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MEDICARE ADVANTAGE AND MEDICARE BENEFICIARIES
Monthly Tracking Report for December 2004

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

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PROGRAM STATUS: 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: Dec. 2004	Change From Last Month	Same Month Last Year	
			Dec. 2003	Change From Dec. 2003 - 2004
Contracts				
Total	300	2	285	+15
CCP	154	1	151	+3
PPO Demo	35	0	33	+2
PFFS	6	0	4	+2
Cost	29	0	30	-1
Other	76	1	67	+9
Enrollment				
Total	5,498,494	+53,376	5,324,101	+174,393
CCP	4,720,532	+37,821	4,622,031	+98,501
PPO Demo	111,316	+3,407	79,223	+32,093
PFFS	51,214	+6,839	25,897	+25,317
Cost	330,665	+327	334,378	-3,713
Other	284,767	+4,982	262,572	+22,195
Penetration*				
Total MA Penetration	12.8%	+0.1% points	12.5%	+0.3% points
CCP + PPO Demo Only	11.0%	+0.1% points	10.9%	+0.1% points

Penetration rates for December 2004 are calculated using the number of eligible beneficiaries reported in the September 2004 State/County File (which was corrected and re-released by CMS on December 1st, 2004). Penetration rates for December 2003 are calculated using the number of eligible beneficiaries reported in the December 2003 State/County File.

- There are pending applications for 7 M+C plans, 2 PFFS plans, 2 PACE plans, 3 PPO Demo plans and 3 Other Demo plans. Service area expansions are pending for 17 M+C plans, 4 PACE plans, 8 PPO Demo plans and 1 Cost plan.

- Please note: the December 2004 geographic service area files show a total of 173 CCP contracts. This data was released after the December State/County File, and may reflect some of the service area expansions and new contracts approved during December.

NEW ON THE WEB FROM CMS

About Requirements, New Contracts and Withdrawals

- On December 6th, HHS Secretary Tommy Thompson announced that CMS has established 26 regions for Medicare Advantage regional PPOs and 34 regions for Private Drug Plans (PDPs). In setting the Medicare Advantage regions, CMS considered four key factors: (1) ensuring that regions would be large enough to support strong networks but small enough to support plans entering right away to maximize beneficiaries' opportunities to enroll in a PPO; (2) encouraging the largest number of insurers possible to participate (which meant regions needed to have potential entrants with some history of multi-state regions and insurance licenses); (3) limiting the variation in costs among states within a region to encourage plans to participate; and (4) preserving current Medicare patient flows so that beneficiaries who enroll in a Medicare PPO will still be able to access providers out of the region in which they reside. More information about the MA and PDP regions is available on the CMS website at: http://www.cms.hhs.gov/medicarereform/mmaregions/.

- CMS issued draft guidance for MA organizations, Cost Plans and PPO Demonstrations that intend to transition to the expanded MA program in 2006 regarding how to comply with transition requirements established in the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. The guidance describes the steps that health plans must take to be compliant with the MMA as of January 1, 2006. Plans must submit up to three pieces of information to CMS, including a signed MA/Cost-based Plan transition attestation, a PD Part D application (if applicable), and an MA-PD bid submission, to begin the process of transition. More information is available online at: http://www.cms.hhs.gov/healthplans/maapplications/default.asp.

- On December 9th, CMS issued 2006 Application Questions & Answers for MA contract applicants. The document covers a variety of questions, including changes that will likely be made to the MA application and the timeline for submitting applications to CMS. The full set of questions and answers can be accessed online at: http://www.cms.hhs.gov/healthplans/Applications/default.asp.

Summary of service area expansions announced in December 2004:

Firm	Areas Served	Is this the only plan in the area (yes/no)	Number of beneficiaries
UnitedHealthcare of Tennessee Inc.	Davidson County, TN	N	103,000
	DeKalb County, TN		
	Hickman County, TN		
	Rutherford County, TN		
UCare Minnesota	Aitking County, MN	N	84,000
	Cass County, MN		
	Crow Wing County, MN		
	Kittson County, MN		
	Marshall County, MN		
	Morrison County, MN		
	Pennington County, MN		
	Polk County, MN		
	Red Lake County, MN		
	Roeau County, MN		
	St. Louis County, MN		
	Todd County, MN		
United Healthcare of Utah Inc.	Salt Lake County, UT Box Elder County, UT Davis County, UT Summit County, UT Wasatch County, UT Weber County, UT	N	144,000
Aetna	Burlington County, NJ	N	164,000
	Gloucester County, NJ		
	Morris County, NJ		
Humana Insurance Co.	Aransas County, TX	N	330,000
	Bastrop County, TX		
	Bexar County, TX		
	Caldwell County, TX		
	Comal County, TX		
	Guadalupe County, TX		
	Fort Bend County, TX		
	Hays County, TX		
	Harris County, TX		
	Kendall County, TX		
	Medina County, TX		
	Montgomery County, TX		
	Nueces County, TX		
	San Patricio County, TX		
	Travis County, TX		
	Williamson County, TX		
Humana Insurance Co.	Cass County, MO	N	200,000
	Clay County, MO		
	Jackson County, MO		
	Platte County, MO		
	Johnson County, KS		

Humana Health Benefit Plan of Louisiana	Ascension Parish, LA	N	270000
	East Baton Rouge Parish, LA		
	Iberville Parish, LA		
	Livingston Parish, LA		
	Orleans Parish, LA		
	Plaquemines Parish, LA		
	St. Bernard Parish, LA		
	St. Charles Parish, LA		
	St. Tammany Parish, LA		
	Washington Parish, LA		
	West Baton Rouge Parish, LA		
Humana Insurance Co.	Hamilton County, OH	N	235,000
	Brown County, OH		
	Butler County, OH		
	Clermont County, OH		
	Warren County, OH		
	Boon County, KY		
	Campbell County, KY		
	Kenton County, KY		
Humana Insurance Co.	Jefferson County, KY	N	141,000
	Bullitt County, KY		
	Oldham County, KY		
	Clark County, IN		
	Floyd County, IN		
Humana Insurance Co.	DeKalb County, GA	N	137,000
	Fulton County, GA		
Humana Medical Plan Inc.	Manatee County, FL	N	58,000
VIVA Health Inc.	Montgomery County, AL	N	42,000
	Autuaga County, AL		
	Lowndes County, AL		
Universal Care Inc.	Ventura County, CA	N	28,000

About Medicare Advantage

- On December 10th, CMS and its contractor – the National Committee on Quality Assurance (NCQA) - held a Special Open Door Forum to discuss proposed quality data reporting requirements for Medicare Advantage PPO plans and to provide stakeholders and prospective PPO plan sponsors with an opportunity to comment before CMS issues final regulations in January. At the forum, CMS and NCQA indicated that initial analysis suggests it is feasible for PPOs to collect data for 17 HEDIS measures starting in 2006. These measures can all be collected using administrative data. Included in this list are measures related to breast cancer screening, osteoporosis management, antidepressant medication management, follow up after hospitalization for mental illness, persistence of beta blocker treatment after heart attack, and glaucoma screening, as well as accessibility of care measures and a member survey. CMS noted that the number of measures that PPOs will be required to collect will likely be expanded in the future based on the results of a current NCQA pilot study of reporting requirements for local PPOs. More information on NCQA's analysis and the HEDIS measures PPOs will be required to report in 2006 is available online at: http://www.cms.hhs.gov/healthplans/performance/.

About Drug Card and Other Features of Medicare Related to MA

- On December 8th, on the 1-year anniversary of the Medicare Modernization Act, HHS Secretary Tommy Thompson announced that nearly 6 million Medicare beneficiaries have enrolled in a Medicare-approved drug discount card and 1.7 million Medicare beneficiaries have enrolled in the transitional assistance program. This announcement is the first official count of the number of beneficiaries who have signed up for the temporary program since July 30th, 2004. (www.hhs.gov/news/press/2004pres/20041208.html)

ON THE CONGRESSIONAL FRONT

MA Specifically

- The Medicare Payment Advisory Commission (MedPAC) will hold its next public meeting on January 12th and 13th, 2005. The meeting will be held at the Ronald Reagan Building in Washington, DC. An agenda will be available approximately one week before the meeting and transcripts will be available approximately 3 – 5 business days after the meeting ends. Both documents will be available online at: www.medpac.gov.

- MedPAC released a *Report to the Congress* on benefit design and cost sharing in Medicare Advantage plans this month. The report contains three major recommendations for the Congress. First, MedPAC recommends CMS continue to provide estimates of out-of-pocket costs on the Medicare Personal Plan Finder, begin to make available more tools that reflect out-of-pocket costs under various scenarios for use of services, and develop advanced decision tools that use individuals' actual experience to project future out-of-pocket spending as soon as feasible. Second, MedPAC recommends that CMS interpret its authority granted in the MMA to negotiate with MA plans broadly on their benefit design and cost sharing to ensure plans do not discriminate on the basis of health status. Third, MedPAC recommends that CMS develop guidelines for plans on benefit and cost sharing that, if adopted, would provide safe harbor from extensive negotiations with the agency. The Commission recommends that the guidelines create an out-of-pocket cap on cost sharing for Medicare-covered services and limitations on disproportionate cost sharing for services that are less discretionary in nature. The report is available at: www.medpac.gov.

Broader Medicare Reform (in Brief)

- On December 9th and 10th, MedPAC held a public meeting to discuss a variety of issues related to the Medicare program including the Commission's draft recommendations to institute a pay-for-performance system for hospitals, physicians and home healthcare. The Commission's recommendations call on Congress to: (1) establish quality incentives in Medicare payment policy for hospitals, physicians and home health agencies; (2) modify the diagnosis related group (DRG) system by redefining DRGs and weighting DRG payments based on hospital costs rather than its charges; (3) freeze payments to home health agencies beginning in calendar year 2006 and eliminate skilled nursing home facility payment updates for fiscal year 2006; and (4) update the "full market basket" for both inpatient and outpatient payments for 2006 to ensure that hospitals do not have negative profit margins for Medicare beneficiaries. A full transcript of the meeting is now available at: www.medpac.gov.

- The Government Accountability Office (GAO) released a report on the accuracy of responses from the 1-800-MEDICARE help line this month. The report, mandated by the MMA, directed GAO to examine several issues related to the 24-hour help line and customer service representatives who staff it. GAO evaluated the accuracy of the information the help line provides, training given to customer service representatives and CMS's efforts to monitor the accuracy of information provided through the help line. GAO found that the 1-800-Medicare help line provided accurate answers to 61 percent of the 420 calls it made and inaccurate answers to 29 percent (another 10 percent of calls were not answered). When customer service representatives provided inaccurate information it was largely because they did not seem to access and/or effectively use the script provided by CMS to answer questions. GAO recommends that CMS revise procedures so that calls are not transferred to other contractors that are closed, assess current scripts and ensure they are understandable, provide more training and testing for customer service representatives to ensure they are able to answer questions correctly and monitor the accuracy rate of the help line. The full report can be accessed at: www.gao.gov.

FROM THE PERSPECTIVE OF BENEFICIARIES

- On December 9th, Consumer Reports launched an educational and outreach initiative and free website, www.CRBestBuyDrugs.org, to help consumers and their doctors identify the most effective and affordable medicines. Consumer Reports plans to release reports comparing drugs in 20 different categories, and where possible choose a "Best Buy Drug" based on price and scientific evidence on the site. It released the first three reports this month. These reports compare drugs in three categories: cholesterol lowering medication, heartburn and acid reflux treatments, and anti-inflammatory drugs used to treat arthritis. In contrast to other work, Consumer Reports relies on outside research for its Best Buy Drug reports (not new research Consumer Reports conducts). Gail Shearer, director of health policy analysis at Consumers Union, said: "We hope that our outreach and educational efforts will result in millions of people being able to afford needed medications, and in large savings for many others whose doctors prescribe an effective, lower-cost prescription." (Consumers Union, December 9th)

FROM OTHER STAKEHOLDERS

- On December 15th, the National Committee for Quality Assurance (NCQA) released its 2004 list of the nation's ten highest quality Medicare and Medicaid health plans. NCQA judged health plans using publicly reported data on plan performance on a range of clinical indicators including measures related to cancer, diabetes, heart disease and asthma. The Medicare Top 10 list includes the MA offerings of many of the plans NCQA named to its Top 10 Commercial list in September. The list of 10 (in alphabetical order) is as follows: Blue Cross Blue Shield of Massachusetts, Capital Health Plan, Excellus BlueCross Blue Shield Rochester Region, Fallon Community Health Plan, Harvard Pilgrim Health Care, HealthPartners, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of the Mid-Atlantic, Kaiser Foundation Health Plan of Hawaii, Keystone Health Plan Central and Rochester Area Health Maintenance Organization dba Preferred Care. NCQA President Margaret O'Kane said of the list: "These health plans provide daily proof that achieving excellence isn't a question of plan type or market or profit status – it's hard work and accountability." (NCQA press release, December 15th)

- On December 17th, the Kaiser Family Foundation in conjunction with Mathematica Policy Research launched a new online tool called the "Medicare Health Plan Tracker." The tool provides information on a variety of topics related to Medicare Advantage, including plan availability, enrollment and benefits at the national, state, and county level for years 1999 through 2004. The Medicare Health Plan Tracker is available online at: http://www.kff.org/medicare/healthplantracker/.

- The Kaiser Family Foundation released a summary of the proposed rule for implementing the Medicare prescription drug benefit that CMS published earlier this year. The proposed rule contains regulations to implement the Medicare Prescription Drug Benefit (Title I of the MMA). The summary, which was prepared by Health Policy Alternatives, outlines the main topics in each subpart of the rule, along with issues raised in the preamble corresponding to each subpart in the proposed regulation. The summary is intended to help interested readers quickly obtain information about how CMS proposes to implement the drug benefit. It will be updated shortly after the final rule is published. The summary is available online at: www.kff.org.

NEWLY RELEASED RESEARCH STUDIES NOT PREVIOUSLY DESCRIBED

- **Achman, Lori and Marsha Gold. "Are the 2004 Payment Increases Helping to Stem Medicare Advantage's Benefit Erosion?" New York, NY: The Commonwealth Fund, December 2004. (www.cmwf.org)**

  In this issue brief, the authors examine trends in MA benefits and premiums in 2004, paying particular attention to the impact of MMA payment increases. The authors use data from the Medicare Health Plan Compare, a database of plan benefit packages maintained by CMS and the geographic service area files to analyze benefits in basic HMO, non-demonstration PPO, point of service and provider service organizations (which are often termed coordinated care plans). The authors found that about one half of the 2004 MMA payment increase was used by plans to reduce enrollee premiums and other cost sharing or to enhance benefits. On average, premiums fell by $9 between 2003 and 2004. In addition, the authors found that average out-of-pocket costs declined to their 2003 level (which they estimate as $1,964). The portion of plans offering prescription drug coverage remained about the same, however, of those plans offering drug coverage, a higher proportion now cover brand name drugs. The authors conclude by noting that it is too early to determine whether payment changes are enough to reverse the downslide in private plans' participation and beneficiaries' enrollment in the MA program.

- **Berenson, Robert. "Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field.'" *Health Affairs*, web exclusive, vol. 4, December 2004. (www.healthaffairs.org)**

  In this paper, the author examines policy elements in the MMA, which he argues tilt the playing field in the favor of private plans by reviewing payment adequacy, the implementation of risk adjustment, the new bidding approach for determining plan payments and the special role envisioned for PPOs. The author argues that tying plan payments to increases in spending in the traditional fee-for-service (FFS) Medicare program and not to plans' underlying costs has repeatedly led to "over" or "underpayments" to private plans. The author also argues that the net effect of various provisions in the MMA, which has retained many of the linkages to FFS spending, is a marked increase in plan payments (which are now, on average, above FFS levels). He concludes by noting that health plans'

reluctance to re-enter Medicare in 2004 may prove prescient if Congress, facing growing budget deficits in 2005, decides to reduce plan overpayments.

- **Biles, Brian, Geraldine Dallek and Lauren Hersch Nicholas. "Medicare Advantage: Déjà vu All Over Again?" *Health Affairs,* web exclusive, vol. 4, December 2004. (www.healthaffairs.org)**

  This paper discusses the factors responsible for the failure of Medicare+Choice (M+C) to grow as intended when it was created and analyzes the challenges posed by the new MMA legislation for beneficiaries and the Medicare program in light of these factors. The authors argue that the six-year experience with the M+C program suggest six major challenges that must be addressed for the new legislation to be successful in increasing the role of private plans in Medicare. First, CMS must ensure that beneficiaries have access to information and education that will allow them to choose a plan that meets their needs from the array of plan benefit packages that are available. Second, CMS must address risk selection issues and ensure that individual plans do not design drug and other benefits in a way that discourages high-cost, sicker beneficiaries from enrolling through strong regulatory and administrative oversight. Third, Congress and CMS must work to stabilize the MA market by working to reduce both plan and provider instability. Fourth, beneficiary "lock-in" must be addressed to ensure that specific groups of enrollees, particularly vulnerable enrollees, are not harmed by their inability to leave an MA-PD or PD plan during the year. Fifth, geographic inequity in plan choice and benefits must be addressed. Sixth, Medicare costs could increase because of spending on private plans and the lack of limits on prescription drug costs. The authors conclude that if "MMA policies lead to experiences with private plans that are similar to what M+C experienced, observers six years from now may conclude the problems facing MMA's prescription drug and MA programs are a classic case of déjà vu all over again."

- **Biles, Brian, Lauren Hersch Nicholas and Barbara S. Cooper. "The Cost of Privatization: Extra Payments to Medicare Advantage Plans – 2005 Update." New York, NY: The Commonwealth Fund, December 2004. (www.cmwf.org)**

  This issue brief updates an earlier analysis published by The Commonwealth Fund that examined Medicare payments in 2004 to MA plans relative to the costs of FFS Medicare. The authors use data from the 2005 MA Rate Calculation File to show that, in 2005, each of the nation's MA plans will be paid a rate higher than the FFS level within the same county. They find that plans will be paid an average of 7.8 percent more (which is equivalent to $546 per MA enrollee) for a total of $2.72 billion more overall. The authors note that the largest extra payments relative to FFS costs will continue to be made to plans in the rural "floor" counties. They also note that the amount by which payments per plan enrollee exceed FFS costs varies greatly by state, with extra payments per enrollee ranging from more than $1,500 in Hawaii, New Mexico, North Carolina, North Dakota and Oregon to less than $200 in Florida and Nevada.

- **Gluck, Michael and Richard Sorian. "Administrative Challenges in Managing the Medicare Program." Washington, DC: AARP, December 2004. (www.aarp.org)**

  In this paper, the authors describe the scope of activities necessary to manage the Medicare program and identify several challenges federal administrators face in performing these tasks. The authors focus on four tasks of particular interest to Medicare beneficiaries and providers: (1) educating and informing beneficiaries about their benefits, rights and options; (2) using information technology as a tool for Medicare administrative tasks; (3) making national coverage decisions for medical services, procedures and technologies; and (4) administering private Medicare plans. The authors reviewed existing literature as of the spring of 2002 (including oral and written histories of the program, reports, government documents, news accounts and congressional testimony), and conducted 37 structured telephone interviews with national experts in Medicare management and policy. The authors found that though Medicare is a diverse and complex program to administer with "grossly inadequate" funding for administrative tasks, CMS performs many of its core responsibilities well. The authors note that CMS is understaffed and has had difficulty in attracting individuals with specialized knowledge (such as individuals with experience in managed care or private health insurance). In addition, the authors found that Congress has "sharply increased its level of involvement in Medicare payment and other policies" without adding resources to enable CMS to perform these responsibilities.

- **Gross, David, Stephen Schondelmeyer and Susan Raetzman. "Trends in Manufacturer Prices of Brand Name Prescription Drugs Used by Older Americans – Second and Third Quarter 2004 Update." Washington, DC: AARP, December 2004. (www.aarp.org)**

  This issue brief describes changes in the prices charged by prescription drug manufacturers through the first three quarters of 2004 (January through September) for the brand name prescription drugs most widely used by Americans aged 50 and older. The issue brief is part of an ongoing series of studies tracking changes in the prices manufacturers charge for drugs they sell to wholesalers. The key findings of the second and third quarter updates are: (1) the annual rate of increase in manufacturer's prices for 197 brand name drugs continued to exceed both the rate of inflation and the rates of the Consumer Price Index-All Urban Consumers (CPI-U); (2) after rising by 3.5 percent in the first quarter, manufacturer prices rose by only 1.0 percent in the second quarter and 0.5 percent in the third quarter; and (3) the average percentage price increase during the first three quarters of 2004 (i.e. from December 31, 2003 through September 30) was 5.0 percent. The authors conclude by noting that despite the fact prices did not increase as much in the second and third quarters of 2004, the average annual increase for the 12-month period beginning in September 2003 is still more than three times the annual rate of general inflation (2.3 percent).

- **Harris, Lindsay, Lori Achman and Marsha Gold. "The Use of Exclusive Discount Drug Cards in Medicare Advantage Plans." Washington, DC: Mathematica Policy Research, December 2004. (www.mathematica-mpr.com)**

  This issue brief profiles the arrangements under which "exclusive" Medicare-approved discount drug cards (the cards offered by MA plans exclusively to their enrollees) are offered, the way in which discount cards integrate with the existing drug benefit offered by many of the MA plans, and the potential lessons from this experience for the Part D benefit. The authors found that 42 MA contracts offer an exclusive card to their enrollees, providing access to 3.2 million of the 4.7 million MA enrollees. They also found that coordinated care plans (CCPs) were more likely than PPO

Demonstration plans or private fee-for-service (PFFS) plans to offer an exclusive discount card, and that plans which provide coverage for generic and brand name drugs were more likely to offer an exclusive card than plans with lesser or no drug coverage. The authors conclude that the majority of MA firms are participating in the Medicare-approved drug discount card program, and that together, these firms account for more than half of drug card sponsors and more than half of drug card enrollment (as of July 2004). They also argue that the main motivation for offering such cards is that enrollees expect it and that plans want to show support for the changes that will be forthcoming under the MMA.

- **Kaiser Family Foundation and Hewitt Associates. "Findings from the Kaiser/Hewitt 2004 Survey on Retiree Health Benefits." Washington, DC: Kaiser Family Foundation, December 2004. (www.kff.org)**

  This survey, conducted between May and September 2004, is the third in a series of surveys that provide detailed information on the state of retiree health benefits. This study provides comprehensive information on how private-sector employers expect to respond to the MMA beginning in 2006. The survey report provides a detailed description of large, private-sector retiree health benefits, including prescription drug coverage, in 2004. It also describes the actions employers have taken in the past year and are planning to take in 2005 before the MMA takes effect. The survey showed: (1) the vast majority of surveyed private-sector firms with 1,000+ employees that offer retiree health benefits provide coverage for both pre-65 retirees and age 65+ retirees, although pre-65 retirees are most typically offered a PPO option while 65+ retirees are offered an indemnity or managed indemnity plan; (2) according to these employers, the total cost of providing retiree health benefits increased by an estimated 12.7 percent, on average, between 2003 and 2004; (3) total premiums are typically higher for pre-65 retirees than they are for those ages 65+ because the employer plan is the main source of coverage for pre-retirees but secondary to Medicare for retirees 65+; (4) for retirees 65 and older, employer-sponsored health benefits are the primary source of drug coverage; and (5) to help control costs, employers have raised cost sharing requirements and implemented new strategies to manage utilization of drugs, and the majority say they are likely to continue to offer drug benefits to their Medicare-eligible retirees when the MMA goes into effect.

- **Love, Jeffrey. "Filling the Rx: An Analysis of the Perceptions and Attitudes of Medicare Rx Discount Card Holders." Washington, DC: AARP, December 2004. (www.aarp.org)**

  In April of 2004, AARP initiated a series of three surveys among people age 65 and older eligible for the Medicare-approved drug discount card. Results from the first survey were reported last summer. This report examines data from the second survey, which was conducted by mail in October 2004. AARP surveyed 4,001 people (including 574 who have signed up for a discount card). Of those who signed up for the card, the majority signed up themselves and were not automatically enrolled. Sixty-three percent of those who signed up for a card considered it very or somewhat easy to choose among the Medicare-approved discount cards offered. The reported average amount saved by respondents who have already seen savings with their discount card is $154. The survey showed that individuals who declined the card did so because they had existing drug coverage (51 percent) or already had a non-Medicare discount card (28 percent). The author notes that the difference in information used by cardholders and non-cardholders in the decision to enroll is striking: non-cardholders were less likely to have received information about cards, were less likely to seek help in making the decision and, when they sought help, looked to different sources than those used by cardholders.

- **Rice, Thomas and Karen Matsuoka. "The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors."** ***Medical Care Research and Review*****, vol. 61, December 2004.**

  This article provides a review of the research that has addressed the impact of patient cost-sharing on the use of services and resulting health status impacts, among the population age 65 and older. The authors review the results from 22 studies published since 1990, including 7 that focus specifically on health status. From this small sample, they conclude that cost-sharing can result in lower health status either through higher mortality or various measures of morbidity. However, the literature suggests that cost-sharing does not impact health status where generous provisions are in place to protect vulnerable populations from financial risk and in the case of patients experiencing myocardial infarctions (MIs). Fifteen studies document the impact of cost-sharing on the use of services. From these studies, the authors conclude that increased cost-sharing generally "tends to reduce the appropriate use of prescription drugs, and somewhat less definitely due to fewer relevant studies, appropriate service use."

- **Town, Feldman and Wholey. "The Impact of Ownership Conversions on HMO Performance."** ***International Journal of Health Care Finance and Economics,*** **vol 4, no. 4, December 2004.**

  In this article, the authors examine the impact of not-for-profit HMOs converting to for-profit status on HMO prices, profit margins, use of hospital days or ambulatory visits, and provision of Medicare and Medicaid products using data on several Blue Cross Blue Shield plans that sponsor HMOs. The authors findings indicated that conversions to for-profit status do not significantly impact HMO prices, profit margins, use of hospital days or ambulatory visits, or provision of Medicare and Medicaid products.

OTHER SIGNIFICANT EVENTS

X None.