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MEDICARE ADVANTAGE AND MEDICARE BENEFICIARIES
Monthly Tracking Report for September, 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: Sept. 2004	Change From Last Month	Same Month Last Year	
			Sept. 2003	Change From Sept. 2003 - 2004
Contracts				
Total	295	+1	273	+22
CCP	151	0	151	0
PPO Demo	35	0	33	+2
PFFS	5	0	4	+1
Cost	29	0	30	-1
Other	75	+1	55	+20
Enrollment				
Total	5,420,078	21,243	5,309,561	110,517
CCP	4,665,927	15,182	4,621,578	44,349
PPO Demo	106,174	1,430	73,794	32,380
PFFS	41,570	2,212	24,110	17,460
Cost	329,074	-307	335,407	6,333
Other	277,333	2,726	254,672	22,661
Penetration*				
Total MA Penetration	12.7%	+0.0% points	12.7%	+0.0% points
CCP + PPO Demo Only	11.0%	-0.2% points	11.0%	+0.0% points

Penetration rates for September 2004 are calculated using the number of eligible beneficiaries reported in the June 2004 State/County File. Penetration rates for September 2003 are calculated using the number of eligible beneficiaries reported in the June 2003 State/County File.

- There are pending applications for 35 M+C plans, 1 PFFS plan, 3 PACE plans, 1 Cost plan and 2 HCPPS plans. Service area expansions are pending for 22 M+C plans, 6 PACE plans, 1 PFFS plan, 4 PPO Demos and 5 other demonstration plans.

NEW ON THE WEB FROM CMS

About Requirements, New Contracts and Withdrawals

- MA contract non-renewal and service area reduction notifications were due to CMS on September 13th, 2004. Many people have speculated that unlike prior years, withdrawals will be very limited this year and there could be substantial new entry (or service area expansion) in light of payment increases. There has also been speculation that plans might also apply for local PPOs in 2005 since they will be prohibited from proposing new ones (or expanding service areas in existing ones) over the 2006-2007 period. HHS released information about non-renewals as we went to press (on October 7th, 2004). HHS Secretary Tommy Thompson announced that 35 Medicare Advantage plans had made new applications and 22 had applied for service area expansions. If approved, these plans will provide 1.6 million more beneficiaries with access to Medicare Advantage plans. A preliminary analysis by CMS suggests that, on average, MA premiums and cost sharing will decline slightly in 2005. (www.hhs.gov/news/press/2004pres/20041006a.html)

- On September 7th, CMS approved a request from United Healthcare Insurance, a subsidiary of United Health Group, to offer private fee-for-service coverage to Medicare beneficiaries in Iowa, Nebraska, South Dakota and Wisconsin. Approximately 509,000 beneficiaries live in these states. All four states are currently served by at least one other MA plan. Nebraska is served by Sterling Life Insurance Co. South Dakota is served by Sterling and Humana. Iowa is served by Sterling, Humana, John Deere Health Plan and Medical Associates Health Plan. Wisconsin is served by Network Health Plan of Wisconsin, Medical Associates Clinic Health Plan, Security Health Plan of Wisconsin and Gunderson Lutheran Health Plan. (www.cms.gov/media/press/release.asp?Counter=1191)

- On September 7th, Excellus Health Plan Inc. received approval from CMS to expand its preferred provider organization (PPO) health plan to Medicare beneficiaries in six counties in the central and southern part of upstate New York. The service area includes Broome, Chemung, Madison, Onondaga, Otsego and Oswego counties, including the cities of Syracuse, Binghamton, Elmira and Oswego. About 160,000 Medicare beneficiaries live in these counties. All six counties are currently served by American Progressive Life and Health Insurance Co.'s Private Fee-for-Service plan. In addition, United Healthcare serves Onondaga County. (www.cms.gov/media/press/release.asp?Counter=1192)

- On September 9th, CMS approved a request by United Healthcare of Arizona to expand managed care coverage to Medicare beneficiaries in Pima and Santa Cruz County in Arizona. About 147,000 beneficiaries live in the two counties, which include the cities of Tucson and Nogales. Beneficiaries in these counties are currently served by Evercare, Health Net Life Insurance Co., HealthNet of Arizona, PacifiCare of Arizona and Sterling Life Insurance Co. (www.cms.gov/media/press/release.asp?Counter=1194)

- On September 8th, Humana Medical Plan received approval to expand managed care coverage to St. Johns County in northeastern Florida. Approximately 24,000 Medicare beneficiaries live in the area, which includes the city of St. Augustine. Humana Medical Plan, which operates as Humana Gold Classic, is the only MA plan operating in St. Johns County. (www.cms.gov/media/press /release.asp?Counter=1193)

- PacifiCare of California, Inc. has received approval from CMS to expand managed care coverage to Medicare beneficiaries in the western part of Nevada County, California. Approximately 18,000 beneficiaries live in PacifiCare's new service area. No other Medicare Advantage plans currently operate in Nevada County. (www.cms.gov/media/press /release.asp?Counter=1205)

- On September 14th, WellCare Health Plans Inc. received approval to expand managed care coverage to Medicare beneficiaries in Ulster County in the Catskill Mountains region of New York. About 29,000 Medicare beneficiaries live in the county. Beneficiaries can enroll in the WellCare plan during Medicare Advantage's open enrollment period. Ulster County is not served by any other Medicare Advantage plans. (www.cms.gov/media/press /release.asp?Counter=1199)

- On September 24th, CMS approved a request by PacfiCare of Arizona, Inc. to expand managed care coverage to Medicare beneficiaries throughout Pinal County in central Arizona. Approximately 29,000 Medicare beneficiaries who live in the county can now enroll in a PacifiCare plan. Beneficiaries also have access to plans from several other firms operating in Pinal County including Health Net of Arizona and Sterling Healthcare. (www.cms.gov/media/press /release.asp?Counter=1210)

- On September 24th, Unicare Life and Health Insurance Co. received approval from CMS to expand its private fee-for-service (PFFS) plan to more Medicare beneficiaries in 6 counties in Michigan, 35 counties in North Carolina and 13 counties in Utah. About 585,000 beneficiaries live in the newly approved service area. These beneficiaries also have access to several other Medicare Advantage plans. (www.cms.gov/media/press /release.asp?Counter=1207)

- On September 30th, CMS approved a request by PacifiCare of Colorado, Inc. to expand managed care coverage to all Medicare beneficiaries in Boulder County, Colorado. Previously, PacifiCare of Colorado was only serving beneficiaries in four zip codes in the county. About 32,000 Medicare beneficiaries live in Boulder County. These beneficiaries are already served by Rocky Mountain HMO and Kaiser Permanente of Colorado. (http://www.cms.hhs.gov/media/press/release.asp?Counter=1218).

- On September 30th, United Healthcare of Alabama received approval to expand managed care coverage to Medicare beneficiaries in Montgomery, Alabama and five southeastern Alabama counties (Elmore, Lowndes, Macon, Montgomery and Russell). Approximately 58,000 Medicare beneficiaries live in the five counties. These counties are not served by any other MA plans. (http://www.cms.hhs.gov/media/press/release.asp?Counter=1219).

Summary of service area expansions announced in September 2004:

Firm	Areas Served	Is this the only plan in the area (yes/no)	Number of beneficiaries
Humana Medical Plan, Inc	St Johns County, FL	Y	24,000
United Healthcare of Arizona, Inc	Pima County, AZ	N	147,000
	Santa Cruz County, AZ		
United Healthcare Insurance	Iowa	N	509,000
	Nebraska		
	Wisconsin		
	South Dakota		
Excellus Health Plan, Inc.	Broome County, NY	N	160,000
	Chemung County, NY		
	Madison County, NY		
	Onondaga County, NY		
	Otsego County, NY		
	Oswego County, NY		
PacifiCare of California	Nevada County, CA	Y	18,000
Wellcare Health Plans, Inc.	Ulster County, NY	Y	29,000
PacifiCare of Arizona, Inc.	Pinal County, AZ	N	29,000
Unicare Life and Health Insurance Co.	Michigan	N	585,000
	North Carolina		
	Utah		
PacifiCare of Colorado, Inc	Boulder County, CO	N	32,000
United Healthcare of Alabama, Inc.	Elmore County, AL	N	58,000
	Lowndes County, AL		
	Macon County, AL		
	Montgomery County, AL		
	Russel County, AL		

About Medicare Advantage

- On September 16th, CMS posted non-renewal model letters on its website. MA plans can use these letters to inform CMS and their enrollees that they do not intend to renew their contracts in 2005. Plans can also use the model letters to inform CMS of their intention to reduce their service areas by no longer serving certain counties or zip codes. The model letters accompany Medicare Advantage non-renewal instructions for 2005 that were issued in June. The letters can be accessed online at: http://www.cms.hhs.gov/healthplans/nonrenewal/default.asp.

- On September 8th, CMS posted a memo to MA plans informing them that the Adjusted Community Rate (ACR) spreadsheets for 2005 contain a default value of $78.10 for the Medicare Part B premium. The letter indicates that if an MA plan is attempting to eliminate the Part B premium for its Medicare enrollees it needs to change this value to $78.20. If this change is not made, MA enrollees will be charged $0.12 each month for the Part B premium. The full memo is available online at: http://www.cms.hhs.gov/healthplans/letters/partbpremium.pdf.

- CMS has posted a new set of MA-related data files containing "several useful trend and competition indicators" on its website. The website provides information on enrollment for all MA plans by state, quarter and over a 13-month period. The data will be updated regularly. A more detailed description and the actual data files are available online at: http://www.cms.hhs.gov/healthplans/statistics/trends/default.asp.

About Drug Card and Other Features of Medicare Related to MA

- The Department of Health and Human Services (HHS) announced the 2005 Medicare Part B premium, deductible and coinsurance fees on September 3rd. The monthly premium paid by beneficiaries enrolled in Medicare Part B, which covers physician services, outpatient hospital services, certain home health services, and durable medical equipment will be $78.20 in 2005. The 2005 premium is 17 percent higher than the 2004 premium, which was $66.60. HHS indicated that the rise in premiums is attributable to increased payment rates for physicians, improvement in the Medicare Advantage program and increased payments into the Part B account of the Medicare Supplementary Medical Insurance Trust Fund. HHS also announced increases in the deductibles for Medicare Part A and B services, consistent with statute. In 2005, the Part A deductible for inpatient hospital care (for care the first 60 days of care) will be $912. The Part B deductible will be $110. Beginning in 2006 the Part B deductible will be indexed to the increase in the average cost of Part B services for aged beneficiaries. (www.hhs.gov/news/presss/2004pres/20040903a.html)

- On September 15th, HHS Secretary Tommy Thompson unveiled a new tool to help Medicare beneficiaries compare the cost of similar prescription drugs used to treat common diseases such as high cholesterol. The tool allows beneficiaries to generate a customized report for each of their medications, including cheaper versions of the same drug and brand name and/or generic versions of similar but less expensive drugs that are used to treat the same condition. Secretary Thompson said "we are creating greater competition among drug companies and making the price of prescription drugs more transparent – giving seniors more power to compare prices and choose the lowest-cost medicine that's right for them." The "Lower Cost Prescription Comparison Tool" is accessible by phone (at 1-800-MEDICARE) or on the Medicare website (www.Medicare.gov).

- On September 14th, CMS announced that it is implementing provisions of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 that protect uniformed service Medicare beneficiaries, by automatically enrolling Medicare beneficiaries who are eligible for TRICARE Health Benefits in Medicare Part B. These beneficiaries will not have to pay a surcharge for late enrollment. CMS also announced that it would refund premium surcharges paid since January 2004 for all retired service Medicare beneficiaries who enrolled in Medicare Part B since 2001 and are paying more than $66.60 per month. The provisions are intended to help Medicare beneficiaries retain their TRICARE benefits as a supplement to Medicare by protecting them from having to make higher payments to enroll in Medicare Part B. (www.cms.gov/media/press /release.asp?Counter=1198)

- On September 22nd, HHS Secretary Tommy Thompson announced that HHS and CMS plan to automatically enroll 1.8 million low-income Medicare beneficiaries in a randomly selected Medicare-approved discount drug card. These beneficiaries will receive a card in the mail next month, which they can begin to use immediately. The 1.8 million people getting the cards will also have the option of choosing a different sponsor's card. These beneficiaries will also be eligible to receive up to $1,200

in transitional assistance (TA) over 2004 and 2005. To activate the TA benefits, beneficiaries must call their card sponsor or 1-800-MEDICARE. Thompson also noted that CMS is working with 100 community-based organizations across the country to help seniors and people with disabilities enroll in the discount cards and transitional assistance. (http://www.hhs.gov/news/press/2004pres/20040922a.html)

- The day after the HHS announcement, CMS announced several new steps to help low-income Medicare beneficiaries save money on their prescription drugs. First, beneficiaries can access a new tool on the Medicare Compare website, which will identify the top five cards for a low-income beneficiary, based on the total cost of their drugs before and after their $600 transitional assistance credit is applied. Second, CMS will now enroll beneficiaries in the transitional assistance program over the phone, instead of requiring beneficiaries to fill out and mail in a paper enrollment form. Mark McClellan, administrator of CMS, noted that, "these new improvements are part of our aggressive effort to make sure seniors and others on Medicare have all the tools we can come up with to help them save money on their prescriptions." (www.cms.gov/media/press /release.asp?Counter=1206)

- On September 30th, HHS Secretary Tommy Thompson launched a public-private outreach effort with hundreds of community organizations to educate and enroll Medicare beneficiaries in Medicare-approved drug discount cards and transitional assistance. One hundred coalitions, representing nearly 700 organizations, will receive $3.95 million in support for this effort from CMS and the Administration on Aging (AoA). (www.hhs.gov/news/pres/2004pres/20040930a.html.

ON THE CONGRESSIONAL FRONT

MA Specifically

- On September 14th, the Senate Committee on Finance held a hearing: "Implementing the Medicare Prescription Drug Benefit and Medicare Advantage Program: Perspectives on the Proposed Rules" to discuss the rules that CMS has proposed for implementing the new drug benefit and expanded Medicare coverage options. At the hearing, Mark McClellan noted that "while many changes in the Medicare Advantage program do not take effect until January 1, 2006, some immediate increases to payments for Medicare Advantage organizations are already improving access to health plan options and reducing costs and improving benefits for Medicare beneficiaries." He suggested that 3.7 million MA enrollees are seeing improved benefits and lower costs. However, other witnesses were less optimistic about payment increases for MA plans. Gerald Shea said that while MA plans had received "billions of dollars in excessive overpayments" beneficiaries "were left with an inadequate benefit." Other witnesses at the hearing included Karen Ignagni, president and CEO of America's Health Insurance Plans (AHIP); Mark Merritt, president and CEO for the Pharmaceutical Care Management Association; Michael Fitzpatrick, executive director, National Alliance for the Mentally Ill; and Larry Burton, executive director of the Business Roundtable. Full transcripts are available at: http://finance.senate.gov/sitepages /hearing091404.htm.

- The Medicare Payment Advisory Commission (MedPAC) held a public meeting to discuss a variety of issues related to the Medicare program including benefit design and cost sharing in Medicare Advantage plans and Medicare Advantage payment rates mandated by the MMA. At the meeting, MedPAC staff presented findings from preliminary analyses on the extent to which cost-sharing

structures under Part C plans affect access to covered services or are used to select enrollees based on health status. Thus far, they have found that there is considerable variation in cost sharing among plans, although cost sharing for MA enrollees is lower than it would be in fee-for-service Medicare. Some plans require cost sharing for specific services that are used by beneficiaries with serious health problems such as inpatient hospital care. MedPAC staff also presented analysis related to plan payment rates. Their preliminary findings suggest that it may be problematic to set payment rates at the county level because there is lots of variation in cost from year to year, particularly in counties with few Medicare beneficiaries. Full transcripts from the meeting are available online at: http://www.medpac.gov/public_meetings/index.cfm?meeting_id=106.

- MedPAC will hold its next public meeting on October 28th and 29th. 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.

- In September, the United States Government Accountability Office (GAO) released a new report on Medicare preferred provider organization (PPO) demonstrations. In this study, GAO (1) described how CMS used its statutory authority to conduct PPO demonstrations; (2) assessed the extent to which demonstration PPOs expanded access to Medicare health plans and attracted enrollees; (3) compared CMS's estimates of out-of-pocket costs beneficiaries incurred in demonstration PPOs with other coverage options; and (4) determined the effects of demonstration PPOs on Medicare spending. GAO found that: (1) CMS had exceeded its statutory authority when it allowed plans in the Medicare PPO Demonstration to cover certain services, such as skilled nursing and routine physical examinations only if beneficiaries obtained them from the plans' network providers; (2) that the demonstration PPOs attracted relatively few enrollees (mostly from other Medicare+Choice options, not fee-for-service Medicare) and did little to expand Medicare beneficiaries' access to private health plans; and (3) demonstration PPO enrollees incurred expenses that were "the same or higher than those they would have incurred with nearly all other types of Medicare." GAO estimates that demonstration PPOs would increase Medicare spending by $100 million for 2002 and 2003 combined. The report can be accessed online at: www.gao.gov.

Broader Medicare Reform (in Brief)

- The Senate Special Committee on Aging held a forum: "Medicare Drug Discount Cards: Measuring the Savings" on September 23rd. At the forum, panelists discussed Medicare drug discount card analyses conducted by the Lewin Group, the American Enterprise Institute, the Kaiser Family Foundation and CMS. The panelists included Sharman Stevens, CMS; Julie James, Healthy Policy Alternatives; Mary Grealy, Healthcare Leadership Council and Robert Helms, American Enterprise Institute. CMS Administrator Mark McClellan also presented new CMS data about the Medicare-approved drug discount program's progress. A transcript will be available soon at: http://aging.senate.gov/.

- The Government Accountability Office (GAO) published a legal opinion indicating that former CMS Administrator Tom Scully had violated the prohibitions in the Consolidated Appropriations Act of 2004 when he threatened to terminate the employment of CMS Chief Actuary Richard Foster if Mr. Foster provided various cost estimates related to pending prescription drug legislation to Congress.

The opinion, which was released on September 7th, relies on factual findings from the Office of the Inspector General (OIG) for the Department of Health and Human Services (HHS) investigation that was conducted earlier this year. GAO found that HHS's appropriation could not be used to pay the Administrator's salary because HHS is barred by law from using appropriated funds to pay the salary of an official "who prohibited another federal employee from communicating with Congress on an issue related to his agency." The full legal opinion can be accessed at: www.gao.gov.

- The Congressional Budget Office (CBO) has released its annual report on the budget and the economy, "The Budget and Economic Outlook: An Update." CBO estimates that Social Security, Medicare and Medicaid will grow to between 12 and 17 percent of GDP by 2030 because the U.S. population is aging. CBO also suggests that Medicare spending is accelerating, fueling growth in mandatory spending. The full report can be accessed at: http://www.cbo.gov/showdoc.cfm?index=5773&sequence=0.

FROM THE PERSPECTIVE OF BENEFICIARIES

- This month, the Henry J. Kaiser Family Foundation and the Health Research and Educational Trust released findings from an annual survey of employer health benefits. The study examines trends in health insurance costs and coverage in the workplace. The results are based on a survey of 2,808 randomly selected public and private firms with three or more employees that was conducted between January and May of 2004. The study found that private health insurance premiums increased by 13.9 percent in 2003. This was the largest increase since 1990. The study also found that while employers are not dropping coverage, most are passing on higher costs to employees through greater cost sharing and higher premiums. The study is currently available at: www.kff.org and will be published in the September/October edition of Health Affairs.

- On September 23rd, the Medicare Rights Center announced that approximately 156,000 Medicare beneficiaries with incomes between 120 and 135 percent of the Federal Poverty Level will lose their Medicare premium support on September 30th unless Congress reauthorizes the Qualified Individuals-1 (QI-1) program immediately. The QI-1 program is one of three Medical Savings Programs that helps low-income people on Medicare lower their out-of-pocket healthcare expenses. All of these beneficiaries will be automatically enrolled in Medicare-approved drug discount cards as part of HHS' new enrollment policy for low-income people. (The Medicare Rights Center, September 23rd, 2004)

- Families USA released an issue brief designed to help states prepare for the Medicare Part D prescription drug benefit that will go into effect in 2006. The issue brief describes what the new drug benefit is and how it will work (especially for low-income beneficiaries) and outlines some of the major issues state policy makers and advocates need to consider as the Medicare Prescription Drug Improvement and Modernization Act (MMA) is implemented. In particular, the brief describes issues that states will need to consider as they enroll Medicare beneficiaries that also receive Medicaid (known as dual eligibles) in Part D and the low-income subsidy, screen and enroll beneficiaries in Medicare Savings Programs, and administer State Pharmaceutical Assistance Programs (SPAPs).

FROM THE OTHER STAKEHOLDERS

- On September 17th, *the New York Times* examined new data from CMS indicating that Medicare pays private health plans more for each beneficiary enrolled in Medicare Advantage than it does for beneficiaries who receive care through the traditional fee-for-service program. *The New York Times* reported that payments were "as high as 116 percent of the traditional Medicare cost in some cities and 123 percent in rural areas." *The New York Times* also obtained estimates from CMS indicating that Medicare would spend $50 billion less in the next 10 years if it paid private plans the same as traditional Medicare pays for the average beneficiary. (*The New York Times*, September 17th 2004)

- On August 31st, Pfizer announced that it would no longer offer its widely used prescription drug discount card for the elderly. Pfizer indicated that it was discontinuing the "Living Share" Card so that the company can coordinate its programs with the Medicare prescription drug plan, despite being urged by CMS and the Medicare Rights Center to continue its program until Medicare Part D goes into effect. Approximately 536,000 low-income seniors that had the Living Share Cards must now find another way to pay for their prescription medications. These seniors can try to access other manufacturer card programs or enroll in a Medicare-approved drug discount card. (*The New York Times*, September 1st)

- On September 29th, the Coalition for Medicare Choices and America's Health Insurance Plans (AHIP) held a rally on Capitol Hill in support of the MMA and the Medicare Advantage program. Senate Majority Leader Bill Frist and Senator Rick Santorum spoke at the rally. Sen. Frist noted that the MMA is encouraging companies to expand coverage, allowing the Medicare Advantage program to "turn the curve." A member of the Coalition presented Sen. Frist with a "Medicare Choices Leadership Award," to recognize him for his efforts to get the MMA passed. More information about the rally is available at: www.ahip.org. (*American Healthline*, September 29, 2004)

- On September 9th, *the New York Times* reported that sharp increases in Medicare premiums and deductibles may prompt more Medicare beneficiaries to join Medicare Advantage (MA) plans because these plans have the flexibility to offer extra benefits such as prescription drug coverage or to refund the Part B premium to enrollees. *The Times* also noted that some industry experts are predicting "a substantial number of expansions in managed care plans to be announced…in response to the higher subsidies." However, other experts suggest that MA plans will wait until after the election to make decisions about service expansions, as payment rates have become a politically charged issue. (*The New York Times*, September 9th)

- On September 10th, *the New York Times* reported that enrollment in a new Medicare demonstration program to provide low-cost drugs to people with cancer and other serious illnesses has fallen far short of expectations. The Bush administration had expected to hold a lottery to choose 50,000 Medicare beneficiaries to participate in the demonstration because the program "offered savings and convenience, reducing the need to visit doctors." However, less than 4,000 Medicare beneficiaries have enrolled in the program. Consumer advocates suggest that some beneficiaries may find the application forms confusing or may not be aware that they can save money by participating in the demonstration. *The Times* noted that Trailblazer Health Enterprises, a subsidiary of Blue Cross and Blue Shield of South Carolina, has an $8.7 million contract with CMS to enroll people in the demonstration program. (*The New York Times*, September 10th)

- *USA Today* reported that seniors will spend a "a large and growing share" of Social Security payments on the Medicare premiums, co-pays and out-of-pocket expenses after the Part D benefit takes effect in 2006. The report, which uses federal data, indicates that on average seniors will spend 37 percent of their Social Security payments on Medicare in 2006. According to the *USA Today* article "unless Congress does something to hold down costs confronting seniors, the official projections suggest that health spending will consume virtually the entire amount of Social Security benefits." In the article, opponents of the MMA, including Representative Pete Stark and Families USA Executive Director Ron Pollack suggest that the Bush administration withheld data to hide failures in the law. However, HHS spokesperson Bill Pierce was quoted as saying "we have a new program, and its got to be reflected with new information." (*USA Today*, September 14th)

- On September 17th, the National Health Policy Forum sponsored a meeting on "From 10 to 50: Options for Medicare Advantage Plan Regions". Michael O'Grady, Assistant Secretary for Planning and Evaluation of HHS, provided the context for the discussion noting that the Secretary had not made any decisions yet and would be considering all options in light of their ability to meet Congress's intent behind the legislation. Leslie Greenwald, of Research Triangle Inc. reviewed a number of the options for defining regions that CMS has presented for public comment. Len Nichols, of the Center for Studying Health Systems Change provided analysis of some of the challenges in establishing regions and speculated on the possible competitive market outcomes of different choices on the relationships between local and regional plans. Key House and Senate Committee staffers on both sides of the aisle gave their reactions.

- On September 22nd, the Alliance for Health Reform and the Commonwealth Fund held a joint briefing: "Previewing the Medicare Advantage program." At the briefing the panelists discussed the key changes that the MMA made to the Medicare Advantage program and how these changes are handled in the proposed regulations from CMS. The panelists also discussed the private plan options that will be available to beneficiaries starting in 2006. Leslie Norwalk noted that CMS is doing everything it can to remove obstacles, such as network requirements, that prevent private firms from participating in Medicare Advantage. Brian Biles noted that the Medicare Advantage program will cost Medicare $4 billion more to pay for the care of beneficiaries enrolled in the program than the program would pay under the fee-for-service program. Karen Ignagni suggested that these estimates were too high. She also noted that Medicare Advantage plans are "worth the investment" because private plans are providing "a safety net for beneficiaries." Speakers at the hearing included: Edward Howard, the Alliance for Health Reform; Barbara Cooper, the Commonwealth Fund; Michael Hash, Health Policy Alternatives; Leslie Norwalk, CMS; Karen Ignagni, America's Health Insurance Plans; Jack Ebeler, the Alliance of Community Health Plans and Brian Biles, George Washington University. A full transcript is available online at: http://www.allhealth.org/.

NEWLY RELEASED RESEARCH STUDIES NOT PREVIOUSLY DESCRIBED

- **Christian-Herman, Jennifer, Matthew Emons and Dorothy George. "Effects of Generic-Only Drug Coverage In A Medicare HMO."** ***Health Affairs*****, Web Exclusive, vol. W4, no. 455, September 2004.**

  In this study, the authors investigate whether there is any association between membership composition, costs, quality of care and the advent of a generic-only benefit in a Medicare health maintenance organization (HMO). The authors analyzed administrative data from a Medicare HMO in California to determine how a switch to a generic-only drug benefit would affect member outcomes. The authors found that a switch to generic-only coverage was associated with reduced health plan pharmacy costs, increased out-of-pocket pharmacy costs for members, and increased overall hospital admissions. In addition, the authors found that the switch had a negative impact on quality for certain conditions such as congestive heart failure (CHF) suggesting that certain subgroups of beneficiaries may be adversely affected by a generic-only benefit.

- **Gold, Marsha, Lori Achman, Jessica Mittler and Beth Stevens. "Monitoring Medicare+Choice: What Have We Learned? Findings and Operational Lessons for Medicare Advantage." Washington, DC: Mathematica Policy Research, September 2004.**

  In this report, the authors summarize and synthesize key findings from a wide-ranging project that monitored the Medicare+Choice program from 1997 through 2003. The authors also discuss the operational policy implications for the program's successor, Medicare Advantage, and highlight key features of the plan, provider and beneficiary environment that have inhibited the growth of private plans in Medicare. The authors conclude that successful development of private plans under Medicare Advantage will require that at least three needs be met: (1) private plans and industry need to view Medicare as a reliable business partner; (2) beneficiaries need education on options available to them; and (3) all stakeholders must have realistic expectations about how much change to expect. The report can be accessed online at: www.mathematica-mpr.com/publications/redirect_pubsdb.asp?strSite=pdfs/monitor.pdf.

- **Meara, Ellen, Mary Beth Landrum, John Ayanian, Barbara McNeil and Edward Guadagnoli. "The Effect of Managed Care Market Share on Appropriate Use of Coronary Angiography among Traditional Medicare Beneficiaries."** ***Inquiry*****, vol 141, Summer 2004.**

  In this study, the authors investigated how managed care market share relates to the quality of health care provided to beneficiaries in the traditional, fee-for-service Medicare program. To determine this relationship, the authors compared the proportion of fee-for-service Medicare beneficiaries who were admitted for acute myocardial infarction (AMI) who underwent angiography in counties with average managed care penetration rates and counties with above average managed care penetration rates. The authors found that the rates of angiography fell slightly as managed care market share increased even after controlling for other factors. For example, the authors note "even moving from a county with an average market share of 5 percent to one with 30 percent market share implied a relatively small decline of 2.4 percentage points in the probability of receiving coronary angiography."

- **Moeller, J.F, Edward Miller and Jessica Banthin. "Looking Inside The Nation's Medicine Cabinet" Trends in Outpatient Drug Spending By Medicare Beneficiaries, 1997 and 2001." *Health Affairs*, vol. 23, no. 5, September/October 2004.**

  In this article, the authors examine trends in outpatient prescription drug spending by Medicare beneficiaries in 1997 and 2001 using nationally representative data from the Medicare Expenditure Panel Survey. The authors find that Medicare beneficiaries' aggregate drug spending increased from $31.5 billion in 1997 to $54.0 billion in 2001, an increase of 72 percent in excess of inflation for all goods and services. The increase was driven by a 10 percent increase in the population with use, a 24 percent increase in prescriptions per user and a 26 percent increase in the average prescription price. The authors also found that the increases were larger in some therapeutic classes, such as antihyperlipidemic agents and antidiabetic agents, than in others.

- **Rosenbaum, Sara. "Grievance and Appeals Procedures: An Analysis of the MMA and Proposed Regulations." Washington, DC: The Henry J. Kaiser Family Foundation, September 2004.**

  This issue brief examines protections afforded under the proposed MMA regulations (which were published by CMS on August 3rd) when a dispute arises between a Medicare beneficiary that is eligible for or enrolled in Part D and the Medicare Part D program. In addition, the study discusses procedural protections for indigent Medicare beneficiaries who need low-income subsidies in order to qualify for Medicare Part D benefits. The author suggests that CMS needs to clarify a number of provisions to ensure beneficiaries have adequate opportunity to file appeals and grievances involving prescription drug coverage. The author also notes that the enrollee safeguards in grievances and appeals could be strengthened as part of the regulatory revision process. The issue brief is available at: www.kff.org.

OTHER SIGNIFICANT EVENTS

X On August 16th, Weiss Ratings Inc. released findings from a survey of 800,000 premium rates among 129 insurers that offer Medicare supplemental insurance (Medigap) plans. Weiss Ratings found dramatic variations in Medigap premium rates for all plans despite the fact that the benefit packages for these plans have been standardized since 1992. For example, the firm found that Medigap Plan A premiums for a 65-year old woman varied from $355 to $6,460 per year. Weiss Ratings attributed variations in Medigap policy prices to difference in healthcare costs, insurers' underwriting and pricing methodologies, the health status of the target population, and state policies that regulate premium rates. (www.weissratings.com)