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TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS
Monthly Report for June 2005

A Brief Summary of Selected Significant Facts and Activities This Month to Provide Background for Those Involved in Monitoring and Researching Medicare Advantage and Prescription Drug Plans

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

PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

From the CMS Medicare Managed Care Contract Report (http://cms.hhs.gov/healthplans/reportfilesdata/):

Plan Participation, Enrollment, and Penetration by type	Current Month: June 2005	Change From Previous Month	Same Month Last Year	
			June 2004	Change From June 2004 – 2005
Contracts				
Total	340	+12	291	+49
CCP*	197	+9	148	+49
PPO Demo	34	0	35	-1
PFFS	12	+3	5	+7
Cost	29	0	29	0
Other*	68	0	74	-6
Enrollment				
Total	5,740,004	-23,109	5,351,309	+388,695
CCP	4,905,690	-24,888	4,617,646	+288,044
PPO Demo	122,125	-322	99,862	+22,263
PFFS	108,631	9,186	35,112	+73,519
Cost	321,853	-5,191	329,986	-8,133
Other*	281,705	-1,894	268,703	+13,002
Penetration**				
Total Private Plan Penetration	13.2%	-0.1% points	12.5%	+0.7% points
CCP + PPO Only	11.6%	0.0% points	11.0%	+0.6% points

*Other includes Other Demo contracts, HCPP and PACE contracts.
** Penetration rates for May and June 2005 are calculated using the number of eligible beneficiaries reported in the March 2005 State/County File. Penetration rates for June 2004 are calculated using the number of eligible beneficiaries reported in the March 2004 State/County File.

DEFINITIONS: Coordinated Care Plans, or CCPs, include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs) and preferred provider organizations (PPOs). Data from the March 2005 Geographic Service Area File show that 81% of CCPs are HMOs. PPO Demo refers to preferred provider organization demonstration plans. The Medicare preferred provider organization demonstration began in January 2003. PFFS refers to private fee-for-service plans. Cost plans are HMOs that are reimbursed on a cost basis, rather than a capitated amount like other private health plans. Other Demo refers to all other demonstration plans that have been a part of the Medicare+Choice / Medicare Advantage program.

A Note on 2005 Monthly Enrollments: Monthly enrollment totals are sensitive to the date on which they are captured because enrollments late in the month may not necessarily be reflected on reports for the 1st of the following month. Such lags are particularly important when there is rapid growth or contraction in enrollment. CMS also has been making systems modifications that have resulted in corrections to enrollment data over the year. Still, it is surprising to see a decline in enrollment in June 2005 as this departs from other recent trends. We suggest readers defer interpretation of these data pending figures for July and August 2005.

Pending Applications

- According to the June 1, 2005 Medicare Managed Care Contract Report, there are pending applications for 112 MA plans, 6 PFFS plans, 4 PACE plans, 4 cost plans, 1 HCPPS plan and 5 Other Demo plans. Service area expansions are pending for 63 MA plans, 8 PACE plans, 4 PFFS plans, 13 PPO Demo plans, 5 Other Demo plans and 4 Cost plans. As noted below, a June 30, 2005 CMS press release implies that many of these applications were approved by the end of June and should be reported when the July 1, 2005 report is released.

Summary of new MA contracts announced in June:

CMS's Monthly Managed Care Report (MMCR) for June 1, 2005 indicates that 12 new contracts were signed in June 2005, including 9 CCP contracts and 3 PFFS contracts. These are:

- Medica Healthcare Plans, Coral Gables FL (new CCP)
- Valley Baptist Health Plan, Harlingen TX (new CCP)
- Humana Health Plans of Puerto Rico Inc, Louisville KT (new CCP)
- New East Health Services, Helena MT (new CCP)
- Instil Health Insurance Company (new CCP)
- United Healthcare Insurance Company, Minnetonka MN (two new CCPs)
- Triple-S Inc, San Juan Puerto Rico (new CCP)
- Blue Cross and Blue Shield of SC, Columbia SC (new PFFS)
- Humana Insurance of Puerto Rico, San Juan PR (new PFFS)
- Healthy Alliance Life Insurance Company, St. Louis MO (new PFFS)\

In addition, the report indicates approval of service area expansion for 22 plans.

- On June 30, 2005, CMS released a press release indicating that, in sum, 143 new MA plans had been approved in 2005, including 53 that will offer services in July, 25 that will offer services in August, and more planned for September (www.cms.hhs.gov/media/press/release.asp?Counter1497). We assume this means CMS approved most of the pending applications noted above. According to CMS, the new plans include 41 plans completely new to Medicare and 66 new local PPOs. In addition, 90

existing plans were approved for a service area expansion in 2005. CMS reports that there will be 428 health plans in total in 2005. The press release indicates that 73 percent of beneficiaries will have access to an HMO, 52 percent to a PPO and 80 percent to a private fee for service plan in 2005. CMS reports that most rural beneficiaries will have access to a PFFS and 20 percent will have access to a CCP. The press release says that beneficiaries in an MA plan will save $100/month on average by joining an MA plan, with the $100 reflecting $29 in extra benefits, $2 in Part B premium reduction, and $70 in reduced cost sharing for A/B services compared to the national actuarial value. However the release does not provide any further detail on the data sources or methods used to develop these calculations though they appear to be from plan rate filings.

NEW ON THE WEB FROM CMS

Relevant to Both Medicare Advantage and Prescription Drug Plans

- On June 16, 2005, President Bush and HHS Secretary Levitt kicked off a national "Medicare Covers America" campaign (webcast available on http://videocast.nih.gov). To enhance support to grassroots sponsors, CMS has expanded the information available on its web site to support work by partners to broaden awareness of the new Medicare drug benefit (www.cms.hhs.gov/partnerships). The new partner home cite "Medicare Rx, Prescription Drug Coverage, It's All Coming Together" includes key messages, support for outreach, call center scripts, and Medicare's preferred terminology along with links to other publications and outreach material. The pamphlet emphasizes that Medicare prescription drug coverage is available to all Medicare beneficiaries, with sign up beginning November 15, 2005 and coverage beginning January 1, 2006 for those who sign up by the end of 2005. May 15, 2006 is the last day for existing enrollees to sign up. CMS will mail the Medicare Handbook for 2006 in October 2005. CMS's four key messages are: (1) Medicare prescription drug coverage helps you pay for the prescriptions you need; (2) Medicare prescription drug coverage is available to all people with Medicare; (3) there is additional help for those who need it most; and (4) Medicare prescription drug coverage pays for brand name as well as generic drugs.

- In June 2005, CMS posted a revised list of key implementation dates for Title I and II (www.cms.hhs.gov/healthplans/letters). Note that on June 6, 2005 all bids for plans to sponsor Part D coverage were due.

- On June 10, 2005, CMS convened a Medicare Part D User Group meeting focusing on Systems Implementation. The focus was on connectivity related to transaction processing as Part D is implemented. This includes eligibility and enrollment as well as claims, etc. (PowerPoint slides can be referenced at www.cms.hhs.gov/pdps.Trning_UsrGrpInfo.asp). CMS estimates the shift to Part D will mean the new system (MARx) would have to support transactions for 41 million beneficiaries (versus 5.3 million now in M+C through the legacy MMCS system), 600+ plans/contracts (versus 300 now) and 6.56 million transactions per month (versus 800,000 now). The methods that will be used in 2006 will require new large plans to use a dedicated line for physical connectivity. A flow chart indicates how eligibility and claims information flows.

- On June 13, 2005, CMS issued revised Data Requirements and Submission Guidelines for the Medicare Prescription Drug Plan Price Comparison Tool (www.cms.hhs.gov/medicarereform/pdbma/general.asp). The requirements apply to both stand alone PDPs and MA-PDPs. Plans will submit test data by July 15, 2005, correct problems identified through CMS' analysis on all plans in

late August, and submit electronic data to CMS for final testing on September 16, 2005. Final files for public release are due October 6, 2005 and will be released October 13, 2005 on the Medicare web site. The submissions are distinct from those plans provide in HPMS, but CMS will verify the data against that file. The file includes detailed data on formularies, beneficiary cost, reference pricing (optional) and pharmacy cost, which plans can update monthly or weekly (depending on the item) after CMS approval of the change. CMS will use these data to support the Price Comparison Tool. CMS has not yet determined which of the elements will be available for download as a file. CMS had previously convened a PDP and MA-PD user group call around these issues on June 8, 2005 (overheads available at the same web site noted above). CMS told plans that the tool will only be accessible through the Medicare web site and would provide a ranking of the plan's net cost based on beneficiary's location, income level, drugs, and pharmacy selection, with pricing information updated weekly. Users can drill down to specific details on drugs, pharmacies, etc. At the same session, CMS discussed the online enrollment center, which can be accessed by plans able to receive such direct data transfers and listed the elements proposed for the enrollment form.

- On June 13, 2005, CMS convened a Special Open Door Forum on the topic of "Using Medicare Prescription Drug Data to Develop Better Evidence." The Forum provided an opportunity to hear Mark McClellan, CMS Administrator, talk about his strategy of using de-identified data from implementation the Medicare prescription drug benefit and to get CMS, FDA, and AHRQ responses on how these data might be better used. CMS circulated a paper in advance of the meeting on "Medicare Prescription Drug Data Strategy: Improving Evidence for Patient Care through the Medicare Prescription Drug Benefit" (see: www.cms.hhs.gov/medicarereform/CMSPaperDataStrategy for MedicareDrugBenefitOverview.pdf). According to the *LA Times* (June 14, 2005, article by Alonso-Zaldivar), the Food and Drug Administration backed the idea, with several pilot programs underway to study of use of Medicare data.

- On June 24, 2005, CMS released "Instructions: Requirements for Submitting Prescription Drug Event Data" (http://www.cms.hhs.gov/pdps/revisedinstrs062305.pdf). The instructions update previous releases and are relevant to both free-standing PDPs and MA-PDPs. CMS's Memorandum released with the instructions indicates that the instructions update the April 12, 2005 release with largely technical changes and that the new version also integrates the previous instructions for PACE and payment demonstration plans (www.cms.hhs.gov/pdps/PmntNtcNRskAdjMdl.asp)

- On June 27, 2005, CMS released the second of two installations of the Part D marketing guidelines related to marketing the Part D benefit. Comments on these guidelines are due to CMS by Friday, July 8, 2005. The guidelines apply to MA-PDs and PDPs. They provide guidance on: (1) acceptable marketing plans; (2) transition from a drug card; (3) materials development related to model documents, advertising, materials pre- and post-enrollment and for the low-income subsidy; and (4) required materials at Part D start up and the process of qualification for file and use. They also include special guidelines on value-added services, marketing multiple lines of business, marketing to populations with special needs, marketing to employer/retiree groups, and anti-discrimination issues. In addition, CMS provides guidelines on acceptable promotional activities that address issues such as gifts, information fairs, etc. and rules for use of the Medicare seal (a logo CMS is developing to help identify Medicare prescription drug coverage). CMS sponsored a guideline training conference on these issues on June 3, 2005. Materials are available at www.cms.hhs.gov/pdps/PrtDPlnMrktngGdlns.asp).

Relevant to Medicare Advantage

- On June 2, 2005, CMS sponsored an MA and MA-PD Marketing Training in Baltimore, MD (www.cms.hhs.gov/healthplans/marketing). The training included an overview of MA and MA-PD marketing for new MA participants and general sessions discussing changes or new elements. These included File and Use eligibility and certification. Attendees also received three model Annual Notice of Change letter formats which could be used in Calendar Year 2006 to notify current enrollees of forthcoming changes. The three versions related to MA only plans, MA only plans with parents who offer PDP coverage, and MA-PD plans. Slides used in the presentations are available.

- On June 3, 2005, CMS released a document on Medicare Advantage Prescription Drug Plan (MA-PD) and Cost Plan Waiver Requests (www.cms.hhs.gov/pdps.specguidncmaterials.asp). The document describes the waivers requested and the rationale for what CMS had approved and disapproved. The referenced waivers apply to avoiding duplication and conflict between Part C and D requirements or improving coordination of the same. The list included a number of types of waivers that were disapproved, often because CMS did not regard the Part D requirements as duplicative or in conflict of those in Part C.

- On June 23, 2005, CMS provided guidance for employers/unions intending to offer regional PPOs or local PFFS plans only for their retirees with respect to service area requirements (www.cms.hhs.gov/medicarereform/pdbma/employer.asp).

Relevant to Prescription Drug Plans

- On June 6, 2005, CMS released: "Draft Coordination of Benefits Guidance" (www.cms.hhs.gov/pdps/cob.asp). The document addresses issues of coordination of benefits (COB) between Part D plans and State Pharmaceutical Assistance Programs (SPAPs) and other providers of prescription drug coverage. (A final version of these guidelines was issued on July 1, 2005 and is now posted on the web site). Based on the MMA, these requirements apply to: (1) enrollment file sharing; (2) claims processing and payment; (3) claims reconciliation; (4) application of the protection against high out-of-pocket expenditures by tracking true out-of-pocket (TrOOP) expenditures; and (5) other processes that CMS determines. The instructions note that CMS will leverage its existing COB processes to facilitate COB under Part D, including tracking of TrOOP balances by Part D plans. The instructions also note that under the MMA, beneficiaries are responsible for providing Part D plans with information on other prescription drug coverage that they may have and thus, Part D plans must regularly survey beneficiaries about this so they can report it to CMS and use it for COB. An appendix addresses issues of coordination for other entities including Medicaid, VA, TRICARE, the Indian Health Service, safety net providers, pharmaceutical patient assistance programs, personal health savings vehicles and Medicare Part B coverage.

- On June 15, 2005, CMS issued a document that summarizes Part D plan sponsor responsibilities regarding fraud, waste and abuse in the PDP program (www.cms.hhs.gov/pdps/PlnRpt_Ovsit.asp). All Part D sponsors are required to have a fraud and waste program with written policies, procedures and standards, a compliance officer and compliance committee who are accountable for the policies and procedures, effective training and education in detecting, correcting, and preventing fraud, and effective lines of communication related to all of the above. Sponsors also must promote the plan standards through well publicized disciplinary guidelines and have procedures for effective internal

monitoring and auditing that ensure prompt response and corrective action. CMS is establishing Medicare Drug Integrity Contractors (MEDICs) to assist it in its efforts. The MEDICs will be responsible for identifying and investigating potential fraud, developing potential fraud cases for referral to law enforcement, and serving as a liaison for law enforcement. Sponsors will have to cooperate with these groups.

- On June 30, 2005, CMS released instructions for submitting PDPs to submit pharmacy access analyses (www.cms.hhs.gov/pdps/aug1pharmaccess.asp). CMS previously extended the date for submitting such analysis until August 1, 2005 to allow plans more time to develop the extensive documentation required for such submissions. However submissions after July 15, 2005 will not be able to appeal and, if successful, participate in 2006 (versus 2007). CMS will notify applicants of their denial/conditional approval by late August/early September 2005 so contracts can be signed by early September 2005.

Relevant to Special Needs Plans Specifically

- In a June 30, 2005 press release, CMS indicates that it has approved 48 Special Needs Plans (SNPs) in 2005 and is reviewing more than 100 additional applications that have been submitted to provide services in 2006.

ON THE CONGRESSIONAL FRONT

About Medicare Health and Drug Plans Specifically

- The Medicare Payment Advisory Commission (MedPAC) released its June 2005 Report to Congress: "Issues in a Modernized Medicare Program" (www.medpac.gov). The first three chapters focus on Part D and MA issues.

    - Chapter 1 describes the Part D benefit and its implementation, including performance measures, information on payment and enrollment, the drug discount card experience and outreach for Part D, formulary exceptions and appeals processes, and a forward look at electronic prescribing. MedPAC recommends that the Secretary of Health and Human Services should have a process in place for timely delivery of Part D data to congressional support agencies to enable them to report on the drug benefit's impact on cost, quality and access.

    - Chapter 2 analyzes the MA local plan payment areas and risk adjustment. MedPAC recommends that Congress establish payment areas for local plans (currently based on counties) in larger areas. Among urban areas, counties should be grouped at the level of MSA within a state. Rural counties within a state should be grouped in collections that reflect health care market areas, such as health service areas. MedPAC also concludes that CMS's new risk-adjustment system (CMS-HCC) predicts beneficiaries' costs better than the "demographic" system used before.

    - Chapter 3 reviews the Medicare Advantage Program, including the new types of plans offered, requirements relevant to quality, enrollment and benefits, the MA bidding process for 2006 and financial neutrality. The report notes that MedPAC supports giving Medicare

beneficiaries a choice in the health care delivery system. However, the report also notes that some changes under the MMA raise issues about financial neutrality and the conditions of competition among choices. MedPAC recommends that Congress should: (1) eliminate the stabilization fund for regional MA PPOs; (2) calculate clinical measures for the fee-for-service program that can be compared to MA; (3) clarify that regional plans should submit bids that are standardized for the region's MA-eligible population; (4) remove the effects of payments for indirect medical education from MA plan benchmarks; (5) set the benchmarks used to evaluate MA plan bids at 100 percent of fee-for-service costs and redirect a share of savings from bids below the benchmark to MA plans based on quality; and (6) put into law the scheduled phase-out of the hold-harmless policy that offsets the impact of risk adjustment on aggregate payments through 2010. The report notes that with bidding already underway, a sharp change in payment could be disruptive and that implementation of the recommendations would take that into account.

- A June 2005 CBO paper focuses on "Prices for Brand-Name Drugs under Selected Federal Programs." Though the paper does not directly focus on Medicare, it describes how prices are determined for prescription drugs by diverse federal and state programs, noting that purchases by federal and state programs account for over 20 percent of US total expenditures for outpatient prescription drugs. Direct federal purchase programs include those related to the federal supply schedule, the "big four" federal ceiling price program, the Veteran's Administration, and the Department of Defense. The paper also describes the Medicaid rebate program and the Public Health Services' 340B drug pricing program. CBO estimates that average prices for single-source brand-name drugs in the third quarter of 2003 ranged from 53 percent of the list price (federal supply schedule) to 41 percent of the list price (DOD).

Broader Medicare Program (in Brief)

- In late June 2005, CMS Administrator Mark McClellan responded to a request for information on the agency's plans for "pay for performance" (P4P) for Medicare providers by House Ways and Means Chairman Bill Thomas and Subcommittee Chairman Nancy Johnson (*CQ HealthBeat*, June 27, 2005). The letter was supportive of the approach, detailing efforts (with Abt Associates) to develop P4P for skilled nursing care and other collaborations involving home health and ESRD where CMS currently collects performance data. McClellan indicated that a starter set of performance data for physicians in primary care was being finalized and that CMS is beginning a pilot test of using claims data to measure individual physicians' use of healthcare resources.

FROM THE PERSPECTIVE OF BENEFICIARIES

General

- On July 8, 2005, the Kaiser Family Foundation convened a workshop titled: "Low-Income Medicare Drug Assistance" on reaching and enrolling eligible low-income seniors for the extra help offered in the MMA. During the workshop, Tricia Neuman (Kaiser Family Foundation) gave an overview of the low-income assistance provisions and a panel responded. Participants included Beatrice Disman (SSA, New York region), James Fireman (National Council on the Aging and Chair, Access to Benefits Coalition), Vicki Gottlich (Center for Medicare Advocacy), and Michael R. McMullen (CMS). A webcast of the program (and PowerPoint slides) is available at:

www.kaisernetwork.org/health_cast.

- On June 10, 2005, the National Health Policy Forum sponsored a program on education and outreach activities related to the Medicare drug benefit. Presenters included: Michael McMullen (CMS), Tom Tobin (SSA), and Marisa Scala-Foley (Access to Benefits Coalition). More information about the forum is available at: www.nhpf.org.

- The AARP Public Policy Institute has circulated a package of four reports and papers on Medicare (www.aarp.gov). These include reports on the status of the Medicare Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds (the Trustees 2005 Annual Report); a brief on the Medicare program; a brief on Original Medicare cost sharing requirements; and a report on "Administrative Challenges in Managing the Medicare Program." The reports/papers are available at: www.aarp.org/ppi/.

- A June 15, 2005 article by Robert Pear of *The New York Times* reports that industry executives say CMS is pressing sponsors of Part D plans to offer an extensive array of prescription drugs (*New York Times*, June 15, 2005). This includes all or substantially all medications for cancer, HIV/AIDS, antidepressants, anti-psychotics, anticonvulsives, and immunosuppressives. CMS explained, in a Question and Answer (Q&A) document on its web site, that the policy on this issue evolved as it reviewed practices in other programs, such as FEHBP, where inclusion rather than granting exceptions is used in certain circumstances. CMS also was particularly concerned about 2006 since a large number of individuals would be transitioning into Part D plans. Drugs coming onto the market after January 1, 2006 will be subject to normal review. On the other hand, press reports also highlight the fact that Medicare won't cover some anxiety drugs because they are one of several types of drugs specifically excluded in the Medicare Modernization Act (*AP* Story, in *Las Vegas Sun*, June 26, 2005).

- The Access to Benefits Coalition released a report in June 2005 on "Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Incomes" (www.AccesstoBenefits.org). Drawing on a range of analyses, the report highlights ten key findings:

    1. Several different outreach and enrollment approaches can be implemented successfully at a reasonable cost.

    2. Success rates and costs vary dramatically across and within approaches. Different approaches can be efficient and yield excellent results, but only if they are implemented well.

    3. Some of the key factors for reducing costs and increasing success include: well-executed phone based enrollment; use of technology such as online eligibility tools and wireless internet access; careful planning of the method, frequency and format of contract; "qualifying" leads by identifying those most likely to be eligible before beginning the enrollment process; and a steady volume of qualified leads matched with an organization's capacity.

    4. The use of lists of likely eligible beneficiaries for targeted outreach and enrollment efforts is among the most promising, cost-effective and scalable approaches, and is necessary to maximize enrollment.

5. A "person centered" approach using trusted intermediaries to provide one-on-one assistance and screening for multiple benefits enhances results.

6. Coordination and division of roles among agencies improves outreach and enrollment outcomes.

7. Much of the target population is geographically concentrated, calling for similarly deployed outreach and enrollment resources.

8. Continuous learning is critical, both from one's own efforts, by testing, analyzing and refining the approach, and from best practices across projects.

9. Government policies and practices that make it easier for consumers to apply for benefits have a large impact on enrollment success.

10. Reaching full, or almost full, low-income subsidy enrollment will likely require hundreds of millions of dollars, millions of hours of one-on-one assistance to potential beneficiaries, and will take well over a year to accomplish.

The Coalition concludes with a "call to action" with steps by federal agencies, state and local governments, philanthropy, corporations, national and local voluntary organizations, and the US Congress to maximize enrollment.

Special Populations

- At a conference sponsored by the Alzheimer's Association, CMS Administrator Mark McClellan indicated that treatment for patients with this condition should improve in the future because special needs plans will be more widely available under the MMA (*CQ HealthBeat*, June 22, 2005).

FROM OTHER STAKEHOLDERS

- Humana announced that it will offer some form of Medicare plan in 46 states in 2006, up from 25 in 2005. The products include regional PPOs and Medicare Prescription Drug Plans (PDPs), as well as the local HMOs and PPOs that Humana already offers. In their press release, Humana indicates that this includes HMO/PPO products in 40 markets and PFFS products in 11 states, increasing to 26 states in 2006. (Humana press release, available at: http://corporatepressroom.com/pacificare/newsrelease/php?ID=472)

- UnitedHealth Group announced an agreement with AARP to offer an AARP-branded prescription drug plan in 2006 in all 50 states (www.unitedhealthgroup.com/news/rel2005/0606AARP_print.htm). UnitedHealth Group previously announced an affiliation with Walgreen Co. and the fact that their drug plan will be offered to all Medicare beneficiaries, including all 50 states, the District of Columbia, and the territories (*Star Tribune*, June 7, 2005).

- Blue Cross and Blue Shield Association has announced that its member plans will be expanding Medicare offerings in 2006. Member plans currently offer local MA products in 13 states. With the addition of 24 new local MA products and "multiple" regional products, the MA products will be

available from a Blue Cross Blue Shield plan in 31 states in 2006. Two thirds of the new products are PPO products. Blue Plans also have submitted 24 applications for PDPs in 2006. If approved, these will be in 25 of the 34 PDP regions and in 39 states. (http://bcbshealthissues.com)

- Aetna has announced that it has applied to offer a nationwide PDP and is teaming up with RiteAide to offer nationwide education and outreach on Medicare Part D. (www.aetna.com/news/2005/pr_20050612.htm)

- In May, Cigna announced that it has formed a strategic alliance with NationsHealth to offer Part D prescription drugs. The press release is available at: www.prnewswire.com/cgi-bin/stories.pl?ACCT=104&STORY=/www/story/05-09-2005/0003589765&EDATE=.

- PacifiCare has announced that it will offer five types of prescription drug plans in each of the 34 PDP regions in 2006. One will be a plan that requires no additional premium. The highest priced plan (with a $45/month premium) will cover more brand-name drugs than the zero premium plan and will be offered by a network of 30,000 insurance brokers (*Bloomberg*, June 10, 2005). PacifiCare also will be launching PFFS plans in 49 states and Washington DC (1,562 counties). A press release is available at: http://corporatepressroom.com/pacificare/newsrelease/php?ID=472.

- HealthNet has announced that it will expand its MA plans in 2006, including a regional PPO in Arizona. HealthNet also will offer Part D drug benefits in 5 new states—Massachusetts, New Jersey, Oregon, Rhode Island and Vermont, in addition to states where it already offers Medicare MA services including California, Connecticut, New York and Oregon (http://investor.health.net/). The firm also will offer special needs plans (SNPs) in Arizona, California, Connecticut and New York. These generally will be for dual eligibles, although PacifiCare will offer SNPs to beneficiaries with COPD and CHF in 2 counties in California.

- The June 20th issue of *Managed Care Week* includes a list of firm announced offerings that includes much of the previous detail with some expansion. These include: Coventry's offer of a nationwide PDP in conjunction with Rite-Aide, Wellpoint's application for Part D benefits in 50 states and some regional PPO benefits, Highmark's application for a PDP in its region (Pennsylvania and Delaware), Blue Cross Blue Shield's application for a statewide PDP in Florida (with expanded local MA offerings), Blue Cross Blue Shield's application for a PDP in North Carolina, and an application by seven Blue Cross Blue Shield plans in the upper Midwest to offer both a PDP and a regional PPO in that large region.

- CMS has posted press releases from a number of organizations indicating their collaboration with CMS to promote the Medicare drug benefit (www.cms.hhs.gov/partnerships):

    - National Community Pharmacists Association announced at their 37th annual meeting on May 4, 2005 that they were partnering with CMS and SSA to assist low-income Medicare beneficiaries in applying for subsidized benefits. The association represents over 24,000 community pharmacies. (www.ncpanet.org)

    - On May 17, 2005 Happy Harry's Discount Drug Stores announced they were partnering with SSA and CMS to increase awareness of the new Medicare drug benefit (www.happy.com).

    - On May 3, 2005, Walmart announced it will partner with CMS to increase awareness of the

Medicare drug benefit.

  - On May 2, 2005, CVS announced it will partner with CMS to broaden outreach for low-income beneficiaries.

- The *Managed Care Magazine* for April 2005 includes an article: "Starting Medicare Advantage Plan Brings Special Set of Problems" by Frank Diamand. The article quotes AHIP CEO Karen Ignagni as saying "CMS has launched an unprecedented effort…We've never before seen this level of ear-to-the-ground outreach on the part of government regulators." It goes on to discuss the challenges the MA product brings in terms of selling to individuals versus employers and treating people whose needs make comprehensive medical management more critical than single disease management.

- AcademyHealth held its 2005 Annual Research Meeting in Boston from June 26-June 28, 2005. On the wide ranging program were a number of sessions relevant to the Part D drug benefit and Medicare Advantage, some featuring previously unreported findings from CMS and other funded studies. Two web sites provide access to partial information from the sessions. The Kaiser Foundation has posted webcasts of selected sessions of the meeting, providing video, transcripts and selected presentation slides for sessions covered on its website (www.kaisernetwork.org). Three covered sessions are particularly relevant to Medicare:

  - "Transitioning from Medicare Drug Discount Card to Benefit" that was moderated by Brigid Goody included papers by Teresa Doksum (Abt Associates), Kelly Dougherty (Harvard University), Dan Waldo (CMS), Sunya Williams (CMS) and Marian Wrobel (Abt Associates).

  - "Translating 'Legislative Sausage' into Understandable Choices for Medicare Beneficiaries" that was moderated by Marsha Gold (Mathematica) included presentations by Liz Fowler (Health Policy Alternatives, formerly Senate Finance Committee), Tricia Neuman (the Kaiser Family Foundation), Diane Archer (Medicare Rights Center) and John Iglehart (Health Affairs).

  - "Medicare Modernization Act: The Impact of State Implementation Decisions" that was moderated by Richard Frank included presentations by Cindy Parks Thomas (Brandeis University) and others.

  In addition, the AcademyHealth web site (www.academyhealth.org/arm/agenda/index.htm) includes a full list of sessions including many of the presentation slides. Abstracts are provided for presented posters.

- In June 2005, Kaiser Family Foundation released a new fact sheet on "Low Income Assistance under the Medicare Drug Benefit" (www.kff.org).

- The National Academy of Social Insurance has released four papers on Medicare's role in reducing racial and ethnic disparities (www.nasi.org/publications2763). They look at: what HHS and CMS can and should do in this area (T.S. Jost), current CMS' programs and initiatives in this area (E. O'Brien), the physician and organized processes that can be used to reduce disparities in clinical care (L. Casolino), and capture of Medicare race/ethnicity data (M. McBean). A final report is anticipated December 2005.

NEWLY RELEASED RESEARCH STUDIES NOT PREVIOUSLY DESCRIBED

- **Adam Atherly, Paul L. Hebert, and Mathew L. Maciejewski. "An Analysis of Disenrollment from Medicare Managed Care Plans by Medicare Beneficiaries with Diabetes"** ***Medical Care*** **vol. 43, pg 500-506, May 2005.**

  This research examines whether high cost, high-risk Medicare patients with diabetes disenroll from Medicare managed care plans faster than those with lower cost and risk. The authors find this to be the case but also find that the effect is mitigated by plans offering better benefits. The authors also found that some patients with very high pre-enrollment Part A costs may remain in the HMOs longer relative to those with lower prior expenses.

- **Ha T. Tu. "Medicare Seniors Much Less Willing to Limit Physician-Hospital Choice for Lower Cost." Washington DC: Center for Studying Health Systems Change, HSC Issue Brief No. 96, June 2005.**

  Using data from a national survey, researchers find that 45 percent of seniors 65 and older said they were willing to trade broad provider choice to save money, compared to 70 percent of people aged 18 to 34, 62 percent aged 35-49, and 58 percent aged 50-64. Not surprisingly, those in HMOs were most willing to limit choice.

OTHER SIGNIFICANT EVENTS

- None.