

TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS

Monthly Report for August 2005

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

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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

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

Plan Participation, Enrollment, and Penetration by type	Current Month: Aug 2005	Change From Previous Month	Same Month Last Year	
			Aug 2004	Change From Aug 2004 – 2005
Contracts				
Total	426	+34	294	+132
CCP*	274	+27	151	+123
PPO Demo	34	0	35	-1
PFFS	16	+3	5	+11
Cost	29	0	29	0
Other*	69	0	74	-5
Enrollment				
Total	5,850,908	+57,241	5,398,835	+452,073
CCP	4,979,570	+35,902	4,650,745	+328,825
PPO Demo	124,466	+1,048	104,744	+19,722
PFFS	135,176	+15,453	39,358	+95,818
Cost	322,043	-298	329,381	-7,338
Other*	289,653	+5,136	274,607	+15,046
Penetration**				
Total Private Plan Penetration	13.5%	+0.1% points	12.6%	+0.9 points
CCP + PPO Only	11.8%	+0.1% points	11.1%	+0.7 points

*Other includes Other Demo contracts, HCPP and PACE contracts. Please note that the total number of contracts does not add to the totals by plan type this month because the number of other plans is 69 (not 73 as would be expected given the total reported in the MMCC report for August). We are currently investigating the cause of the discrepancy in the file released by CMS.

** Penetration rates for August and July 2005 are calculated using the number of eligible beneficiaries reported in the June 2005 State/County File. Penetration rates for August 2004 are calculated using the number of eligible beneficiaries reported in the June 2004 State/County File.

DEFINITIONS: Coordinated Care Plans, or CCPs, include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs) and preferred provider organizations (PPOs). Data from the June 2005 Geographic Service Area File show that HMOs account for 80 percent of CCP contracts and 99 percent of CCP enrollment. The Medicare preferred provider organization demonstration began in January 2003. PFFS refers to private fee-for-service plans. Cost plans are HMOs that are reimbursed on a cost basis, rather than a capitated amount like other private health plans. Other Demo refers to all other demonstration plans that have been a part of the Medicare+Choice / Medicare Advantage program.

Pending Applications

- According to the August 1, 2005 Medicare Managed Care Contract Report, there are pending applications for 31 MA contracts, 4 PACE contracts, 2 PFFS contracts, 11 cost contracts and 8 other demonstrations. Service area expansions also are pending for 14 MA plans, 8 PACE plans, 3 PPO demonstrations, 5 other demonstrations, and 2 cost plans. (These counts may not include applications relevant to 2006 versus 2005, a distinction particularly relevant to regional MA plans. CMS has indicated that it will issue information on approved contracts for 2006 by mid September 2005).

Summary of new MA contracts announced in June:

CMS's Monthly Medicare Managed Care Contracts Report (MMCC) for August 1, 2005 indicates that 31 new contracts were signed in July 2005, including 28 CCP contracts and 3 PFFS contracts. As noted previously, the report does not indicate whether new CCPs are for local HMO or PPO plans. Though the latter have been limited in number, there has been recent growth. CMS's June 30, 2005 press release (noted previously) indicates that 66 new local PPOs were approved in 2005 (www.cms.hhs.gov/media/press/release.asp?counter1497). Applicants wishing to offer local PPOs must have them approved now because the MMA establishes a two-year moratorium for new local PPOs from the start of 2006. New contracts approved this month include:

- Liberty Health Advantage, Northridge, NY (CCP)
- Humana, Louisville KY and Chicago, IL (3 CCP contracts)
- Selectcare of Oklahoma, Houston, TX (CCP)
- Aetna, Blue Bell PA (5 CCP contracts)
- Lovelace Insurance Company, Albuquerque, NM (CCP)
- United Healthcare, Minnetonka MN, White Plains, NY and Hartford, CT (3 CCP contracts)
- Anthem Insurance Company, Mason, OH (2 CCPs)
- Qualchoice Health Plan, Cleveland, OH (CCP)
- Alliance Health and Life Insurance, location not indicated (CCP)
- Ion Health, Erie, PA (CCP)
- Healthsun Health Plans, Miami, FL (CCP)
- PSO Health Services, San Antonio, TX (CCP)
- Tufts Associated HMO, Waltham, MA (CCP)
- Orange County Health Authority Orange, CA (CCP)
- Blue Cross and Blue Shield of Florida, Jacksonville, FL (CCP)
- HCSC Insurance Services Company, Chicago, IL (2 CCP contacts)
- First Medical Health Plan Inc, San Juan, PR (CCP)

- Pyramid Life Insurance Company, Weston, FL (PFFS)

- Medical Health Plan of Wisconsin and Minnetonka, Minnetonka, MN (2 PFFS contracts)

In addition, the report indicates that 18 contracts were approved to expand their service area.

NEW ON THE WEB FROM CMS

Relevant to Both Medicare Advantage and Prescription Drug Plans

- On August 9, 2005, CMS released benchmarks relevant to Part D and to regional MA plans, along with related information (www.cms.hhs.gov/healthplans/rates/). CMS noted that the average \$32 per month premium for the drug benefit was about \$5 lower than previously estimated. (*Kaiser Health Policy Report*, August 10, 2005)
 - **The Part D base beneficiary premium** for 2006 is **\$32.20**. (This statistic is a product of the beneficiary premium percentage and the national average monthly bid amount.) The premium percentage is calculated based on a numerator that is 25.5 percent and a denominator that expresses 100 percent minus CMS's estimated reinsurance payments for Part D as a percentage of the total plan standardized bid including CMS and beneficiary payments. That is, as we understand it, the adjustments add CMS's reinsurance costs to the standardized plan bid and calculate the average beneficiary premium consistent with beneficiaries' paying 25.5 percent of the total cost of the Part D benefit.
 - **The Part D national average bid amount** (referred to as the "Part D benchmark") is **\$92.30**. It is calculated as a weighted average of standardized bids for each PDP and MA-PD plan (excluding bids from PFFS, MSAs, specialized MA plans, PACE and cost contracts). Weights are based on enrollees in the reference month relative to total number of Part D eligibles. For 2006, CMS weighted each PDP equally in establishing the bid, assigning MA-PD weights based on March 31, 2005 enrollment. There will be no geographic adjustment to the national average monthly bid amount in 2006.
 - **The Part D regional low-income Premium subsidy amount** is what CMS will pay to subsidize the Part D premium for those entitled to the full low-income subsidy. These range from a low of **\$23.46 in Nevada to \$36.30 in North Carolina**. This amount is the *lesser* of the actual Part D premium (or share of enhanced alternative coverage reflecting basic coverage); *or* either (1) the low-income premium amount for a PDP region or (2) the lowest monthly beneficiary premium for a PDP that offers prescription drug coverage (whichever is greater). (The low income Part D premium amount would appear to be calculated the same way as the general Part D statistics except that the calculation is performed specifically for each PDP region based on that region's statistics and available products) The spreadsheet showing these rates is available at www.cms.hhs.gov/healthplans/rates/. Subsidy amounts can vary substantially between nearby regions (e.g. \$36.09 in region 1 (NH, ME) versus \$30.27 in region 2 (CT, MA, RI). Given the definitions employed, we speculate that the regional differences are likely to reflect differences in: available PDP offerings per region, bid levels that differ by region even for PDPs offered nationally, and level of MA penetration. Thus, existing enrollment in MA-PD plans affects the weighting of MA plan bids vis-à-vis PDPs.

- **The MA Regional Benchmarks** is a blend of the weighted average county capitation rates in a region (the “statutory component”) and the competitive bids submitted by regional plans (the “plan bid” component). For 2006, 87.4 percent of the regional reflects the statutory component and 12.6 percent reflects the plan bid component reflecting the split in national market share for traditional Medicare and MA. The statutory amount is calculated by weighting county capitation rates by the number of beneficiaries in that county. (ESRD beneficiaries are excluded because their costs are not included in the bid for 2006). The plan bid component first creates a consolidated plan bid in cases where multiple bids are offered by an organization (using plan projected enrollment to consolidate) and then equally weighting bids for each organization. (Each component is further divided into amounts for demographic versus risk adjusted share; thus the regional benchmark is based on 4 component rates that vary by MA region; figures can be downloaded from www.cms.hhs.gov/healthplans/rates/).
- The release indicates a plan bid component for all but five regions: 1 (ME, NH), 2 (CT, MA, RI), 20 (NM,CO), 23 (ID, OR, UT), and 26 (AK). This would indicate that no regional bids were received from these five regions but that at least one regional plan has applied to serve each of the other regions.
- On August 15, 2005, CMS released the final marketing guidelines for MA plans, noting that the released combined the MA guidance with that applying to PDP plans and cost plans as well. (www.cms.hhs.gov/healthplans/marketing/). In its transmittal letter, CMS notes that they have combined MA and PDP guidelines to allow organizations that offer both types of products to reference a single document. Included are MA marketing guidelines (for MA plans and 1,876 cost plans) that reflect changes based on public comment, and Phase 1 and 2 of the Part D marketing guidelines (Phase 1 was finalized on June 1st and Phase 2 was finalized in August).
- On August 10, 2005 CMS released guidance to prescription drug plan applications about allowable updates in conditionally approved formularies during an open period in September 2005 to allow enhancements prior to January 1, 2006 (www.cms.hhs.gov/pdps/FrmUpldInstGdncMatrl.asp). CMS has established a window from September 1, 2005 through 5 PM EDT September 15, 2005 to provide plans with a last opportunity to incorporate updates to their formulary until 60 days after the beginning of the new year. Only 1 upload will be allowed per plan and CMS is expecting only minor adjustments to conditionally approved drugs. CMS will aim to review all formularies before marketing begins October 1st but plans should not begin marketing until receiving a letter indicating this is done. (Plans with no updates are set to proceed October 1st.)
- On August 12, 2005, CMS notified PDPs and MA-PDs (except PACE and employer subsidy plans) that the analysis of test data used for Medicare Compare tests would be sent them by August 15, 2005. (CMS Medicare PDP list serve) Issues raised must be addressed by August 29, 2005. Plans will receive unique login information so that they can submit data by September 16, 2005.
- CMS continues to add resources to its website for various partners important to the Part D benefit, MA, and beneficiary education (www.cms.hhs.gov/partnerships/default.asp). *Congressional Quarterly's* Health Beat (August 1, 2005) notes that CMS has launched a secure Web site for employers and unions to apply for the Part D subsidy available to them. Materials to assist physicians and their staff in educating Medicare beneficiaries also are posted. CMS intends to provide software

to physicians in October that allows them to list their patients' drugs and identify possible plans that best meet their patients' needs.

- On August 30 and September 1, 2005, CMS convened a conference on enrollment and payment issues for MA and PDP plans in Baltimore, Maryland. According to the advance agenda, there were to be two simultaneous tracks-for MA and PDPs. The conference focused on providing an overview of the requirements for sending enrollment and updates on legislation, review of system databases, reports and payments. Each track also was to have tailored topics and attendance was to be limited to two per organization (www.aspenznet.com/enrollment/about_training/about_enp.asp).

Relevant to Medicare Advantage

- On August 4, 2005, CMS's convened a Technical user group training call.
- On August 9, 2005, CMS provided guidance to MA plans on handling the rebate reallocation process during bid negotiations (www.hhs.gov/healthplans/rates). The guidance is not relevant to local MA plans that are *not* offering prescription drug coverage, as no additional changes are required for them.
 - Local and regional MA plans may have proposed a target premium in their initial bids (e.g. zero premium for LIS beneficiaries, zero premium for all, a dollar figure) but the actual premium (after CMS calculated benchmarks) may have been more or less than that because the amount differed from what plans assumed in calculating how they would finance the benefit. Part D plans cannot have a negative premium; therefore any excess that brings the premium below zero must be reallocated elsewhere (e.g. other benefit improvements). When the final figure is below the target (but at least zero) plans have the option to leave the final Part D basic premium as is or reallocate funds from elsewhere to improve benefits or reduce premiums for supplemental benefits. (Partial returns are not allowed). Plans whose premium is higher than targeted in the original bid analogously have the option to leave the difference or reallocate (partial reallocations also not allowed). Other reallocations may be made if excess rebate dollars exist but plans are not allowed to change the benefit design or pricing of Part D as this would affect projected reinsurance. Plans also may not redesign their supplemental benefits though they may buy down cost, add another benefit etc. Funds also may be used to reduce the Part B premium.
 - The guidance reiterates the requirement that each MA coordinated care plan organization (or another MA plan offered by the same organization in the same area) offer a plan that includes required drug coverage (i.e. either a basic plan or an enhanced plan with no beneficiary premium for the Part D supplemental benefit). To comply with this requirement, organizations may need to reallocate funds from other benefits.
 - Regional MA plans in addition to meeting these requirements, must also adjust the amount of funds available to offset changes ("rebate dollars") to reflect the regional benchmarks issued by CMS.
 - Local MA plans are allowed to segment their service area but must offer the same benefit package across plan segments. However the guidance notes that premiums and cost sharing may differ across segments. *However*, Part D segments are not allowed and the same Part D

benefit package must be allowed across the entire service area.

- On August 15, 2005, CMS released a revised and final notice of change in Medicare plan benefits which MA plans and Medicare cost plans must use in notifying enrollees about changes in 2006 (www.cms.hhs.gov/healthplans/marketing). Three model notices of change are provided: (1) MA-only, (2) MA-PD, and (3) MA-only for whom the plan will facilitate enrollment of its full benefit dual eligible enrollees into an MA-PD plan effective January 1, 2006. Plans are required to send these notices to members, along with summary of benefits information, by October 31, 2006. Cost plans must provide the information by December 1, 2005.
- On August 25, 2005, CMS released information clarifying its August 9, 2005 guidance on rounding rules for organizations offering MA-PD plans (www.cms.hhs.gov/healthplans/rates). CMS clarifies that organizations may round the consolidated monthly premium to the nearest dollar without requiring additional offsets or resubmissions. Resubmitted bids are due by August 26, 2005.

Relevant to Prescription Drug Plans

- On August 29, 2005, CMS released preliminary information on likely number of available stand-alone PDPs in each region. CMS also release the associated weighted average monthly beneficiary premiums and premium distribution in each region (www.hhs.gov/new/press/2005pres/20050829.html). The press release indicates that Medicare beneficiaries in all regions, except Alaska, will have access to at least one prescription drug plan with a premium of \$20 per month or lower. It also indicates that multiple plan options with premiums of less than \$30 will exist in all regions. The release notes that some plans will offer additional coverage (e.g. generic drugs in the coverage gap). Accompanying the release were tables showing the # of PDP choices (and premium distribution) per region and also the # of PDP organizations whose premiums are at or below the level needed to qualify for auto-enrollment of those with low-income subsidies. (Eligible beneficiaries can voluntarily join higher priced plans but they must pay the difference.)
 - From 16 to 23 free-standing PDPs will be available in each region except Hawaii (where there will be 12 choices) and Alaska (where there will be 11 choices). In most regions, at least about half of these PDPs have premiums sufficiently low that they will be available to those who are auto-enrolled. Availability of free-standing PDPs to those who qualify will be most limited (compared to all available offerings) in Arizona (5 of 19 choices), Florida (5 of 20), Nevada (6 of 19 choices), New Mexico (7 of 18) and California (7 of 19 choices).
 - The press release is accompanied by region specific fact sheets that embed the tabular information for that region into a 2-page summary of the choices available per region overall and those that will be available at zero premium for those with limited means. (This refers to the low-income subsidy program.)
 - The release notes that beneficiaries also will have access to prescription drug coverage via MA plans and that many of these plans will have additional benefits and premiums substantially below \$20 and that additional detail on these and PDP plans will be available later.

Relevant to Special Needs Plans Specifically

- None

ON THE CONGRESSIONAL FRONT

About Medicare Health and Drug Plans Specifically

- None

Broader Medicare Program (in Brief)

- This month, the Government Accountability Office (GAO) released a report titled “Medicare Contracting Reform: CMS’s Plan Has Gaps and Its Anticipated Savings Are Uncertain (GAO-05-873, August 17, 2005).” With the Medicare Modernization Act of 2003, contracting for Medicare claims administration services has changed to become more competitive. CMS will begin using competitive procedures to select Medicare administrative contractors (MACs). In February, CMS submitted a report to Congress detailing its plan for implementing these changes. The GAO report evaluates CMS’s plan. While CMS has succeeded in some areas of its framework for contracting reform, there are some gaps in the plan. The GAO concluded that one gap is the fact that the plan does not include a detailed schedule to coordinate other major initiatives involving the new MACs scheduled to occur at the same time. In addition, GAO found that CMS’s plan also fails to address risk factors (and ways to mitigate these risks) involved in transitioning claims data from current contractors to the MACs. In addition to the gaps in CMS’s plan, the GAO described how CMS’s plan also has questionable assumptions about potential savings that may result from the MACs. The GAO stated that even though these saving assumptions are questionable, the assumptions were used in the decision to accelerate the implementation schedule of the MACs. The GAO stated that this could create additional challenges during the transition and therefore recommends extending the timeframe scheduled for the implementation in order to be better prepared and thus avoid such risks. The full GAO report is available online at: www.gao.gov.

FROM THE PERSPECTIVE OF BENEFICIARIES

General

- Bush Administration Officials including HHS Secretary Mike Leavitt, CMS Administrator Mark McClellan and CMS Deputy Administrator Leslie Norwalk have begun a promotional tour on the new Medicare drug benefit. This is part of a “100-city tour” to discuss the new benefit with Medicare beneficiaries and senior advocates. It is specifically designed to help raise awareness of the benefit and then provide them with important dates about when and how to register as well as how those that qualify can apply for financial assistance. Some of the various stops made during August have included Arizona, California, Montana, Texas, Louisiana and Ohio. The tour will continue through September. (*The Atlanta Journal-Constitution*, August 7, 2005; *Pittsburgh Tribune-Review*, August 18, 2005; *St. Petersburg Times*, August 24, 2005; *The Washington Times*, August 22, 2005.)

- Congressional Members have also participated in part of the tour during their August recess.
 - The tour has included stops made by U.S. Senator Tom DeLay (R-Texas), Representative Joe Pitts (R-Penn), Rep. Jack Kingston (R-Georgia) and former U.S. Senator Bob Dole (R-Kansas).
 - Representative Pete Stark (D-California) also has been promoting education of the new prescription drug benefit. However, his message has been different in that he is cautioning Medicare beneficiaries to take their time in deciding whether or not to enroll in the plan (*CQ HealthBeat, August 11, 2005*).
- On August 23, 2005, an article in the *Chicago Tribune* (Bruce Jaspen, August 7, 2005) headlined “Medicare Late-Signup Fee Already Bitter Pill for Some,” described how some seniors think late enrollment penalties for the new drug penalty are unfair. The initial enrollment window is between November 15, 2005 and May 15, 2006. Eligible seniors who miss this window face penalties of 12 percent per year. One senior living in Chicago described that the penalty as “blackmail and undue pressure.” The Bush administration and members of Congress describe the penalty as necessary in order for the program to work. Representative Pete Stark (D-Calif.), who opposed the overall drug benefit passed by Congress, stated “The penalty is a fair thing to do to keep the program economically viable.”
- The August 2005 Health Poll Report Survey released from the Kaiser Family Foundation reported that in August, for the first time since the tracking poll began in February of 2004, seniors are just as likely to have a favorable view of the new Medicare drug benefit as an unfavorable view (both at 32 percent). Data from earlier polls show that the percentage of seniors with favorable views of the Medicare Drug Benefit has increased from 17 percent in February 2004 to 32 percent in August 2005 while the percentage of seniors with unfavorable views has decreased (from 55 percent in February 2004 to 32 percent in August 2005). The survey also shows that 28 percent of seniors report knowing more about the Medicare drug benefit than they did a year ago, 13 percent reported knowing less and 53 percent reported knowing about the same. The survey was conducted on a nationally representative sample of 1,205 respondents aged 18 and older including 300 respondents 65 years or older. The report is available online at www.kff.org.

Special Populations

- On August 23, 2005, an article in Ohio’s *Beacon Journal* (Cheryl Powell, August 23, 2005), headlined “Managed Care: Some Insurers Helping Patients to Coordinate Health Care in New Medicare Program Through Nursing Homes,” described how Medicare beneficiaries at participating nursing homes in Ohio that are enrolled in a managed care plan are less likely to be hospitalized than seniors in the same facility that are not enrolled in the plan. The managed-care plan, Evercare, specifically targets seniors in long-term facilities. The plan employs a nurse practitioner to visit the enrolled residents to help them coordinate care with their physicians thereby helping to ensure that they are receiving needed services and avoiding potentially costly hospitalizations. Evercare is operated by UnitedHealth Group, which has other similar managed care programs including

programs for low income seniors enrolled in both Medicare and Medicaid and seniors suffering from chronic health problems.

FROM OTHER STAKEHOLDERS

- Although marketing of specific Part D products is not allowed until October, Humana is also participating in the “100-city” tour to educate older Americans about the new Medicare drug benefit. Humana’s chief executive stated, “We will not be out selling Humana’s 2006 products on this tour. That’s not what this is about. This is about education.” Humana is pairing with Wal-Mart and Sam’s Club warehouse stores to help with this beneficiary education (*Lexington Herald-Leader*, August 18, 2005).
- This month, *Medicare Today* released “Medicare Tomorrow: Future Savings for Beneficiaries,” a study prepared by analysts at PricewaterhouseCoopers (www.medicaretoday.org). The study indicates that all Medicare beneficiaries could save on out-of-pocket prescription drug spending, with low-income seniors having the potential to save the most. Specifically, the estimates include that on average Medicare beneficiaries could save nearly \$700 annually and that low-income seniors could save nearly 1,500 annually.
- This month, the Alliance of Community Health Plans (ACHP) released “Performance Measurement and Paying for Performance in Medicare: Health Plans, Hospitals and Physicians (www.achp.org).” The issue brief provides an overview of current efforts to measure Medicare health plan, hospital, and physician performance and to link improvement in performance with financial incentives. Within the issue brief, ACHP also describes a set of principles they developed to help guide the process. One principle included is that there should be development of measures to evaluate both fee-for-service Medicare and Medicare Advantage plans. Until development, incentives should be based on existing measures emphasizing clinical effectiveness.

NEWLY RELEASED RESEARCH STUDIES NOT PREVIOUSLY DESCRIBED

- **Amal N. Trivedi, Alan M. Zaslavsky, Eric C. Schneider, John Z. Ayanian.** “Trends in the Quality of Care and Racial Disparities in Medicare Managed Care.” *New England Journal of Medicine*, vol. 353(7): 692-700, August 18, 2005.

The authors of this article analyzed quality of care for white and black Medicare beneficiaries in managed-care plans using HEDIS measures. The authors analyzed 1.8 million individual-level observations from 183 plans from 1997 to 2003. The results show improvements on clinical measures over time for both racial groups with declining racial disparities for most, but not all, HEDIS measures studied. Authors call for more research on factors that contribute to the narrowing of disparities and a focus on interventions to eliminate persistent disparities.

- **David J. Gross, Stephen W. Schondelmeyer, and Susan O. Raetzman.** “Trends in Manufacturer List Prices of Generic Prescription Drugs Used by Older Americans-First Quarter 2005 Update.” Washington, DC: AARP Public Policy Institute, August 2005. (www.aarp.org)

In an update of prior work, this study reports on changes in the prices generic drug manufacturers charge wholesalers and direct purchasers during the first quarter of 2005. The authors identified the

most widely used prescription medications using sales data from the AARP Pharmacy Service. The authors identified the wholesale drug prices using costs published in the Medi-Span Price-Check PC database. The authors found that manufacturer list prices for a sample of 75 commonly used generic drugs rose by 0.7 percent in the 12 months ending with the first quarter (March) of 2005 (when measured as a 12-month rolling average and weighted by actual 2003 sales to Americans age 50 and over). The authors also measured “year-to-date” percentage changes through the first three quarters of 2005. They found that only 3 of the 75 generic drugs studied had an increase in manufacturer list price over this time period. This study is the latest in a series examining trends in prescription drugs, also available on AARP’s website.

- **Steven D. Pizer, Roger Feldman, and Austin B. Frakt. “Defective Design: Regional Competition In Medicare.” *Health Affairs*, Web Exclusive W5-403, August 23, 2005. (www.healthaffairs.org)**

In this article, the authors conclude that a little-noticed section of the regulations implementing the Medicare Modernization Act of 2003 will offset the competitive disadvantage the law otherwise creates for regional PPOs (vis-à-vis local HMOs). As a result, firms will have a strong incentive to offer such PPOs in some regions. The impact of the incentive could, they estimate from modeling, involve a cost of up to \$60 million or more. This is because such regional plans are only profitable because of overpayments that derive because regional benchmarks are weighted by the distribution of beneficiaries in a region rather than by the likely distribution of enrollees. A change in this policy, they conclude, would make regional PPOs disappear. The authors question whether the incentives created are the best way to address policy concerns though they note there also are problems with other approaches that could be taken.

Estimates are derived from a model that assumes MA choice involves regional PPOs and local HMOs and that regional PPOs avoid direct competition with local HMOs (because they cannot match their benefits) and structure products to target beneficiaries in counties where local HMOs do not operate. The analysis also assumes there will be no difference in drug benefits between regional PPOs and local HMOs. Based on our discussions of this study with others, we sense agreement that the regulatory issue raised by the authors is a real one though it is hard to say whether the financial estimates are right. (The financial estimates are based on predictions about entry that are hard to make and involve assumptions that depart in significant ways from the way the program works on the ground (e.g. firms can offer local PPO as regional ones; PPO and HMO costs are likely to differ).

OTHER SIGNIFICANT EVENTS

- This month, Cigna launched a website that allows its customers to compare the prices of prescription drugs charged by 52,000 pharmacies nationwide as well as by mail-order or home-delivery services. The site also allows for comparisons of brand-name and generic drugs. Cigna customers do not need to know what their benefits and co-payments are to use the program; instead, they simply enter the dosage and quantity of the medication(s) of interest. The website is also designed so that customers will be alerted when they are shopping for drugs that may cause potential complications with prescription drugs they are already taking. The website design is similar to one developed by New York Attorney General Eliot Spitzer. Spitzer’s website allows drug price comparisons for many New York pharmacies in order to help increase consumer

engagement on medical expenses and also to increase pharmacies' compliance with price disclosure rules (*The Indianapolis Star*, August 24).