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MEDICARE ADVANTAGE AND MEDICARE BENEFICIARIES
Monthly Tracking Report for July, 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: July 2004	Change From Last Month	Same Month Last Year	
			July 2003	Change From July 2003 - 2004
Contracts				
Total	292	+1	270	+22
CCP	149	+1	150	-1
PPO Demo	35	0	31	+4
PFFS	5	0	4	+1
Cost	29	0	30	-1
Other	74	0	55	+19
Enrollment				
Total	5,376,650	25,341	5,301,138	75,512
CCP	4,634,134	16,488	4,622,471	11,663
PPO Demo	102,634	2,772	67,561	35,073
PFFS	37,357	2,245	23,009	14,348
Cost	330,081	95	334,639	-4,558
Other	272,444	3,741	253,458	18,986
Penetration*				
Total MA Penetration	12.7%	+0.4% pts	12.6%	+0.1% pts
CCP + PPO Demo Only	11.2%	+0.1% pts	11.2%	0.0% pts

* Penetration rates in June and July 2004 are calculated using the number of eligible beneficiaries reported in the March 2004 State/County File. Penetration rates in June 2003 are calculated using the number of eligible beneficiaries reported in the March 2003 State/County File.

- There are pending applications for 10 M+C plans, 1 PFFS plan, 1 PACE plan, and 2 other demonstration plans. Service area expansions are pending for 16 M+C plans, 4 PACE plans, 2 PFFS plans and 3 other demonstration plans.

NEW ON THE WEB FROM CMS

About Requirements, New Contracts and Withdrawals

- On July 1st CarePlus Health Plans Inc. received approval to expand managed care coverage to Medicare beneficiaries in Palm Beach County, Florida. About 250,000 beneficiaries live in Palm Beach County. Beneficiaries in Palm Beach County are already served by America's Health Choice Medical Plan, Well Care HMO Inc., Health Options, Humana Medical Plan Inc., Vista Health Plan Inc. and United Healthcare Florida Inc. (http://www.cms.hhs.gov/media/pres/release.asp?Counter=1106).

- On July 20th, CMS approved a request by Preferred Medicare Choice, Inc. to offer managed care coverage to beneficiaries in San Juan and 29 other municipalities in northern and western Puerto Rico. Approximately 343, 000 beneficiaries live in the affected municipalities. MMM is the only other plan operating in the 30 municipalities. Preferred Medicare Choice Inc. will begin serving beneficiaries on August 1st. (http://www.cms.hhs.gov/media/press/release.asp?Counter=1119).

- CMS approved a request by Community Insurance Co. Inc., a subsidiary of Anthem Inc., to expand managed care coverage to Medicare beneficiaries in Clark County, Ohio on July 23rd. About 250,000 Medicare beneficiaries live in Clark County, which is in the western part of the state. Beneficiaries in Clark County are already served by United Healthcare Medicare Complete and United Healthcare Medicare Complete Choice. Community Insurance Inc. already operates in 23 counties in Ohio. Community Insurance Inc., which operates as Anthem Senior Advantage, will begin serving beneficiaries on August 1st.

- On July 28th, UnitedHealthcare of Florida, Inc., a subsidiary of UnitedHealth Group, received approval to expand managed care coverage to Medicare beneficiaries in Polk County, Florida. Polk County is in the Tampa Bay area. About 100,000 beneficiaries live in the affected area. UnitedHealthcare of Florida currently serves eight Florida counties including the cities of St. Petersburg, Tampa, Fort Myers and Sarasota.

About Other Program Features

- On July 7th, HHS Secretary Tommy Thompson announced $125 million in grants to states with state pharmaceutical assistance programs (SPAPs) to help educate low-income Medicare beneficiaries who currently get their prescription drugs through state-funded programs about the 2006 Medicare drug benefit. The grants will come from funds set aside in the MMA. The amount of money each state will receive will be determined by the number of SPAP enrollees in the state as of October 1, 2003. The funds can be used to establish telephone support and counseling services to help eligible beneficiaries select and enroll in one of the new Part D plans and to aid in the coordination of enrollment, coverage and payment between state funded drug programs and the new Part D. State SPAP programs have until August 9th, 2004, to submit a grant application. (http://www.cms.hhs.gov/media/press/release.asp?Counter=1108).

- On July 6th, the Associated Press reported that the Bush administration is resisting calls to expand automatic enrollment of Medicare beneficiaries in prescription drug card plans even though some healthcare analysts suggest that as many as 700,000 low-income beneficiaries could be enrolled in the program if the federal government expanded automatic enrollment. Instead, the Bush administration has provided the Access to Benefits Coalition, a group of civic organizations dedicated to persuading low-income beneficiaries to enroll on their own, with $5 million for this effort. CMS administrator Mark McClellan said that he had not "ruled out broader automatic sign-ups" however. To date, 3.7 million people have enrolled in the Medicare prescription drug card program. Approximately 66 percent of beneficiaries in the program were enrolled automatically either because of their membership in a managed care organization or in a state prescription drug assistance plan. (http://www.detnews.com/2004/health/0407/06/a03-204028.htm).

- On July 26th, HHS Secretary Tommy Thompson announced proposed regulations to implement a voluntary prescription drug benefit under Medicare (as set forth in the MMA). The proposed regulations also include rules for the Medicare Advantage program that would make regional preferred provider organizations (PPOs) available to all Medicare beneficiaries. The rule will be published in the Federal Register on August 3rd. The comment period will last 60 days, and will close on October 4th. More information is available at: www.cms.hhs.gov/medicarereform.

- On July 21st, CMS with its contractor (RTI International) held a meeting to discuss regional options for Medicare managed care and prescription drug plans. CMS presented analysis of five regional options, which include (1) 50 state-based regions, (2) 10 multi-state regions based on CMS administrative regions, (3) 11 multi-state regions based on equal Medicare eligible populations, (4) 24 multi-state regions based on median PPO activity and (5) 41 multi-state regions based on minimum PPO activity. At the meeting officials from CMS acknowledged that a great deal of work to refine current options and identify more options is still needed. They also noted that initial feedback from stakeholder groups had included support for both state-based regions and regions based on contiguous groups of states. (*BNA Medicare Report*, Vol. 10, No. 30, July 23rd). Transcripts, other materials and a Webcast of the meeting are available online at: http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=1241.

- On July 30th, CMS administrator Mark McClellan announced that enrollment in the Medicare-approved drug discount card program has surpassed the 4 million mark. According to CMS, more than 100,000 Medicare beneficiaries are signing up for a drug card each week. McClellan noted that "the steady increase and continuing enrollment in the Medicare-approved drug discount card program shows that beneficiaries have discovered that the cards provide real savings and are helpful in lowering their prescription drug costs." Of the 4 million who are now enrolled nearly 1 million are receiving transitional assistance. Approximately 2.3 million enrollees were automatically enrolled in a drug card program by their health plans. This was the first time CMS released specific auto-enrollment numbers for MA plans separate from number for state pharmaceutical assistance programs (SPAPs). (www.cms.hhs.gov/media/pressrelease.asp?Counter=1142).

- On July 30th, CMS announced that United States Pharmacopeia (USP), the non-governmental organization charged with establishing model guidelines for Medicare drug coverage for the full Part D benefit, will host a public meeting to discuss the development of standards for drug classes and categories. The USP guidelines will be used by prescription drug plans and MA prescription drug

plans as they develop formularies and drug classes. The meeting will be held from 9am to 4pm on August 27th, in Baltimore, MD. For more information please visit: http://www.usp.org/drugInformation/mmg/publicMeeting.html.

- On July 15th CMS announced that it has made improvements to the Medicare-approved discount drug card program website and the 1-800-MEDICARE number. CMS has improved the Price Compare tool by simplifying the process of entering beneficiary information, creating an integrated drug dictionary to make it easier to enter drug information and providing the five lowest priced Medicare-approved drug discount cards that fit the beneficiary's individual drug needs to address concerns that beneficiaries were being overloaded with information. CMS has also enhanced customer service for the telephone hotline and enhanced information on state and manufacturer programs. The improvements are intended to make it easier for Medicare beneficiaries to start using a Medicare drug card. (http://www.cms.hhs.gov/media/press/release.asp?Counter=1113).

- On July 19th CMS and OMB sent a letter to the states stating that MMA benefits "shall not be taken into account in determining an individual's eligibility for, or the amounts of benefits under, any other federal program." As a result, low-income Medicare beneficiaries who qualify for transitional assistance can be sure that this help will not be counted against them when they apply for Medicaid or other federal government benefit programs like housing and food stamps. MMA rules bar federal agencies from counting the $600 credit as an asset or resource for the purposes of Medicaid eligibility. The policy does not apply to discounts or subsidies received through health insurance or other discount programs like those often offered by drug manufacturers. The letter is available at: http://www.cms.hhs.gov/states/letters/.

- CMS has posted a list of frequently asked questions (FAQs) regarding the 2005 Call Letter instructions for MA plans wishing to participate in the 2005 contract year, which was posted last month. The list of questions and answers is available online at: http://www.cms.hhs.gov/healthplans/letters/callletter2faq.pdf.

- CMS has posted the capacity limits for 2004 on its website. CMS indicates that it has approve capacity limits for 19 contracts in 56 counties. Capacity limits have been lifted for 1 plan. For more information please visit: http://www.cms.hhs.gov/healthplans/capacity/capacitylimit7-2004.pdf.

ON THE CONGRESSIONAL FRONT

M+C Specifically

- None.

Broader Medicare Reform (in Brief)

- On June 19th, the Senate Special Committee on Aging held a hearing to discuss how the MMA will help low-income seniors purchase prescription drugs. Witnesses at the hearing included Mark McClellan, administrator of CMS, Gail Wilensky, senior fellow at Project Hope, Byron Thames, trustee with AARP, Jane Delgado, president and CEO of the National Alliance for Hispanic Health, and Patricia Nemore, attorney for the Center for Medicare Advocacy. At the hearing Mark McClellan noted that "the Medicare-approved prescription drug cards…are already providing substantially lower drug prices for almost four million individuals, almost a million of whom have low incomes" and that the full benefit (that will begin in 2006) will give those with low-incomes and few assets "substantial additional help paying for prescription drug costs." Other witnesses were less optimistic. Patricia Nemore suggested that CMS needs to do more to ensure that low-income beneficiaries, many of whom are frail or disabled, have access to comprehensive information about prescription drugs and drug plans. She also suggested that more must be done to reduce barriers to enrollment including "difficulties with language and transportation issues and restrictive assets tests." Prepared witness testimony is available online at: http://aging.senate.gov

- MedPAC released an updated version of *"A Data Book: Healthcare Spending and the Medicare Program."* The Data Book is divided up into three sections. The first details Medicare beneficiary demographics, quality and access in the Medicare program, Medicare beneficiary and other payer liability, national healthcare and Medicare spending. The second provides information on Medicare spending, utilization and availability of different provider settings – such as hospitals or post-acute care. Finally, the third section covers Medicare Advantage and the availability of other supplemental options for Medicare beneficiaries. In this section, MedPAC reports that MA plans are available in at least parts of 45 states (although CCP plans are only available in 38 states, and 7 states only have a PFFS plan option). MedPAC also reports that 2004 enrollment in MA plans is at the same level as it was just before the passage of the BBA in 1997. Approximately 28 percent of Medicare beneficiaries live in counties where a "large urban" floor determines the payment rates, another 19 percent of beneficiaries live in counties where the lower floor determines payment rates, and 53 percent of beneficiaries live in counties where rates were high enough so that they were not determined by a floor. The full report is available at: www.medpac.gov.

- On July 9th, Representatives Henry Waxman and Louise Slaughter sent a letter to HHS Secretary Tommy Thompson charging that the Medicare Compare website that lists prescription drug prices for the new drug discount card program contains a number of errors that could lead beneficiaries to sign up for a drug discount card that does not offer the best savings. Staff members from the House Government Reform Committee surveyed 10 independently owned pharmacies in Washington, DC. They found that the Medicare Compare website displayed incorrect information on the number and types of cards the pharmacies honor for the majority of the 10 sites. Waxman and Slaughter wrote: "Seniors who go to the Web site and choose a drug card because they believe that their local pharmacy is a participant may find that this is not the case. As a result, the card they choose could leave them without access to their local pharmacy." HHS Spokesperson Bill Pierce noted that Waxman and Slaughter focused on a few regularities in a program with more than 50,000 participating pharmacies. (*Roll Call*, 7/8/04 and Kaiser Daily Health Reports, 7/8/04).

- A new report by the Democrats on the Joint Economic Committee suggests that the new Medicare prescription drug benefit could result in a reduction in Social Security payments to beneficiaries. The JEC report says that "Seniors are exposed to the possibility that large increases in medical costs, especially prescription drug costs, could eat up a large piece of ther Social Security COLA [Cost of Living Adjustment] and, for some, even reduce the size of their Social Security check" because the MMA does not link Part D premiums to annual cost-of-living increases in Social Security benefits. The law ties the Part D premium to drug price inflation, while Social Security COLA increases are tied to the overall rate of inflation. (*American Healthline*, July 12th)

- On July 15th Democrats in the House Committee on Government Reform issued a report that found that Medicare Beneficiaries in Nassau County, NY, could save more on drugs by purchasing their medications from Canada or through the Department of Veterans Affairs than through Medicare discount card programs. The report analyzed discounts offered by the 34 drug discount cards available in Nassau County. The authors found that Medicare beneficiaries who purchase their medications online pay approximately the same as they would pay with the discount cards. The report also suggests that low-income beneficiaries benefit from the discount cards the most because they receive a $600 subsidy and do not have to pay card enrollment fees. (http://www.newsday.com/news/local/longisland/ny-lidrug153893261jul15,0,3840266story?coll=ny-topstories-headlines).

FROM THE PERSPECTIVE OF BENEFICIARIES

- On July 18th *USA Today* reported that Medica Health Plans, an HMO in Minnesota, suffered significant losses when a computer programming glitch told pharmacists to give thousands of Minnesota retirees free generic prescriptions. Medica intended to offer 3,501 seniors enrolled in its Medicare-supplement insurance plan, Medica Prime Solution, a one-time offer whereby the company would pay for those switching from 21 brand-name drugs to generics. However, a computer programming error mistakenly told pharmacists that all 28,261 enrollees in Prime Solution qualified for free generic drugs. The company is still trying to determine how many enrollees received free medications and how much money it lost. Medica has decided that enrollees who received free prescriptions will be allowed not be charged and may keep the prescriptions. (*USA Today*, June 18th).

- On July 27th, AARP Segunda Juventud announced the launch of a bilingual prescription drug channel. The new channel features the latest information on the Medicare drug program as well as news and guidance about drug prices and safety. There is also an interactive Medicare Drug Benefit Calculator that lets beneficiaries plug in their current and projected spending levels to get a general idea of how they will fare under the new law. The tool gives Spanish-speaking seniors an online resource for information about Medicare and the new prescription drug benefit. The channel can be accessed at: www.aarpsegundajuventad.org.

- On June 24th, Families USA released a new report: "Private Health Plans that Serve Medicare Provide Lavish Compensation to Executives." The report documents top executives' salaries, bonuses and stock options in 11 publicly traded, for-profit managed care companies that serve Medicare beneficiaries. The companies examined in the report are: Aetna Inc., Anthem Inc., CIGNA Corp., Coventry Health Care Inc., Health Net Inc., Humana Inc., Oxford Health Plans Inc., PacifiCare Health

Systems Inc., Sierra Health Services Inc., UnitedHealth Group Inc. and WellPoint Health Networks. The full report is available at: www.familesusa.org.

- The Center for Medicare Education release an issue brief: "Medicare Savings Programs: Helping Your Clients Get and Use the Benefits" by Patricia Nemore. The brief discusses issues that Medicare beneficiaries who are dually eligible for Medicare and Medicaid may face as they seek to enroll in and use Medicare Savings Programs (MSPs). The author suggests that MSP-eligible persons may face significant challenges and barriers to participation including lack of information about the program itself and recovery of benefits from beneficiaries' estates. She indicates that states can reduce these barriers by improving outreach to eligible beneficiaries. The author also discusses challenges faced by Qualified Medicare Beneficiaries (QMBs). She indicates that states could reduce the burden of Part A enrollment by establishing a buy-in agreement that allows the state to enroll someone at any time in the year. Additionally, the author notes that Medicare professionals can help beneficiaries in MA plans by informing the plans that they are not allowed to bill QMBs for co-pays, and by finding out how the state reimburses MA providers. The full issue brief is available at: www.MedicareEd.org.

- The Kaiser Commission on Medicaid and the Uninsured released a new issue paper: "The New Medicare Prescription Drug Law: Issues for Dual Eligibles with Disabling and Serious Conditions" at the end of June. The paper discusses the issues individuals who are eligible for both Medicare and Medicaid (often called "dual eligibles"), many of whom are in poor health and have significant need for prescription drugs, will face when their prescription drug coverage switches from Medicaid to private Medicare Part D plans in 2006. The authors argue that many provisions in the MMA could restrict access to needed medications because it allows plans to charge dual eligibles premiums and co-pays that are unaffordable. Additionally, the authors suggest that provisions in the MMA that restrict beneficiaries' rights to appeal coverage decisions made by prescription drug plans may disproportionately affect dual eligibles because of their low incomes, extensive reliance on medications and the magnitude of problems they face when medication is interrupted. The full issue paper is available at: http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=40714.

- The Robert Wood Johnson Foundation has released a policy brief to accompany the research synthesis: "Geographic Variation in Medicare Per Capita Spending: Should Policymakers Be Concerned?" by Marsha Gold. For more information about the full report please refer to the Newly Released Research section of this report. The brief is available online at: www.rwjf.org.

FROM THE OTHER STAKEHOLDERS

- On July 6th, the HHS Office of Inspector General (OIG) concluded that former CMS administrator Tom Scully broke no law when he ordered Medicare chief actuary Richard Foster to withhold information about the cost of the MMA legislation from Congress. OIG conducted an investigation into whether: (1) CMS provided information requested by Congressional Members and staff about the MMA, and if CMS did not, whether withholding such information violated any criminal law; (2) Scully threatened Foster, and if threats occurred, whether such threats violated any criminal law or administrative policy; and (3) the CMS Actuary has an independent legal obligation to disclose information to Congress. Based on its investigation, OIG found that CMS did not provide estimates to

Congress but failed to produce any evidence that withholding information violated any criminal statutes. OIG also found that although Scully had warned Foster he would take disciplinary action if Foster provided certain information to Congress, Scully's conduct did not violate criminal law. Finally, OIG concluded that the CMS Actuary had no legal authority to disclose information independently to Congress. (http://oig.hhs.gov/publications/docs/press/2004/070704IGStatement.pdf)

- Pfizer announced a new initiative to provide prescription drug discounts to the uninsured on July 8th. Under the new initiative, Pfizer will offer discounts to individuals without prescription drug coverage who have annual incomes of $31,000 or less ($45,000 for families). The plan will also allow low-income Medicare beneficiaries who have exhausted their $600 subsidy available under the new prescription drug card program to play a flat fee of $15 per Pfizer prescription. There is no enrollment fee for the program. Beneficiaries will be enrolled by telephone or internet. (http://www.pfizer.com/are/news_releases/2004pr/mn_2004_0707.html).

- On June 7th, the HHS Office of Inspector General (OIG) released an audit reviewing Providence Health Plans' compliance with Medicare+Choice prompt payment regulations between September 1, 2002 and February 28, 2003. OIG found that Providence did not comply with the guidelines for prompt payment or denial of claims from non-contracted providers because it did not pay at least 95 percent of clean claims within 30 days of receipt, did not calculate and pay interest on clean claims not paid within 30 days and did not pay or deny all claims within 60 days of receipt. OIG recommended that Providence undertake procedural improvements to ensure that these problems are rectified. The complete report is available online at: http://oig.hhs.gov/oas/reports/region10/100300013.pdf.

- The HHS Office of Inspector General (OIG) released an audit of Keystone Health Plan West Medicare+Choice program payments to non-contracted providers on July 7th, 2004. OIG found that Keystone had complied with Federal prompt payment regulations to pay or deny claims from non-contracted providers on a timely basis. Specifically, OIG found that Keystone complied with the guidelines for prompt payment or denial of claims from non-contracted providers because it paid at least 95 percent of clean claims within 30 days of receipt, calculated and paid interest on clean claims not paid within 30 days and paid or denied all claims within 60 days of receipt. The full report is available online at: http://oig.hhs.gov/oas/reports/region3/30400013.pdf.

NEWLY RELEASED RESEARCH STUDIES NOT PREVIOUSLY DESCRIBED

- **Anderson, Gerard, Dennis Shea, Peter Hussey, Salomeh Keyhani, and Laurie Zephryin. "Doughnut Holes and Price Controls"** *Health Affairs,* **Web Exclusive, July 21, 2004.**

  In this study, the authors examine whether or not it would be possible for senior citizens in the United States to receive full prescription drug coverage under Medicare, without causing any increase in Medicare spending. The authors suggest that this could be possible if the United States had prescription drug prices comparable to those in Canada, the UK and France. Using pharmaceutical pricing data from IMS Health, the authors analyzed the cost of a "market basket" of 30 widely used prescription medications in each of the four countries (U.S., Canada, UK, and France). They found that prices are between 34 and 59 percent lower abroad than they are in the U.S. The authors suggest that if U.S. prices were brought into line with those in other countries, it would be feasible for the

Medicare program to offer a more comprehensive prescription drug benefit for seniors. They also argue that lower prices would dramatically reduce what Americans spend on prescription drugs.

- **Black, William and Marsha Gold. "MMA Attempts to Breath Life Into Troubled Markets, 2004."** ***Operational Insights.*** **Washington, DC: Mathematica Policy Research, July 2004.**

  In this brief, the authors how the Medicare Modernization Act of 2003 has affected Medicare+Choice plan options in six markets – Albuquerque, NM, Baltimore, MD, Detroit, MI, New Orleans, LA, Orange County, CA, and Orlando, FL. The authors note that between 1998 and 2003 plan choice and penetration fell dramatically in these communities. In 1998, each market had at least 4 choices. By 2003, only Orange County had 4 or more options. The MMA authorized a number of changes to the Medicare+Choice program including changing the program's name to Medicare Advantage, and increasing payment rates to plans in 2004. The authors conclude that the MMA helped plans to improve the benefits package they offered and reduce premiums and/or cost sharing. However, the authors note that despite these changes market penetration in these communities to date has not grown.

- **Dallek, Geraldine. "Consumer Protection Issues Raised by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003." Washington, DC: Henry J. Kaiser Family Foundation, July 2004. (www.kff.org)**

  This paper examines several aspects of the MMA from a consumer perspective. It seeks to identify specific challenges for consumers, offer suggestions to ease the transition as the new drug benefit begins in 2006, simplify the process for people on Medicare and strengthen consumer protections. The author suggests that prior to and following enrollment beneficiaries will require a wide range of information (including information on premiums and cost-sharing in the health plan choices available to them), in order to make informed choices about their coverage. She also indicates that for the program to be successful CMS will need to monitor aggressive marketing by MA and/or stand-alone drug plans, premium or cost sharing increases, the flexibility of formularies, and how the appeals process affects beneficiaries' coverage. Additionally, she calls for CMS and states to reduce barriers to enrollment that individuals who are dually eligible for Medicaid and Medicare may face when they try to access Part D plans and subsidies.

- **Health Policy Alternatives, Inc. "Medicare Drug Discount Cards: A Work In Progress." Washington, DC: Henry J. Kaiser Family Foundation, July 2004.**

  The report examines the Medicare drug discount card program, with an emphasis on issues affecting beneficiaries. In Part I, the authors describe the cards that are available, noting card characteristics, requirements, enrollment fees, drug pricing, and pharmacy networks. In Part II, the authors analyze potential savings for drug card enrollees. They find that some cards offer good value (when compared to retail prices) and that drug plan prices have remained relatively stable since the program's inception.

- **Huskamp, Haiden and Nancy Keating. "The New Medicare Drug Benefit: Potential Effects of Pharmacy Management Tools on Access to Medications."** ***An issue brief.*** **Washington, DC: Henry J. Kaiser Family Foundation, July 2004.**

The authors discuss how provisions of the MMA that give Part D plans flexibility in structuring pharmacy management tools that they will use to control utilization could be used to restrict access to needed medications or discourage beneficiaries with high prescription drug expenditures from enrolling. They suggest that formulary designs could limit access if plans are allowed to define drug categories and classes broadly because it could cover a much smaller number of drugs used to treat a given condition. Additionally, the authors suggest that plans may be able to discourage high-cost beneficiaries from enrolling by assigning high-cost/higher-efficacy drugs to high-tier plans or by requiring higher coinsurance rates on high-cost medications.

- **Shaviro, Daniel. *Who Should Pay for Medicare?* Washington, DC: University of Chicago Press., July 2004. (summary available at www.aei.org)**

  In this book, Daniel Shaviro seeks to "restore some balance and needed perspective to the discussion of Medicare" by asking the question: who should pay for Medicare? The author argues that for Medicare to be solvent in the future, decision makers will have to make choices about enrollees' covered care and how the program is financed. He argues that decision makers must take policy action immediately. The author's principal conclusions are that: (1) income and payroll taxes should play a major role in narrowing the fiscal gap; (2) reducing or eliminating the existing income-tax exclusion for employer-provided health insurance would aid Medicare both as a tax increase and as a way of controlling system-wide costs; (3) a value-added consumption tax could be used to make seniors share the burden of narrowing the fiscal gap; (4) to increase cost-consciousness and narrow the fiscal gap seniors ought to pay more co-payments for routine expenditures; and (5) cost-sharing by Medicare enrollees should be means tested to mitigate some of the burden on low-income seniors.

- **Marsha Gold. "Geographic Variation in Medicare Per Capita Spending: Should Policymakers be Concerned?" Princeton, NJ: The Robert Wood Johnson Foundation, July 2004.**

  In this research synthesis, the author analyzes reasons for geographic variation in Medicare spending per capita. Through an analysis of existing research, the author found that: (1) Medicare spending varies widely and persistently across geographical areas however they are defined; (2) less than half the variation in spending across areas is explained by population mix and the difference in price of individual services; (3) differences in the use of services across areas explain more than half of the total variation in spending; and (4) people in higher spending areas receive better care; however; states with higher use do not rank higher on quality (although the research on this issue is limited). The author argues that more information is needed to address geographic variation issues.

OTHER SIGNIFICANT EVENTS

X None