FFS. For the PFFS plans, the portion of Medicare program payments that represents the cost of providing the Medicare Part A and Part B benefit, on average, is about 110 percent of expenditure levels in traditional Medicare FFS. Therefore, for PFFS plans, there is a 12 percentage point difference between average benchmarks (at 122 percent of FFS) and the plans' average bids for the Medicare Part A and Part B benefit. Of the 12 percentage point difference between the bid and the benchmark, one-quarter (averaging 3 percent of FFS expenditures) is retained in the Trust Funds, and three-quarters (averaging 9 percent of FFS expenditures) is added to the plans' bids to determine the total Medicare program payments to the plans. Thus, for PFFS plans, the Medicare program pays the bid for Part A and Part B services—at 110 percent of FFS expenditure levels—plus the rebate amount that averages 9 percent of FFS expenditures. The total amount of Medicare program payments to PFFS plans averages 119 percent of FFS expenditure levels (Table 4-1, p. 244, and Figure 4-1).

The highest bid-to-benchmark difference among types of plans is for HMOs. Overall, HMO benchmarks are at 115 percent of FFS and payments are at 110 percent of FFS, meaning that, on average, the Trust Funds retain 5 percentage points of the amount by which the benchmarks exceed FFS (representing 25 percent of the difference between the benchmark and the bid). This also means that, on average, HMO bids include rebates (75 percent of the difference between the bids and benchmarks, for bids below the benchmark) valued at about 15 percent of FFS payment rates (Figure 4-1). A similar situation occurs with SNP plans, as they are predominantly HMO-model plans.

In some counties in south Florida, the difference between bids and benchmarks is such that actual MA payment rates are below Medicare FFS rates. That is, bids are low enough in relation to the benchmarks that 25 percent of the difference between bids and benchmarks is sufficient to bring MA payment levels below Medicare FFS levels. South Florida, with more than 90 percent of enrollees in HMO plans, is the only part of the country where this situation has arisen. PPOs (both local and regional) and PFFS plans are more likely to have bids closer to benchmark levels—and therefore have fewer rebate dollars and a smaller amount of funds retained by the Trust Funds.

Employer group plans

To date, we have not looked specifically at employer group plans (the last category of Table 4-1, p. 244), but we intend to look more closely at this category in the future. These plans are overwhelmingly HMOs. Their bids may be higher than other types of HMO plans because they do not necessarily compete to attract individual (non-group-sponsored) Medicare beneficiaries. While such plans have lower marketing and member acquisition costs than plans offered in the individual Medicare market, the enrollees of these plans may have relatively higher utilization of health care. Medicare Current Beneficiary Survey data show that beneficiaries in FFS Medicare with employer-sponsored coverage historically have had relatively high rates of utilization, and this may also be true for these types of enrollees in MA plans (MedPAC 2006a).

Plan enrollment in 2006

From December 2005 to July 2006, enrollment in MA plans and similar types of plans grew by nearly 20 percent, or 1.2 million enrollees (Table 4-2, p. 248). This number includes enrollment in MA-only and Medicare Advantage–Prescription Drug plans (MA–PDs) as well as enrollment in non-MA plans other than Part D plans, such as cost plans (cost-reimbursed HMOs and health care prepayment plans) and certain demonstration plans.

TABLE 4–2

Private plan enrollment increased between 2005 and 2006, with the fastest growth in rural areas

	Private plan enrollment (in millions)			
	December 2005	July 2006	Change	Private plan penetration July 2006
Total	6.2	7.4	20%	17%
Rural	0.5	0.8	77	7
Urban	5.8	6.7	16	20

Note: Amounts may not sum to total due to rounding. Penetration is the percent of the total Medicare population (or the total Medicare population in a given area) enrolled in a plan. Data are for Medicare Advantage plans as well as other plan types, such as cost-reimbursed plans.

Source: MedPAC analysis of enrollment data from CMS and Census Bureau classification of counties.

As of July 2006, 7.4 million beneficiaries were enrolled in private plans, comprising 17 percent of all Medicare beneficiaries. This level of penetration (the proportion of the population enrolled in plans) is close to the historic high of 18 percent attained in 1999 (a penetration figure that includes enrollment in risk-based plans for 1999 as well as nonrisk plans such as cost-reimbursed plans).[8]

PFFS plans accounted for about 46 percent of total enrollment growth, adding 565,000 new enrollees between December 2005 and July 2006. PFFS enrollment in December 2005 stood at 209,000. At 270 percent, the rate of growth among PFFS plans was significantly higher than in other types of plans. Growth in enrollment in local HMOs and PPOs together was a more modest 11 percent, or about 600,000 enrollees, which is about equal to the absolute number of new enrollees in PFFS. Enrollment in other types of plans that operated in 2005, such as cost-reimbursed plans, declined by about 7 percent.

Enrollment growth was very strong in rural areas, but enrollment patterns still differ between urban and rural areas. Plan enrollment growth between 2005 and 2006 was about 77 percent in rural areas and about 16 percent in urban areas. In 2006, about 20 percent of Medicare beneficiaries in urban counties and about 7 percent of rural beneficiaries were enrolled in private plans. Rural enrollees were more likely to be in PFFS plans (nearly 40 percent of them in 2006, compared with only about 7 percent of urban enrollees). About 52 percent of the growth in rural enrollment was due to increased enrollment in PFFS plans, with rural enrollees accounting for 39 percent of the total enrollment of PFFS plans (nearly 304,000 enrollees). There were nearly 17,000 rural enrollees of regional PPO plans in July of 2006, representing 20 percent of the enrollment in such plans. Among HMO plans, 4 percent of enrollees (214,000) resided in rural counties. SNPs had rural enrollment of 71,000, or 13 percent of their total enrollment. Among local PPO plans, about 10 percent of enrollment was drawn from rural counties (nearly 28,000).[9]

Plan availability and benefits for 2007

Private plan alternatives to the FFS Medicare program are now available to all Medicare beneficiaries, a very slight change from 2006 when 99.6 percent of beneficiaries had access to a private plan, and a significant increase from 84 percent in 2005 (Table 4-3). Increased availability is mainly the result of continued growth in PFFS plans in the MA program. In 2007, 82 percent of Medicare beneficiaries have a local HMO or PPO plan operating in their county of residence, up from 80 percent in 2006 and 67 percent in 2005. PFFS plan availability increased substantially in 2007 to virtually 100 percent of beneficiaries, up from 80 percent in 2006 and 45 percent in 2005.

Overall access to local HMOs and PPOs or regional PPOs (the coordinated care plans) increased to 99 percent of beneficiaries in 2007, up from 98 percent in 2006. Access to regional PPOs was unchanged, although the regions that had plans in 2006 tend to have more plans in 2007.

TABLE 4–3

Availability of MA plans has grown

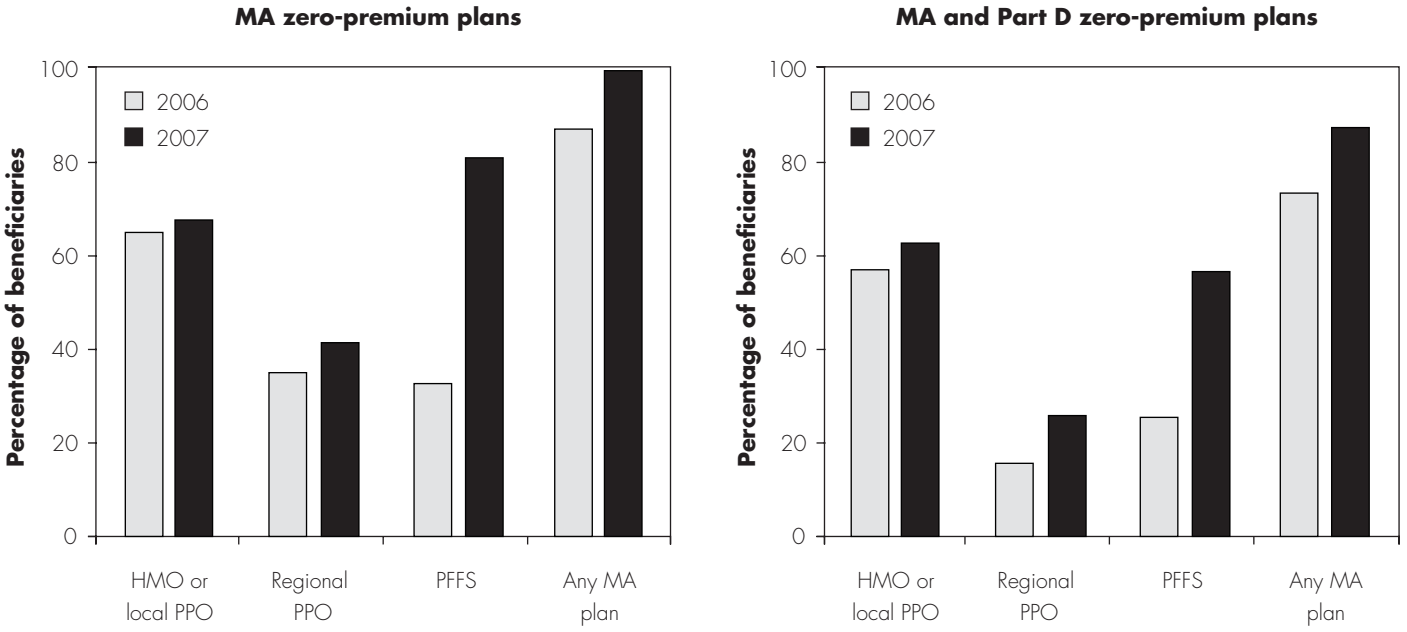
	2005	2006	2007
Any MA plan	84%	100%	100%
CCP	67	98	99
HMO or local PPO	67	80	82
Regional PPO	N/A	87	87
PFFS	45	80	100
MSA	N/A	N/A	78

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service), MSA (medical savings account), N/A (not available).

Source: MedPAC analysis of plan finder data from CMS.

FIGURE 4–2

Availability of zero-premium plans has grown



Note: MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service). Enrollees of MA zero-premium plans pay only the Medicare Part B premium. Some plans offer reductions of the Part B premium as a plan benefit also. MA plans have a separate premium for Part D coverage, which can also be reduced to zero.

Source: MedPAC analysis of bid and plan finder data from CMS.

Beneficiaries have many more plan options in 2007 than in the past. Excluding employer-only plans and SNPs, each county has an average of 20 MA plan options (i.e., 20 benefit package options) in 2007, compared with 12 in 2006 and 5 in 2005.

Zero-premium and Part B premium reduction plans

Across all plan types, in 2007 there is increased availability of benefit packages with no plan premiums—the "zero-premium" plans with no premium payments other than the Medicare Part B premium (Figure 4-2). More beneficiaries than in 2006 have access to zero-premium MA plans—plans with no Part C (MA) premium for the coverage of Medicare Part A and Part B services and no premium for any additional services the plan may cover (e.g., dental or vision care not covered by Medicare). In 2007, almost all Medicare beneficiaries (99 percent) have access to such plans. More beneficiaries can obtain an MA plan with Part D drug coverage (an MA–PD plan) for which the enrollee pays no premium for either the drug coverage or the coverage of Medicare Part A and Part B services. In 2007, 86 percent of Medicare beneficiaries have access to at least one MA–PD plan with no premium (beyond the Medicare Part B premium) for the combined coverage (and no premium for any non-Medicare-covered benefits included in the benefit package), compared with 73 percent in 2006. Particularly noteworthy is the increased availability of PFFS plans offering such coverage. In 2006, 25 percent of beneficiaries had access to a PFFS plan with no plan premium for Part C and Part D coverage—a figure that grew to 55 percent in 2007.

In most cases, enrollees of MA plans continue paying their Medicare Part B premium, but some MA plans use rebate dollars to reduce or eliminate their enrollees' Part B premium obligation. In 2007, 31 percent of Medicare beneficiaries have access to an MA plan that reduces or eliminates their Part B premium; 16 percent of beneficiaries have access to a plan that eliminates the entire standard Part B premium ($93.50 per month

in 2007). In the latter group, 9 percent of beneficiaries reside in a county where the only plan option that offers a full reduction of the Part B premium is a PFFS plan; a little more than 1 percent of beneficiaries can obtain this kind of coverage only through a local HMO or PPO; and 6 percent of the population can enroll in a full Part B premium reduction plan offered by PFFS plans as well as local HMOs or locals PPOs in their county.

High-deductible plans with medical savings accounts

In 2007, the first high-deductible plans linked to medical savings accounts (MSAs) were introduced as MA options, with plans available in 38 states and the District of Columbia. The MSA plans differ from other MA plans in many ways, including their enrollment and payment rules.

As with similar plans available in the commercial marketplace, the Medicare MSA plans consist of health plans with a high deductible and catastrophic coverage, combined with savings accounts in which funds are deposited on behalf of the enrollee. In the case of the Medicare MSA, the only permissible source of funds for the enrollee deposit is the payment from Medicare. The deposit, a uniform amount for each plan enrollee, is an annual payment made to the beneficiary's account at the beginning of the year. The enrollee's deposit amount is the difference between the MSA plan premium (the equivalent of an MA bid) and the plan benchmark (if the amount is below the benchmark).[10] Unlike other MA plans that have bids below the benchmark, for which 25 percent of the bid-to-benchmark difference is retained in the Trust Funds, MSA plans are not subject to this retention requirement (reflecting the statutory provision applicable to MSAs). Unlike the payments of other MA plans, the bid-based payments of MSA plans are also not subject to geographic adjustment. That is, the payment reflects the expected geographic mix by county that was the basis of the MSA premium, rather than being based on the county of residence of the plan enrollees (reflecting the statutory provision whereby payments are adjusted only for the demographic and risk factors of the individual enrollees).

The deductible level is also the catastrophic cap, as required by the statute. The statutory provision specifies a maximum deductible (an indexed amount, which is $9,500 for 2007), but no minimum is specified. The MSA plans cover Medicare Part A and Part B benefits only (and no additional benefits, except through optional supplemental packages).[11] MSA plans are not permitted to offer MA–PD plans, but enrollees may elect a stand-alone prescription drug plan (PDP). Beneficiaries pay the full Medicare-allowable costs for care until they reach the deductible (i.e., the catastrophic cap), and the plan pays for all Medicare-covered care above the catastrophic cap. Beneficiaries can use their MSA account funds to pay for the cost of care before they reach the deductible, though any use of the funds for qualified medical expenses is tax-exempt (e.g., the funds can be used to purchase long-term care insurance).

The available MSA plans in 38 states and the District of Columbia have deductibles between $2,500 and $4,500 for 2007. Deposits to the savings account range from $1,000 to $1,725 per year. Beneficiaries in New York and Pennsylvania can join a demonstration plan that is a variation of the MSA model. The available benefit packages in the demonstration have deductibles between $2,500 and $4,000. Deposits to the savings account range from $1,422 to $1,558 per year. Unlike the standard MSA plan design, the demonstration has separate deductibles and catastrophic caps, with catastrophic caps between $2,500 and $4,800. Unlike the standard design, the demonstration plans pay for some care below the deductible (preventive care, for example), and enrollees have cost sharing for expenditures between the deductible level and the catastrophic cap. Including both the standard MSA plans and the demonstration plan, 77 percent of beneficiaries will have access to an MSA plan in 2007. Both the demonstration plan and the standard plans have Medicare MSA products for employer group enrollees available throughout the United States.

We intend to monitor the status of MSA plans and are concerned about the different treatment, under the statute, of these types of MA plans with respect to the provision that requires that 25 percent of the bid-to-benchmark difference be retained in the Trust Funds.

Growth in plans designed for specific populations

MA organizations can design plans targeted to specific populations, and enrollment in such plans can be limited to Medicare beneficiaries who meet certain criteria. Until the end of 2008 SNPs limit their enrollment to beneficiaries with special needs. MA organizations can

TABLE 4–4 **The number of special needs plans and access to such plans have grown substantially**

Type of SNP	2006 Number of plans	2006 Percent of beneficiaries with access	2006 Enrollment (in thousands)	2007 Number of plans	2007 Percent of beneficiaries with access
All	276	59%	530	424	76%
Dual eligibles	226	57	440	271	67
Institutional	37	26	20	81	48
Chronic condition	13	9	70	72	38

Note: SNP (special needs plan).

Source: MedPAC analysis of bid and enrollment data from CMS.

also arrange with employers or unions to offer retiree coverage through plans with enrollment limited to the retirees and dependents eligible for coverage under such arrangements.[12]

The number of SNPs has grown rapidly since their inception in 2004, when there were just 11 SNPs. The number had grown to 125 in 2005 and more than doubled to 276 in 2006. For 2007, there are 424 SNPs (Table 4-4). The most numerous plans are for dual eligibles, making up 271 of the plans, up from 226 in 2006. The next most common plans are for the institutionalized, increasing from 37 plans in 2006 to 81 plans in 2007. The least common type of SNP is also the fastest growing: Chronic condition SNPs grew from 13 plans in 2006 to 72 plans in 2007.

The increase in the number of SNPs raises the percentage of Medicare beneficiaries who have an opportunity to enroll in a SNP. In 2007, 76 percent of Medicare beneficiaries live in a county where a SNP is operating, versus 59 percent in 2006. The percentages of beneficiaries with access to different types of SNPs for 2007 are: 67 percent for dual-eligible SNPs, 48 percent for institutional SNPs, and 38 percent for chronic condition SNPs.

In 2006, about 440,000 beneficiaries were enrolled in dual-eligible SNPs, 70,000 were enrolled in chronic condition SNPs (69,000 were in one plan in Puerto Rico), and 20,000 were enrolled in institutional SNPs.

In 2006, about 1 million beneficiaries were enrolled in employer- or union-sponsored group MA plans not available to the general Medicare population. The number of group-only plans appears to have grown substantially, especially PFFS and MSA varieties (though to date the enrollment in group-only products has been concentrated in HMO plans, which had about 90 percent of such enrollment in July 2006). Group-only plans are available in all counties for 2007; in 2006, they were available in fewer than two-thirds of counties. As noted previously, we intend to look more closely at these plans in the future.

Policy issues related to Medicare's private plans: Past recommendations for Medicare Advantage policy

In this section, we briefly review the Commission's past recommendations with respect to MA policy, focusing on recommendations the Commission made in the June 2005 report to the Congress, as shown in the text box (p. 252). As we noted previously, the Commission will continue examining MA policy issues; in particular, we will look at PFFS plans, SNPs, employer group plans, and MSA plans.

The Commission supports private plans in the Medicare program. Medicare beneficiaries should be able to choose between the FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans have the flexibility to use care management techniques that FFS Medicare does not encourage, and they have greater incentive to innovate.

The Commission supports financial neutrality between payment rates for the FFS program and private plans. Financial neutrality means that the Medicare program

Medicare Advantage recommendations from the June 2005 report to the Congress

Medicare Advantage (MA) recommendations from MedPAC's June 2005 report to the Congress are summarized below:

- The Commission recommended that the Congress eliminate the $10 billion stabilization fund for regional preferred provider organizations (PPOs). Authorization of the fund was one of several provisions intended to promote the development of regional PPOs. The fund was available in 2007 but was not used. The Tax Relief and Health Care Act of 2006 reduced the fund to $3.5 billion and made funds unavailable until the year 2012.
- The Commission recommended that the Congress clarify that regional plans should submit bids that are standardized for the region's MA-eligible population. Regional PPOs can have an advantage over local plans as a result of the MA bidding process. Because of the different method used to determine benchmarks for regional PPOs in relation to the method used for other plans, and because of the bidding approach used for regional plans, there can be distortions in competition between regional and local plans.
- The Commission recommended that the Congress remove the effect of payments for indirect medical education from the MA plan benchmarks. MA rates set at 100 percent of fee-for-service (FFS) include medical education payments, but at the same time Medicare makes separate indirect medical education payments to hospitals treating MA enrollees.
- The Commission recommended that the Congress set the benchmarks that CMS uses to evaluate Medicare Advantage plan bids at 100 percent of FFS costs. The Commission has consistently supported the concept of financial neutrality between payment rates for the FFS program and private plans. However, financial neutrality can be achieved gradually to minimize the impact on beneficiaries.
- The Commission believes that pay-for-performance should apply in MA to reward plans that provide higher quality care. The Commission recommended that the Congress redirect the amounts retained in the Trust Funds for bids below the benchmarks to a fund that would redistribute the savings back to MA plans based on quality measures.
- The Commission recommended that the Secretary calculate clinical measures for the FFS program that would permit CMS to compare the FFS program to MA plans. The Commission believes that more can be done to facilitate beneficiary choice and decision making by enabling a direct comparison between the quality of care in private plans and quality in the FFS system.

One recommendation became a provision of the Deficit Reduction Act, which specifies in statute the time line for phasing out the hold-harmless policy that offsets the impact of risk adjustment on aggregate plan payments through 2010. ■

should pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses. Additionally, the Commission supports pay for performance as a feature of health plan payments. We have found that organizations are more likely to be efficient when they face financial pressure. The Medicare program needs to exert consistent financial pressure on both the FFS and MA programs, coupled with meaningful quality measurement and pay-for-performance programs, to maximize the value it receives for the dollars it is spending.

The Commission recognizes that changing MA plan payment rates too quickly to achieve financial neutrality may cause disruptions for beneficiaries and may have unintended consequences. The timing of the transition to a plan payment system that is financially neutral needs to take into account the effect on beneficiaries. Financial neutrality may also take the form of having plan benchmarks set at 100 percent of FFS, on average, across geographic areas. Benchmarks could be higher in areas that have trouble attracting plans and lower in areas where

plans are able to bid below the benchmarks. On average, across all geographic areas, MA payment rates would be at 100 percent of FFS.

With respect to pay for performance in MA, in our March 2004 report, the Commission concluded that Medicare should introduce pay-for-performance incentives to provide high-quality care in the MA program because MA meets all the Commission's criteria for successful implementation (MedPAC 2004b). CMS collects standardized, credible performance measures on all MA plans. Every year, plans collect data on specific clinical process measures and data that reflect members' satisfaction with the plan's service provision, though not all plans report on all measures; for example, PPOs and PFFS plans are exempted from reporting on measures that involve obtaining data from medical records. Together, these data show a widely accepted, broad cross section of plan quality. Most of the process measures in these data sets do not require risk adjustment, and CMS has developed risk adjusters for the satisfaction measures. Plans have developed various strategies to improve their scores on these measures by working with providers in their networks. The Commission has argued that, by including all private plans in a pay-for-performance program, CMS would maintain a level playing field between plan types and simultaneously reward those plans that invest in improving quality.

Part D plan offerings for 2007

For 2007, the second year of operations for Part D, Medicare's outpatient prescription drug benefit, we find that:

- More plans entered the market for 2007 than in 2006. Sponsors are offering about 30 percent more stand-alone PDPs and 25 percent more MA–PDs.
- Sponsors are offering larger proportions of PDPs with the defined standard benefit structure or enhanced benefits (basic plus supplemental coverage) for 2007 and a smaller proportion of benefits with the same average value as the standard benefit but with alternative benefit designs (called actuarially equivalent benefits). The larger share of defined standard plans probably reflects competition for enrollees who receive Part D's low-income subsidy (LIS) as well as for other beneficiaries who are most interested in low premiums when they select a plan. The larger share of enhanced plans may reflect CMS's efforts to encourage sponsors to offer more plans with coverage in the gap—drug spending between the defined standard benefit's initial coverage limit and its out-of-pocket spending limit in which the enrollee must pay 100 percent coinsurance. A larger proportion of MA–PDs are also offering enhanced benefits in 2007 than in 2006.
- More PDPs include some benefits in the coverage gap (28 percent in 2007, compared with 15 percent in 2006), but nearly all cover only generic drugs. Among MA–PDs, 32 percent provide benefits in the coverage gap, up from 28 percent in 2006.
- Part D basic plans with premiums at the higher end of the distribution in 2006 tended to lower their bids for 2007, while those with the lowest bids tended to raise them. The average premium offered by basic plans—not weighted by enrollment—is lower. However, the average (unweighted) premium for plans offering enhanced coverage is higher. Among the plans we analyzed, if enrollees in Part D remain in the same plan for 2007, the average enrollee with coverage through either a PDP or an MA–PD will pay about $25 per month in 2007 compared with $23 in 2006.

Like the MA program, private plans deliver Part D benefits and compete for enrollees on the basis of premiums, benefit design, drug formularies, pharmacy networks, and quality of services. Organizations that offer Part D plans bear insurance risk for some of their members' benefit spending. Plan sponsors submit bids to CMS to provide Part D benefits. CMS calculates the national average of bids for basic benefits and then Medicare pays plans the same capitated amount per enrollee based on a percentage of the national average, adjusted for the risk of the individual enrollee.[13] Plans may also receive payments from Medicare to cover the premiums and cost sharing of members who qualify to receive Part D's LIS and to cover individual reinsurance subsidies for enrollees who have very high spending for drugs.[14]

Before the start of Part D, policymakers were concerned that few private organizations would be willing to offer stand-alone drug coverage—a product largely unseen in insurance markets. Instead, there was considerable market entry.

Another uncertainty was whether Medicare beneficiaries would enroll in the voluntary program. As of October 2006, CMS estimates that of 43.1 million beneficiaries,

TABLE 4–5 **Defined standard benefit parameters increase over time**

	2006	2007
Deductible	$250.00	$265.00
Initial coverage limit	2,250.00	2,400.00
True out-of-pocket spending limit	3,600.00	3,850.00
Total covered drug spending at true out-of-pocket limit	5,100.00	5,451.25
Minimum cost sharing above the true out-of-pocket limit:		
Copay for generic/preferred multi-source drug prescription	2.00	2.15
Copay for other prescription drugs	5.00	5.35

Source: CMS, Office of the Actuary. 2006. *Medicare Part D benefit parameters for standard benefit: Annual adjustments for 2007* (May 22).

23.1 million (nearly 54 percent) actively enrolled or were automatically enrolled in Part D plans, including 16.9 million in PDPs and 6.2 million in MA–PDs (CMS 2006a). Another 6.8 million have primary coverage through employer-sponsored health plans that receive Medicare's retiree drug subsidy.[15] About 3.5 million Medicare beneficiaries have drug coverage through TRICARE and the Federal Employees Health Benefits program, and another 5.4 million have drug coverage whose value is equal to or greater than that of Part D (called creditable coverage) through other sources. CMS estimates that more than 90 percent of Medicare beneficiaries have Part D coverage or creditable coverage, compared with about 75 percent before the program started (CBO 2002). Enrollment was highly concentrated among plans offered by a small number of parent organizations.

Under the law, Part D's defined standard coverage has benefit parameters that increase over time at the same growth rate as in the program's per capita drug spending. The defined standard benefits for 2006 and 2007 are shown in Table 4-5.[16]

Stand-alone drug plans

Part D drew even more PDPs into the field for 2007 than it did in 2006. Plan sponsors offer 1,866 PDPs in 2007 compared with 1,429 in 2006—about 30 percent more (Table 4-6). Seventeen organizations offer at least one PDP in each region, totaling 80 percent of all stand-alone plans. In 2006, 10 organizations operated in all PDP regions, offering 62 percent of all PDPs. (Numbers of plans exclude employer-only plans and plans offered in U.S. territories.) New PDPs for 2007 emerged in every region of the country, and the median number of plans offered in each region rose from 43 in 2006 to 55.

Organizations may offer a defined standard benefit or, within certain constraints, one that is actuarially equivalent to it (i.e., has the same average dollar value of insured benefit spending). Both types are considered basic benefits. Many actuarially equivalent plans charge no deductible and use tiered copayments equivalent in value to more than 25 percent coinsurance up to the initial coverage limit.

In 2006, PDPs with actuarially equivalent benefits were the most popular, drawing 61 percent of total PDP enrollment. Fifty-six percent of PDP enrollees chose plans with no deductible. However, premium considerations also strongly affected enrollment. Beneficiaries who received Part D's LIS made up more than half of all PDP enrollees in 2006. Most of them pay no premium for Part D so long as they enroll in plans with premiums below or near LIS thresholds set for each region. Since plans with the defined standard benefit structure tend to have lower premiums and most LIS recipients were automatically assigned to qualifying plans, defined standard plans won 22 percent of all PDP enrollees. LIS enrollees in defined standard plans pay nominal copays rather than the benefit's deductible, 25 percent coinsurance, and coverage gap.

Once a sponsor offers at least one basic benefit package in a region, it may also offer an enhanced plan—one that includes basic and supplemental benefits.[17] For 2007, sponsors are offering more benefit designs of all types. However, defined standard benefits and enhanced benefits make up larger proportions of PDPs in 2007 (counts unweighted by enrollment) than they did in 2006 (12 percent and 48 percent, respectively, compared with 9 percent and 43 percent in 2006). Actuarially equivalent benefit designs make up a smaller proportion of plans. The larger share of defined standard plans likely reflects

TABLE 4–6

Characteristics of PDPs

	2006				2007		
	Plans		Enrollees[a]		Plans		
	Number	Percent	Number (in millions)	Percent	Number	Percent	Weighted by July 2006 enrollment[b]
Total	1,429	100%	15.5	100%	1,866	100%	100%
Type of organization							
National[c]	886	62	8.3	54	1,507	80	87
Near-national[d]	339	24	4.0	26	159	8	2
Other	204	14	3.1	20	200	11	11
Type of benefit							
Defined standard	132	9	3.4	22	219	12	19
Actuarially equivalent[e]	689	48	9.5	61	760	41	59
Enhanced	608	43	2.6	17	887	48	22
Type of deductible							
Zero	834	58	8.7	56	1,127	60	60
Reduced	112	8	0.3	2	157	8	4
Defined standard	483	34	6.5	42	582	31	36

Note: PDP (prescription drug plan). The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. Sums of percentages may not add to totals due to rounding.

[a] Number of enrollees as of July 2006.

[b] Nearly 97 percent of July 2006 enrollees were in 2006 plans that could be matched to 2007 plans. Note that some beneficiaries will choose to enroll in a different plan for 2007.

[c] Reflects total numbers of plans for organizations with at least one PDP in all 34 PDP regions.

[d] Totals for organizations offering 30 or more PDPs across the country, but without one in each PDP region.

[e] Benefits labeled actuarially equivalent to Part D's standard benefit include what CMS calls "actuarially equivalent standard" and "basic alternative" benefits.

Source: MedPAC analysis of CMS landscape, bid, and enrollment data.

considerable competition for LIS enrollees and other beneficiaries who look for low premiums when they select a plan. The larger share of enhanced plans may reflect the fact that, for 2007, CMS tried to encourage sponsors to include more plans with coverage in the gap.

More PDPs include some benefits in the coverage gap for 2007 than for 2006. However, nearly all cover only generic drugs in the gap—27 percent offer generics only while 1 percent of plans offer generics and brand name drugs (Table 4-7, p. 256). Among those plans that provide coverage for brand name drugs, most limit the benefit to preferred drugs. In 2006, one organization offered 31 of the 33 PDPs (under the name Humana Complete) with generic and brand name drug benefits in the coverage gap. For 2007, however, that sponsor changed the benefits to include only generic drugs in the gap after reportedly drawing more enrollees than expected with relatively high drug spending into its enhanced benefit in 2006 (Rapaport 2006).

In 2006, 94 percent of PDP enrollees were in plans that offered no additional benefits in the coverage gap; 55 percent were LIS enrollees. As most LIS enrollees do not face a coverage gap, the number of beneficiaries who face 100 percent coinsurance is considerably smaller than 94 percent. In addition, many enrollees were unlikely to exceed the initial coverage limit for drug spending: Estimates suggest that 3 million to 4 million individuals, or between 25 percent and 40 percent of plan enrollees who did not receive LIS (also known as extra help), had spending in the coverage gap in 2006 (Cubanski and Neuman 2006, PricewaterhouseCoopers 2006). Those numbers made up between 13 percent and 18 percent of all 23.1 million Part D enrollees in 2006. If Part D enrollees remain in the same plan for 2007, 91 percent will be in

TABLE 4–7

Benefits in the coverage gap among PDPs

	2006						2007			
	Plans		Enrollees				Plans		Enrollees[a]	
			Total		With LIS					
	Number	Percent	Number (in millions)	Percent	Number (in millions)	Percent of total	Number	Percent	Percent of total	LIS percent of total
Total	1,429	100%	15.48	100%	8.02	52%	1,866	100%	100%	51%
Drugs covered in the gap										
Generic only	187	13	0.44	3	0.05	10	511	27	8	10
Generic and brand name[b]	33	2	0.47	3	0.03	6	27	1	0[c]	2
None	1,209	85	14.56	94	7.95	55	1,328	71	91	55

Note: PDP (prescription drug plan), LIS (low-income subsidy). LIS enrollees receive extra help to cover some or all premiums and cost sharing. Their benefit effectively has no gap in coverage. The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. Gap coverage refers to benefits provided within the range of beneficiary drug spending above the standard benefit's initial coverage limit and below its out-of-pocket threshold. Part D's defined standard benefit requires the enrollee to pay 100 percent coinsurance in this coverage gap. Number of total enrollees and number of enrollees with LIS are not available for 2007. Sums of percentages may not add to totals due to rounding.

[a] Percentages of enrollees for plans offered in 2007 reflect enrollment levels of those plans as of July 1, 2006. New plan entrants have no enrollment. Nearly 97 percent of July 2006 enrollees were in 2006 plans that could be matched to 2007 plans. Note that some beneficiaries will choose to enroll in a different plan for 2007.

[b] Not all brand name drugs are necessarily covered. Most plans cover preferred brand name drugs in the coverage gap and only two plans cover all branded drugs on the plans' formulary.

[c] Less than 0.5 percent.

Source: MedPAC analysis of CMS landscape, bid, and enrollment data.

plans without gap coverage. Of that 91 percent, 55 percent would be LIS enrollees who receive some or all coverage in the gap.

When organizations prepared their bids for 2006, many plan sponsors had little information from which to estimate the drug-spending profile of their future enrollees. As a result, there was a broad range of premiums for both basic and enhanced benefits. Some enhanced benefits cost less than $20 per month in certain regions, while a handful of basic plans cost more than $75 per month. However, PDP enrollment was concentrated in plans with lower premiums because LIS enrollees were automatically assigned to lower cost plans and other beneficiaries selected plans with lower premiums. For these reasons, in 2006, the average enrollee in a PDP with basic benefits paid about $24 per month, even though the average premium offered by PDPs was about $33 (Table 4-8). Similarly, the average enrollee in an enhanced PDP paid about $35 per month in 2006, even though the average premium for enhanced benefits offered by PDPs was $43.

The unweighted distribution of plan premiums for basic benefits is tighter for 2007 than it was in 2006. In other words, plans with premiums at the higher end of the distribution last year tended to lower their bids for 2007, while those with the lowest bids tended to raise them. As a result, the average premium offered by PDPs for basic benefits is lower: $29 per month in 2007 compared with $33 in 2006. But the average PDP enrollee who remains in the same basic-benefit plan for 2007 as in 2006 will pay a premium of about $25 per month compared with about $24 in 2006.

Premiums for PDPs with enhanced coverage tend to be higher in 2007—an average of $46 per month compared with $43 in 2006. A few enhanced PDPs that were very popular in 2006 increased their premiums by considerably more. PDP enrollees with enhanced coverage who remain in the same plan will pay an average of about $42 per month in 2007 compared with about $35 in 2006.

TABLE 4–8

Average Part D premiums

	2006		2007	
	Unweighted plan offers	Weighted by 2006 enrollment	Unweighted plan offers	Weighted by 2006 enrollment*
All plans				
Basic coverage	$29.01	$23.49	$25.86	$24.84
Enhanced coverage	27.80	20.64	29.16	24.45
Any coverage	28.38	22.61	27.85	24.70
PDPs				
Basic coverage	33.11	24.16	28.79	25.30
Enhanced coverage	43.27	35.34	45.66	42.34
Any coverage	37.43	26.03	36.81	29.04
MA–PDs**				
Basic coverage	21.88	16.84	18.79	16.55
Enhanced coverage	16.47	10.42	17.14	7.31
Any coverage	18.43	12.08	17.24	8.78

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. The MA–PDs and enrollment described here exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans.
* Values for plans offered in 2007 reflect enrollment levels of those plans as of July 1, 2006. New plan entrants have no enrollment. Nearly 97 percent of July 2006 PDP enrollees and about 81 percent of MA–PD enrollees were in 2006 plans that could be matched to 2007 plans. Note that some beneficiaries will choose to enroll in a different plan for 2007.
** MA–PD premiums reflect rebate dollars (75 percent of the difference between a plan's payment benchmark and its bid for providing Part A and Part B services) that were used to offset Part D premium costs.

Source: MedPAC analysis of CMS landscape, bid, and enrollment data.

Medicare Advantage drug plans

Similar to stand-alone plans, there were more MA–PDs for 2007 than for 2006. Sponsors are offering 1,622 MA–PDs around the country, compared with 1,303 the year before (about 25 percent more). Beneficiaries in MA–PDs elect to have their broader package of health care services (e.g., hospital and physician care) provided by the MA plan.[18]

Offerings through MA–PDs differ systematically from PDPs. For example, the law allows MA–PDs to use 75 percent of the difference between an MA plan's benchmark payment and its bid for providing Part A and Part B services (called rebate dollars) to supplement its package of benefits, including any Part D coverage it offers, or to lower its premiums. As a result, a larger share of MA–PDs than PDPs offer enhanced benefits. In 2006, 64 percent of MA–PDs offered enhanced benefits, and those plans attracted 74 percent of MA–PD enrollees (Table 4-9, p. 258). For 2007, 75 percent of MA–PDs include enhanced benefits. If MA–PD enrollees do not change plans, enhanced plans will have even greater enrollment in 2007 than in 2006.

MA–PDs are more likely than PDPs to provide some additional benefits in the coverage gap, although mostly for generics. In 2006, 28 percent of MA–PDs included some gap coverage—23 percent with generics only and 5 percent with generic and brand name drug coverage (Table 4-10, p. 259). Those plans accounted for 28 percent of MA–PD enrollment. Among MA–PD enrollees with no gap coverage, 15 percent were LIS enrollees.[19] For 2007, 33 percent of MA–PDs provide some gap coverage (28 percent generics only and 5 percent generic and brands) and, if enrollees remain in the same plan as in 2006, about 34 percent of them will have some benefits in the coverage gap.

TABLE 4–9

Characteristics of MA–PDs

	2006				2007		
	Plans		Enrollees[a]		Plans		Weighted by July 2006 enrollment[b] (in percent)
	Number	Percent	Number (in millions)	Percent	Number	Percent	
Total	1,303	100%	5.0	100%	1,622	100%	100%
Type of organization							
Local HMO	856	66	4.1	82	947	58	82
Local PPO	275	21	0.2	4	274	17	5
PFFS	124	10	0.6	12	367	23	12
Regional PPO	48	4	0.1	1	34	2	2
Type of benefit							
Defined standard	96	7	0.1	3	84	5	1
Actuarially equivalent[c]	376	29	1.1	23	321	20	15
Enhanced	831	64	3.7	74	1,217	75	84
Type of deductible							
Zero	1,045	80	4.5	90	1,461	90	95
Reduced	41	3	0.1	2	38	2	1
Defined standard	217	17	0.4	8	123	8	4

Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), PPO (preferred provider organization), PFFS (private fee-for-service). The MA–PDs and enrollment described here exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans. Sums of percentages may not add to totals due to rounding.

[a] Number of enrollees as of July 2006.

[b] About 81 percent of July 2006 enrollees were in 2006 plans that could be matched to 2007 plans. New plan entrants have no enrollment. Note that some beneficiaries will choose to enroll in a different plan for 2007.

[c] Benefits labeled actuarially equivalent to Part D's standard benefit include what CMS calls "actuarially equivalent standard" and "basic alternative" benefits.

Source: MedPAC analysis of CMS landscape, bid, and enrollment data.

As with PDPs, MA–PD enrollment for 2006 was concentrated among plans with lower premiums. In addition, many MA–PD plan sponsors used rebate dollars to reduce the Part D portion of their plan premium to zero. Among MA–PD enrollees with basic benefits (26 percent of all MA–PD enrollees), about one-third paid no additional premium for drug coverage in 2006. Three-quarters of MA–PD enrollees had enhanced benefits in 2006, and nearly two-thirds of them paid no additional premium for drug coverage (data not shown). This reflects the fact noted earlier about Medicare beneficiaries' widespread access to MA plans that charge no premium for Part D coverage.

MA–PD premiums in 2007 are similar to those in 2006 (Table 4-8, p. 257). Plan sponsors tended to lower their premiums for basic benefits and raised them slightly for enhanced coverage. Among plans offering basic benefits, the average (unweighted) premium offered by MA–PDs is $19 per month in 2007, compared with $22 in 2006. However, if MA–PD enrollees with basic benefits remain in the same plan for 2007, the average enrollee will pay about the same as last year—$17 per month. MA–PDs with enhanced coverage are charging a slightly higher (unweighted) average premium of about $17 per month in 2007. If MA–PD enrollees with enhanced benefits remain in the same plan for 2007, the average enrollee will pay less: about $7 per month compared with approximately $10 in 2006.

TABLE 4–10

Benefits in the coverage gap among MA–PDs

	2006						2007			
	Plans		Enrollees				Plans		Enrollees*	
			Total		With LIS					
	Number	Percent	Number (in millions)	Percent	Number (in millions)	Percent of total	Number	Percent	Percent of total	LIS percent of total
Total	1,303	100%	5.02	100%	0.75	15%	1,622	100%	100%	16%
Drugs covered in the gap										
Generic only	300	23	1.21	24	0.18	15	448	28	25	13
Generic and brand name**	60	5	0.19	4	0.03	14	78	5	9	17
None	943	72	3.62	72	0.55	15	1,096	68	66	16

Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy). LIS enrollees receive extra help to cover some or all premiums and cost sharing. Their benefit effectively has no gap in coverage. Gap coverage refers to benefits provided within the range of beneficiary drug spending above the standard benefit's initial coverage limit and below its out-of-pocket threshold. Part D's defined standard benefit requires the enrollee to pay 100 percent coinsurance in this coverage gap. The MA–PDs and enrollment described here exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans. Sums of percentages may not add to totals due to rounding.
* Percentages of enrollees for plans offered in 2007 reflect enrollment levels of those plans as of July 1, 2006. About 81 percent of July 2006 enrollees were in 2006 plans that could be matched to 2007 plans. Note that some beneficiaries will choose to enroll in a different plan for 2007.
** Not all brand name drugs are necessarily covered. Most plans cover preferred brand name drugs in the coverage gap and only a few plans cover all branded drugs on the plans' formulary.

Source: MedPAC analysis of CMS landscape, bid, and enrollment data.

Previous recommendations applicable to Part D policy

The Commission has made two recommendations recently that address current concerns about Part D.

Demonstrations for setting 2007 plan payments, enrollee premiums, and low-income premium subsidies

Before the start of Part D, CMS had no information to estimate what shares of enrollment individual PDPs might obtain. That situation led to higher Part D subsidies for 2006 than the 74.5 percent of program costs prescribed by law. When calculating the national average bid for Part D services, CMS weighted all PDP bids equally. (The bids of MA–PDs were weighted by prior-year enrollment in MA plans.) This approach created a higher national average bid and thus raised Medicare's subsidy. One investment research firm estimated in April 2006 that the federal subsidy for Part D was 78 percent (BernsteinResearch 2006).

Under current law, plan enrollment for 2006 should have affected Part D for 2007 in two ways:

- CMS should have weighted bids for services in 2007 by each plan's 2006 enrollment level when calculating the national average bid. This national average affects how much Medicare pays Part D plans each month and how much enrollees must pay as a monthly premium. Because 2006 Part D enrollment was concentrated among plans with lower premiums, the move to enrollment weighting for 2007 would have led to a lower national average bid, lower Medicare program payments, and higher enrollee premiums. Using unweighted bids for 2007 increases program payments, lowers enrollee premiums, and raises Medicare's Part D subsidies above 74.5 percent of program costs.
- Current law also calls for taking 2006 plan enrollment into account when CMS calculates each region's low-income premium subsidy amount for 2007. Following

current law for 2007 would have reduced the low-income premium thresholds, and thus a sizable number of plans that qualified to receive automatically assigned beneficiaries in 2006 would have had 2007 premiums higher than the new low-income premium subsidy amounts (Stahlman 2006). As a result, potentially large numbers of LIS enrollees would have had their coverage disrupted: Those automatically assigned to plans in 2006 would have had to switch to a plan with a premium below the new LIS threshold or begin paying the portion of their premium above the LIS premium subsidy to stay in the same plan. Given that LIS enrollees made up 60 percent or more of the total enrollment in certain PDPs, this change would have strong financial implications for plan sponsors. Using unweighted premiums keeps LIS thresholds high and avoids disruption but increases federal LIS payments to plans and allows more plans to keep their automatically assigned enrollees.

Rather than using the formula specified in the law that created Part D, CMS is using its general demonstration authority to transition to enrollment weighting over time for both of these forms of payments (direct program payments and LIS premium subsidy amounts). These are two separate demonstration programs.

- In August 2006, the agency announced that it is transitioning to an enrollment-weighted national average bid (CMS 2006b). For 2007, 80 percent of the national average is based on the 2006 (unweighted) approach, while 20 percent is based on an enrollment-weighted average.

- In June 2006, CMS announced that for 2007 it will use the same methodology as in 2006 to calculate LIS premium thresholds: weighting PDP premiums equally (i.e., unweighted) (CMS 2006c). The agency is also using a policy in which LIS beneficiaries may stay in their 2006 plan without paying a portion of the premium so long as its 2007 premium does not exceed the 2007 LIS premium threshold by a minimal amount ($2 per month). Plans that have premiums less than $2 above the LIS premium thresholds will not have new LIS beneficiaries automatically assigned to them.

Significant pros and cons are associated with these two categories of payment changes. On the one hand, among all beneficiaries, fewer Part D enrollees will find it necessary to switch to plans with lower premiums. Likewise, the policy means less disruption of coverage among LIS enrollees, since fewer will need to switch to plans with premiums below the LIS amounts. According to CMS's Office of the Actuary (OACT), the LIS premium threshold demonstration will reduce the number of LIS beneficiaries who must switch plans or pay a partial premium from 3.3 million (46 percent) to 0.5 million (7 percent). A CMS official estimated that 247,000 LIS beneficiaries were reassigned to new PDP sponsors because of premium increases (CMS 2006a). As we discussed in our June 2004 report to the Congress, transitioning enrollment from one plan to another involves many complexities (MedPAC 2004a). Ensuring that such transitions are as seamless as possible is important so that beneficiaries have minimal problems arising from changes in pharmacy networks and formulary systems. Phasing in enrollment weighting gives CMS and plans time to further develop information systems and better prepare for issues that arise when beneficiaries switch plans.

On the other hand, one could question the appropriateness of CMS using its demonstration authority on such a broad scale (see text box). These demonstrations increase program spending to deal with a particular policy problem. CMS's demonstration authority is intended for smaller scale projects that help decision makers learn about innovations in financing and delivering Medicare services.

Moreover, the policy increases program spending at a time when Medicare already faces serious problems with cost control and long-term financing. OACT estimates that the demonstrations will raise Medicare spending in 2007 by $1 billion relative to current law—$0.6 billion for higher plan payments that limit the increase in enrollee premiums and $0.4 billion for the transition in setting LIS premium thresholds. OACT notes that Medicare spending in 2008 and future years will also be higher than under current law because of the demonstrations but likely lower than the 2007 amount in each subsequent year.[20] However, the magnitude of higher spending depends on how CMS decides to phase in the move to enrollment weighting.

Arguably, the demonstrations also run counter to an underlying philosophy of Part D: Beneficiaries' enrollment choices should drive the competitive outcome among plans. Under the demonstrations, plans that would otherwise have had higher 2007 premiums or premiums above the new LIS thresholds will probably retain many of their enrollees. This could mean that some sponsoring organizations with higher premium plans remain in the Part D market longer than they would have in the absence of the demonstrations.

Past recommendation on CMS demonstrations

This is not the first time the Commission has expressed concern about CMS's use of its demonstration authority. Last year, the Commission looked at a demonstration that paid oncologists for surveying cancer patients about their quality of life while undergoing treatment (MedPAC 2006b). Payment included the 20 percent coinsurance paid by beneficiaries. Many physicians reported that the payments ensured that they continued to provide care to Medicare beneficiaries in the midst of other major changes to their reimbursement for physician-administered drugs. At the same time, physicians reported that they did not believe the demonstration would improve quality or provide useful research results. The payments made it difficult to evaluate the effect of Medicare payment changes. Within that context, the Commission recommended that the Secretary should use his demonstration authority to test innovations in the delivery and quality of health care. Demonstrations should not be used as a mechanism to increase payments. (See pp. 23–28 of MedPAC's January 2006 report, *Effects of Medicare Payment Changes on Oncology Services* (available on our website) for a discussion of the Commission's previous recommendation.) ■

Supporters contend that the demonstrations' costs should be considered within the context of lower than expected spending for the Part D program. Federal costs for Part D in 2006 were about $30 billion, $13 billion lower than estimates made earlier in the year (Associated Press 2006). Medicare actuaries gave nearly equal credit for the lower spending to competition among sponsoring organizations and to Part D enrollment that was lower than expected. Even so, the decision to phase in enrollment weighting under the two CMS demonstrations means that Medicare program spending for Part D will be at least $1 billion higher than it would have been under current law.

One could also argue that CMS's approach to setting payments and low-income premium subsidies for 2007 simply postpones transition issues that will arise as CMS lowers Medicare's subsidy of Part D benefits to the 74.5 percent of program costs called for under current law. As CMS begins the process of evaluating Part D bids for 2008 and calculating program payments and premiums, a situation similar to that for 2007 is likely to arise: Using full enrollment weighting would lead to lower program payments, increases in Part D premiums, and lower LIS premium thresholds. Policymakers' decisions about how to phase in enrollment weighting will have important ramifications for beneficiaries, the industry structure of Part D providers, and federal program spending.

When announcing both demonstrations, CMS cited authority under 42 U.S. Code, sec. 1395b-1(a)(1)(A), which is made applicable to Part D in sec. 1860D-42(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. That broad language allows demonstrations and experiments that change payment methods or permit payment for services not typically covered by Medicare to improve program economy, efficiency, or effectiveness.

CMS plans to evaluate the demonstrations in early 2007. Officials suggest that the evaluation will likely consist of a simulation exercise to determine what would have happened had premiums been set at the levels required under current law. The agency may also look at financial implications and effects on plan choice for those LIS beneficiaries who enrolled in plans with fully subsidized premiums in 2006 but whose plans have 2007 premiums above LIS benchmark levels.

Prescription drug data needs

In the course of administering Part D and paying plans, CMS is collecting a comprehensive set of data. Plan sponsors submit detailed bid information to CMS that describes benefit designs, formularies, and bid amounts. In addition, sponsors submit prescription drug claims to CMS at least monthly, including the drug dispensed and the amounts paid by the patient, third-party payers, and the plan. Also included are identifiers for the beneficiary, the plan, the prescribing provider, and the pharmacy that dispensed the product. Through beneficiary identifiers, drug claims can be linked with Medicare claims for Part A and Part B services. Part D sponsors must submit data on pharmacy discounts, aggregate pharmaceutical manufacturer rebates, generic dispensing rates, prior

Past recommendation on providing access to Part D data

The Commission recommended that the Secretary should have a process in place for timely delivery of Part D data to congressional support agencies to enable them to report to the Congress on the drug benefit's impact on cost, quality, and access. (See p. 14 of MedPAC's June 2005 report to the Congress for a discussion of the Commission's earlier recommendation on Part D data.) ■

authorizations, nonformulary exceptions, appeals, coordination of benefits for out-of-pocket determinations, call-center operations, grievances, and levels of enrollment and disenrollment. CMS is also collecting satisfaction survey data.

Under the law, CMS has clear authority to collect Part D claims and other data for purposes of making payments. Until recently, however, the agency was less clear about whether it had authority to use Part D data for purposes such as public reporting of aggregate program statistics, overseeing individual plans, supporting legislative proposals, conducting demonstration projects and internal research studies, and evaluating the Part D program overall. It has also been unclear whether CMS has legal authority to provide claims and other Part D data to federal agencies such as the Food and Drug Administration, to congressional support agencies, and to private researchers. These types of organizations routinely use claims data for Medicare Part A and Part B. Indeed, it is unprecedented to block the Secretary from making Medicare data available.

A number of organizations argue that using Part D data for purposes other than payment and sharing data with other entities is extremely important. CMS needs Part D data for program evaluation, reporting, and conducting research. Congressional support agencies must report to the Congress about the effects of Medicare payment policies on cost, quality, and access (see text box). Data on Part D are necessary for analyzing program performance and making policy recommendations. Detailed data on quality measures would help researchers evaluate the performance of individual plans and providers, which could help Part D consumers make more informed choices. Other federal agencies need Part D data to carry out postmarketing surveillance of drug safety and efficacy, to help monitor the prevalence and treatment of specific conditions, and to support research on clinical outcomes and the effectiveness of covered drugs. Federal and private researchers could make significant contributions to public health and health services research by analyzing linked files of Part A, Part B, and Part D claims.

In October 2006, CMS issued a proposed regulation to resolve statutory ambiguity and explain how the agency would use Part D claims data for purposes other than payment (CMS 2006d). That proposal would rely on CMS's authority to add terms to its contracts with plans to allow the agency to use data collected to support payment purposes for other research, analysis, reporting, and public health functions. This interpretation would also allow CMS to share Part D data with federal agencies and researchers under the same safeguards that exist for the release of other Medicare data.

If this regulation goes forward, it will address concerns of executive agencies such as the Food and Drug Administration, congressional support agencies, and private researchers about gaining access to Part D claims information. The proposed rule is similar but not identical to language introduced in September 2006 within bill S.3897 that would explicitly grant authority—indeed assign responsibility—to CMS for sharing prescription drug data with other government agencies, congressional support agencies, and private researchers. ■

Endnotes

1 While a particular county may have its benchmark set at FFS rates, the hold-harmless provision related to risk adjustment that we discuss in this chapter and the way indirect medical education payments are made affect the benchmarks and the relationship between MA payments and FFS expenditure levels.

2 The rates used are therefore the best estimates possible as of the date of CMS's publication of MA rates for 2007. Medicare administrative costs are a component of these rates, which take into account payments that involve a lag in determining the total level of program payments (e.g., cost report settlements). The rates may underestimate the cost of Medicare services that beneficiaries receive because some beneficiaries receive care from Department of Veterans Affairs' facilities that Medicare would otherwise cover (MedPAC 2005, p. 78).

3 SNPs can limit their enrollment to Medicare beneficiaries with special needs, including Medicare beneficiaries with Medicaid eligibility, the institutionalized, and beneficiaries with certain chronic conditions or disabilities. The statutory authority for plans to limit enrollment to beneficiaries with special needs expires at the end of 2008.

4 The enrollment data shown in Table 4-1 are for plans participating in the bidding process and exclude, for example, non-MA plans such as cost-reimbursed plans. Enrollment data shown later in this chapter are for all types of plans.

5 The Balanced Budget Act of 1997 (BBA) provision established a minimum payment rate of $367 for each county of the United States for 1998, which represented a doubling of the pre-BBA payment rates in some counties. Subsequent legislation increased the floor to $475 and added another floor, which was a minimum payment rate for 2001 of $525 in counties within a metropolitan statistical area where the population of the area was greater than 250,000. The year-to-year increase in each of these floor payment rates was set at the national rate of growth of Medicare expenditures, while other counties grew at minimum growth rates established in the statute. Many counties changed to floor status over the years because the floor rate was the highest possible rate.

6 The benchmarks for regional PPOs includes a "statutory" component, which is the population-weighted average of local MA benchmarks for each county in the region, and a bid component, which is an enrollment-weighted average of the bids of regional plans for the region (MedPAC 2005, p. 75). For 2006, the net effect of the bid component (with some bids over the benchmark but with most below it) was to reduce regional benchmarks by 1 percent in relation to what they would have been had the benchmarks been computed solely on the basis of the statutory component.

7 In the case of regional plans, half of the retained amount of 25 percent is available for the regional plan stabilization fund. For plans that choose to offer a reduced Part B premium financed by rebate dollars, the plan payment does not include rebate dollars destined for that use. Instead, the government retains the funds needed to reduce Part B premiums for enrollees of such plans.

8 Counting only risk-based enrollment in plans covering Medicare Part A and Part B benefits, the penetration levels for 1999 and July 2006 are the same, at 16 percent of the Medicare population. For example, in Table III.A3 of the 2006 *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, the 1999 penetration figure for what is referred to as Part C can be computed as 15.8 percent. As indicated in a footnote to the table, the 1999 Trustees Report enrollment figure for Part C includes only beneficiaries enrolled in Medicare+Choice plans (the risk-based precursors of MA plans).

9 We classified counties as rural based on whether they were in metropolitan statistical areas, using the definition of such areas before the June 2003 change that introduced micropolitan statistical areas and otherwise reclassified some counties (as explained by the U.S. Census Bureau at http://www.census.gov/population/www/estimates/metrodef.htm). Therefore, the numbers presented here on rural enrollment, access, and penetration may differ from those of other sources.

10 An MSA plan has no premium unless its proposed premium (the equivalent of its bid) exceeds the benchmark. In such a case, no funds are available for deposit in an enrollee's account. For 2006, the MSAs and demonstration MSA plans all have deposit contributions. It is unlikely that a plan sponsor would offer a product in which there was no deposit and the enrollee would have to pay a plan premium.

11 That is, for MSA plans rebate dollars cannot be used to finance extra benefits not covered by Medicare. However, an MSA plan may offer optional supplemental benefits, which are benefits—such as dental or vision care—that an enrollee may elect to purchase from the plan for a premium. Such packages are financed entirely by member premiums. An MSA plan's optional supplemental package cannot include a reduction in cost sharing, which is an option available to other types of MA plans.

12 The MMA also permitted direct MA contracting between CMS and an employer, union, or trust, in which the employer or other entity operates an MA contract. In 2007, one such contract is operating as a PFFS plan and offering its enrollees a partial reduction of the Medicare Part B premium.

13 More detail about Part D payments and how Medicare subsidizes Part D is available at: http://www.medpac.gov/publications/other_reports/Sept06_MedPAC_Payment_Basics_PartD.pdf.

14 Medicare subsidizes 80 percent of an individual's drug spending above the defined standard benefit's out-of-pocket threshold; enrollees pay 5 percent cost sharing and their plan covers the remaining 15 percent. Individual reinsurance acts as a form of risk adjustment by providing greater federal subsidies for the highest cost enrollees. In addition, Medicare establishes symmetric risk corridors separately for each plan to limit its overall losses or profits. Under risk corridors, Medicare limits a plan's potential losses (or gains) by financing some of the higher-than-expected costs (or recouping excessive profits). These corridors are scheduled to widen, meaning that plans should bear more insurance risk over time.

15 Medicare provides a tax-free subsidy to employers for 28 percent of each eligible individual's drug costs that fall within a specified range of spending.

16 The term "true out-of-pocket" refers to a feature of Part D in which fewer federal subsidy dollars are directed toward enrollees who have supplemental coverage. Only certain types of spending on behalf of the beneficiary count toward the catastrophic threshold: the beneficiary's out-of-pocket spending, that of a family member or official charity, supplemental drug coverage provided through qualifying state pharmacy assistance programs or Part D's low-income subsidies, and supplemental drug coverage paid for with MA rebate dollars under CMS's demonstration authority.

17 Enhanced plans have a higher average benefit value than basic plans. Their supplemental benefits need not include benefits within the coverage gap; in fact, relatively few enhanced plans provide gap coverage. For 2006, the most common type of enhancement was to eliminate the plan's deductible.

18 Numbers of plans exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, SNPs, demonstration plans, and Part B-only plans.

19 MA–PDs have substantially fewer LIS enrollees than PDPs, because most LIS enrollees were dual eligibles in FFS Medicare before the start of Part D rather than in MA plans. CMS automatically assigned most dual eligibles to PDPs unless they were already enrolled in an MA plan.

20 The federal cost would be lower because plan bids for 2007 were more compressed than they were for 2006. In other words, plans with premiums at the low end of the distribution in 2006 tended to raise their bids for 2007, while those with higher premiums in 2006 tended to lower their bids for 2007. With a more compressed distribution of bids, the unweighted average is closer to the enrollment-weighted average.

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