Number 83
March 3, 2006

TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS
Monthly Report for February 2006

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

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

PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

From the CMS Medicare Managed Care Contract Report (http://www.cms.hhs.gov/HealthPlanRepFileData/

Note: CMS has not released the monthly Medicare Managed Care Contract Report for January or February 2006 nor indicated when such data will be available on 2006 enrollment trends. For point of comparison we show December 2005, the last reported data. (CMS also did not release February 2005 data)

Plan Participation, Enrollment, and Penetration by type	Current Month: Feb 2006	Change From Previous Month Not Available Column Shows December 2005	Same Month Last Year	
			Feb 2005	Change From Feb 2005 – 2006
Contracts				
Total	Not available	459	Not Available	Not Available
CCP		302		
PPO Demo		34		
PFFS		17		
Cost		29		
Other*		77		
Enrollment				
Total	Not Available	6,121,678	Not Available	Not Available
CCP		5,157,629		
PPO Demo		163,787		
PFFS		208,990		
Cost		321,555		
Other*		269,719		
Penetration**				
Total Private Plan Penetration	Not Available	14.0%	Not Available	Not Available
CCP + PPO Only		12.1%		

MATHEMATICA
Policy Research, Inc.

*Other includes Other Demo contracts, HCPP and PACE contracts.
** Penetration rates for December 2005 are calculated using the number of eligible beneficiaries reported in the September 2005 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 September 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

- None (CMS has not released its usual Monthly report with this information)

Summary of new MA contracts announced in February:

- CMS did not release its usual Monthly report listing new contracts.

NEW ON THE WEB FROM CMS

Relevant to Both Medicare Advantage and Prescription Drug Plans

- On February 17, 2006, a CMS press release titled "More Beneficiaries Participate in Medicare Advantage After Plan Approvals in 2005. This information is available online at http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1783.
    - The release quotes CMS Administrator, Mark McClellan saying that since the new prescription drug plan began, MA enrollment increased by over 460,000, which he attributes to the enhanced drug coverage offered by MA plans and their wide availability. The release does not provide enrollment data however and CMS has not yet released these data, previously available monthly, for 2006. (The release indicates that more than 5 million beneficiaries currently are enrolled in MA plans, with an average of 50,000 beneficiaries joining per month since 2004. However, because more than 5 million already were enrolled in December 2005, the release leaves unclear how the total enrollment in MA has changed since the introduction of the drug benefit in 2006.)
    - Beneficiaries in each state have access to some form of plan. Seventy-four percent of Medicare beneficiaries have access to HMO plans, 52 percent of beneficiaries have access to a local PPO and 98 percent of beneficiaries have access to private fee-for-service plans. In rural areas, 20 percent have access to a local HMO or PPO; the vast majority has access to a PFFS plan.

- The February 17, 2006 press release also drew attention to the CMS's issue of the preliminary "45-day notice" of the methods that will be used to calculate the 2007 risk adjustment for Medicare Advantage plan payments--"The Advance Notice of Methodological Changes for Calendar year 2007 Medicare Advantage Payment Rates and Part D Payment" (http://new.cms.hhs.gov/MedicareAdvtgSpecRateStats/AD/itemdetail.asp?filterType=data&filterValue=2007&filterByDID=1&sortByDID=1&sortOrder=ascending&itemID=CMS057845) CMS

indicates that preliminary estimates are that the national per capital MA growth percentage will increase by 6.9 percent in 2007. (The estimate incorporates an estimated 2.5 percent trend change in 2007 together and corrections for underestimates of prior year's growth in Medicare spending.) The increase is 6.5 percent for aged beneficiaries, 9.6 percent for disabled beneficiaries, and 4.7 percent for ESRD beneficiaries. The national growth percentage is used to update annual MA rates. Actual increases in 2007 also will be influenced by other policy changes. In 2007, for example, CMS will fully adjust rates for risk (versus 75 percent adjustment in 2006) and the risk adjustment model will be recalibrated and updated. CMS also will phase out the "budget neutrality" adjustment used to hold MA plans harmless, in aggregate, for revenue shifts attribution to risk adjustment. Instead of a 100 percent budget neutrality adjustment, CMS will use only a 55 percent adjustment. CMS also indicates that it will be re-basing county based FFS rates in 2007 and may move to annual adjustment in future years. The solicitation also indicates that CMS is authorized to pay entry and retention bonuses to regional MA plans from the Stabilization Fund and will implement subsequent guidance on this process. (Monthly bid amounts and regional low-income subsidy amounts for PDPs and MA plans for whom they are applicable also will use actual enrollment in 2007 versus equal weighting (for PDPs) or prior enrollment (for MA). This preliminary estimate will be updated before final 2007 capitation rates for all counties are announced in April).

- On February 21, 2006, CMS held a conference call for all MA plans, MA-PD plans, and other stakeholders. The purpose of the call was to provide the attendees with an overview of the Advance Notice 2007. More information on this call is available at http://www.cms.hhs.gov.

Relevant to Medicare Advantage

- On February 10, 2006, CMS updated its MA payment guide. The guide is intended to assist MA plans in situations where they are required to pay the original Medicare rate to out of network, non-contract providers. The guide notes that PFFS plans may set their own fee-schedules and balance billing requirements, which differ from Medicare's. The information is available at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/

Relevant to Prescription Drug Plans

- On February 2, 2006, in a CMS press release titled, "Medicare Drug Costs Drop Substantially: Lower Costs helping beneficiaries, taxpayers, states," CMS administrator McClellan stated that as of January 31, 2006, there are 3.6 million self-enrolled in the new prescription drug benefit. He noted that around 300,000 are new enrollees in MA plans with drug coverage. He also stated that beneficiary premiums are now expected to average $25 a month, which is lower than the projected $37 from July's budget estimate. McClellan stated the lower average premium is due to stronger than expected competition and lower drug costs. This press release is available on CMS's website at http://www.cms.hhs.gov/apps/medica/press/release.asp?Counter=1766.

- On February 9, 2006, CMS released a tip sheet for Medicare partners to be used to help beneficiaries as they enroll prescription drug plans. CMS recommends that people should enroll or change plans before the 15th day of any month to ensure that the enrollee will have an easier time at the pharmacy counter than if they waited to enroll later in the month. The tip sheet stated this is because it will allow more time for the information to be processed. The tip sheet also included recommendations that new enrollees should do as they go to their pharmacy to get their medicines using their new insurance plan. The recommendations include: 1) Bring the

acknowledgement letter or confirmation letter from the plan the enrollee joined. 2) If the beneficiary has not received the confirmation letter, CMS recommends they bring a welcome letter, enrollment confirmation number or a copy of an enrollment application signed by a plan representative. 3) If the beneficiary qualifies for the low-income subsidy (LIS), CMS recommends the beneficiary bring the copy of the yellow automatic enrollment letter from Medicare, a Medicaid card, or the approval letter from the Social Security Administration. In addition, CMS stated that as a last resort if new enrollees pay out-of-pocket for their prescriptions, to save their receipts and then work with their plan to be reimbursed. This tip sheet is available at http://www.cms.hhs.gov/partnerships/downloads/earlyinmonthtipsheet.pdf

- On February 11, 2006, in his weekly radio address, President Bush acknowledged the problems in the new prescription drug benefit stating "when you make a big change in a program involving millions of people, there are bound to be some challenges." He then stated that with the new competition however that the program is getting cheaper for both beneficiaries and taxpayers. President Bush's radio address is available at http://www.whitehouse.gov/news/releases/2006/02/20060211.html

- On February 22, 2006, Mike Leavitt, Secretary of Health and Human Services released a progress report on the Medicare Prescription Drug Benefit. The report states that there has been solid progress with the implementation of the Medicare prescription drug benefit and that costs of drug coverage are less than expected. The report includes an update on the states that have been working with CMS to complete the transition to Part D, as well as how the prescription drug benefit has allowed for improvements with Medicare Advantage plans because more of these plans are now able to include drug coverage. The report also described why it is important for beneficiaries to enroll early in the month, as it increases the likelihood that the plan will have been able to process the enrollment information and pharmacies will have received the necessary information for beneficiaries to have their prescriptions filled without delays. Finally, the progress report also provides a summary of action steps that CMS will continue to take such as to continue to work with health plans and states to improve the transition process in order to decrease delays for beneficiaries when they go to the pharmacy to get their prescriptions filled. The progress report is available online at http://www.hhs.gov/medicare2final.pdf

Relevant to Special Needs Plans Specifically

- On February 14, 2006, CMS released "Special Needs Plan—Fact Sheet and Data Summary." This three page document includes information on the three types of individuals that qualify for special needs plans: 1) Institutionalized Beneficiaries; 2) Dually eligible beneficiaries; and 3) Beneficiaries with chronic conditions. The document also provides contract and plan level data. As of January 1, 2006, there are 164 contracts with one or more SNPs operating in 42 states and Puerto Rico. Of these, 140 contracts include dual SNPs; 32 included institutional SNPs, 12 are chronic conditions SNPs, 20 are demonstrations, 23 contracts are local PPOs, and 3 are contracts with RPPOs. The plan level information includes that 276 SNPs are approved to operate in 2006 with 226 dual plans, 37 institutional plans, and 13 chronic condition SNPs. This document is available at http://www.cms.hhs.gov/SpecialNeedsPlans/.

Other

- On February 3, 2006, CMS announced that enrollment is over 100,000 in the eight pilot programs designed to help coordinate care for Medicare beneficiaries in the traditional fee-for-service program with chronic conditions. These pilot programs were announced in December 2004 and began operations between August 2005 and January 2006. CMS is paying eight companies including Aetna, CIGNA, and American Healthways to coordinate the beneficiaries' care. http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1772

ON THE CONGRESSIONAL FRONT

About Medicare Health and Drug Plans Specifically

- On February 2, 2006, the U.S. Senate Special Committee on Aging held a hearing titled "Meeting the Challenges of Medicare Drug Benefit Implementation." Panel one witness testimony included CMS Administrator Mark McClellan and SSA Deputy Commissioner, Linda McMahon. Panel two included two beneficiaries and Sharon Farr, Accounts Receivables Supervisor for the Center for Individual and Family Services. Panel three included Massachusetts DHHS Secretary, Timothy Murphy; Sue Sutter, President Elect, Pharmacy Society of Wisconsin; and Mark Ganz, President and CEO of Blue Cross Blue Shield of Oregon. Testimony of each panel member as well as other information is available on the Special Committee on Aging website at http://aging.senate.gov/public/index.cfm?Fuseaction=Hearings.detail&HearingID=72

    - CMS Administrator Mark McClellan discussed the implementation of the new drug coverage and the work CMS has been doing to help ensure a smooth transition. McClellan stated that CMS has been most concerned about helping dual eligibles in using their new benefit but stated that CMS requires plans to have a transition process for dual eligible enrollees. He also discussed the emergency actions CMS has taken to ensure dual individuals who need emergency fills of their prescription are able to receive them in a timely fashion.

- On February 8, 2006, the Senate Committee on Finance held a hearing titled "Implementation of the New Medicare Drug Benefit." Senators Charles Grassley and Max Baucus made opening statements. Panel speakers included CMS Administrator, Mark McClellan and Vice President, Pharmacy Management, Humana Inc, William Fleming. Other speakers included President of Senior Services at Wellpoint, Susan Rawlings; Chairman and CEO of Walgreen Co., David Bernauer; Owner of Sykes Pharmacy, Tobey Schule; CEO of Aetna, Agency on Aging of Southwestern Illinois, Joy Paeth and Pamela Willoghby, R.N. from Faith Community Nurses. More information on this hearing as well as transcripts for all speaker is available at http://finance.senate.gov/sitepages/hearing020806.htm

    - CMS Administrator Mark McClellan stated that CMS is working to address problems with the new prescription drug benefit and outlined steps CMS has taken to address the various problems including: 1) Requiring insurers offering the new benefit to provide enrollees with a 3 month supply of any medication taken before the new benefit took effect; 2) Increases in the number of 1-800 Medicare phone line representatives; 3) Conducting daily transfers of information between Medicare and drug plans; 4) Hiring a

company to streamline information on beneficiaries between pharmacists, states and drug plans.

- Vice President, Pharmacy Management, Humana Inc, William Fleming discussed implementation challenges, transitional policies as well as detailed information on the pdp benefits Humana is offering. In addition, Fleming discussed opportunities for improvement and "lessons learned." One of the recommendations he had for improvement is providing more direction on how to handle pharmacy needs directly after enrolling in a new plan. He stated that those beneficiaries who wait and enroll in the last days of the month but still have an effective date of the first of the following month. He stated that even with the most effective system it is still difficult to ensure every thing is working by the first of the month. Humana is currently providing information on how to handle transitional pharmacy needs on its website.

- MedPAC will hold its next public meeting March 9-10, 2006. 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.

Broader Medicare Program (in Brief)

- On February 8, 2006, the House Ways and Means Committee held a hearing on the President's fiscal year 2007 Budget for the Department of Health and Human Services. HHS Secretary Mike Leavitt testified at the hearing. He stated that the proposed cuts in Medicare provide steps to improving the long-term fiscal health of Medicare. His testimony as well as other information on the hearing is available at http://waysandmeans.house.gov/Hearings.asp?congress=17

FROM THE PERSPECTIVE OF BENEFICIARIES

General

- This month, Kaiser Family Foundation released findings from their tracking poll on the Medicare prescription drug benefit, which is part of a larger *Health Poll Report Survey.* The tracking poll is based on interviews with 262 adults ages 65 and older that were interviewed as part of the entire survey of a nationally representative sample of 1,203 adults aged 18 and older between February 2 and February 7, 2006 (the margin of sampling error for respondents ages 65 and older is +/- 7 percentage points). The findings include that 45 percent of seniors say they have enrolled or plan to enroll in a drug plan, 29 percent say they do not intend to enroll in a drug plan, and another 23 percent say they are uncertain. The tracking poll also reported that seniors have become less enthusiastic about the new prescription drug benefit over the past six months. The February tracking poll results showed that 45 percent say they view the benefit unfavorably and 23 percent viewed the benefit favorably, whereas in August 32 percent viewed the benefit unfavorably and 32 percent viewed the benefit favorably. More detail including the chartpack and toplines is available on the Kaiser Family Foundation website at http://kff.org/kaiserpolls/pomr021706pkg.cfm

- Consumers Union released a press release on February 5, 2006 titled "Some Medicare Drug Plans Hiked Prices After One Month; Consumers Union Calls for Halt to Increases and Price Tracking Information." The Consumers Union sampled drug prices in five zip codes from the Medicare.gov Website and compared prices of five drugs for various ailments (including Lipitor) from the end of December 2005 and the end of January 2006, one month into the new program. They report that the cost of some prescriptions has dramatically increased in just one month. They found that in New York, 38 plans increased the cost of the five drugs, with an average increase of $155.80. This press release is available at http://www.consumersunion.org/pub/healthmedicareprescription/003123.html

- An article in the *New York Times* (Pear, Robert, February 14, 2006) titled "Rules of Medicare Drug Plans Slow Access to Benefits" described how both doctors and pharmacists have complained about the diverse requirements of the numerous different drug plans, which have delayed or denied access to needed medications for many beneficiaries. Most plans require prior authorization for different drugs, which involves filling out numerous different forms by both doctors and pharmacists and in addition some plans require doctors to provide detailed laboratory test results. One health plan executive stated, however, that these forms are necessary to prevent the overuse of high-cost medications and to ensure that "equally effective, less expensive agents are used first." The chairman of Walgreen, David Bernauer stated however that the government "should use its leverage to promote greater standardization of policies and procedures.",

- This month, Kaiser Family Foundation released a new policy brief titled, "Tracking Prescription Drug Coverage Under Medicare: Five Ways to look at the New Enrollment Numbers." The five approaches for measuring enrollment and coverage show: 1) 60 percent of all Medicare beneficiaries (25.9 million) have prescription drug coverage from Part D or other creditable sources; 40 percent (17.5 million) do not; 2) The majority of those with creditable coverage most likely had drug coverage prior to this year under employer plans, Medicaid or Medicare Advantage plans; 3) 15.9 million Medicare beneficiaries are enrolled in Part D plans; another 13.4 million would need to sign up for a Part D plan to reach the Administration's projected target of 29.3 million Part D enrollees in 2006; 4) 5.4 million of the 22.9 million beneficiaries most likely to consider voluntarily enrolling in a Medicare drug plan (because they were not auto-assigned to a plan and did not have other coverage) have signed up for a Medicare Part D plan this year. This issue brief is available at http://www.kff.org/medicare/7466.cfm.

Special Populations

- None

FROM OTHER STAKEHOLDERS

- This month, AcademyHealth held a National Health Policy Conference. The agenda and other information on the conference are available at http://academthealth.org/nhpc/agenda.htm. AcademyHealth will be posting a summary of the meeting. Sessions particularly relevant to Medicare included:

    - MMA Implementation: Registering Low-income Beneficiaries. Mike Hash of Health Policy Administration was the moderator. Speakers included Beatrice Disman, Social Security Administration; Cheryl Matheis, AARP; Thomas Paul, Ovations, UnitedHealth Group Company; and Michael McMullen of CMS. The session was mainly focused on

one particular aspect of implementation--finding and enrolling individuals eligible for LIS.

- o Congressional Health Policy Agenda. The panel included Mark Hayes, Senate Finance Committee (majority), Steve Northup, Senate Health, Education, Labor, & Pensions Committee (majority), Chuck Clapton, Chief Counsel, House Health, Energy, & Commerce Committee (majority), and Cybele Bjorklund, House Ways and Means Subcommittee on Health (minority). David Helms introduced the session and panelists explaining that the panel gives congressional staff the opportunity to share thoughts on upcoming activities and issues occurring on Capitol Hill such as the President's proposed budget, agendas of key health committees and other issues surrounding the Administration's goals in health policy such as the Medicare Part D benefit.

- o The Administration's Health Policy Agenda. This session included Roy Ramthun, Special Assistant to the President for Economic Policy; Marc McClellan, Administrator, Centers for Medicare and Medicaid Services; Janet Woodcock, Director, Center for Drug Evaluation and Research, FDA, and Carolyn Clancy, Director, Agency for Healthcare Research and Quality. Mark McClellan discussed the implementation of the new prescription drug coverage. He stated that the until the new drug benefit, Medicare was lagging in contemporary health care in which prescription drugs have become essential in managing illnesses. He also discussed the transition problems and the steps CMS has taken to ensure a smoother transition.

- On February 9, 2006, the Center for American Progress held a web cast titled "Has Medicare Been Privatized? Implications of the Medicare Modernization Act, Beyond the Drug Benefit." Director of health policy at the Center for American Progress, Karen Davenport was the moderator. Speakers included Jeanne Lambrew, senior fellow at the Center for American Progress; Marilyn Moon, vice president and director at AIR, and Chip Kahn, president of the Federation of Hospitals. The speakers discussed how the MMA has affected Medicare Advantage program. Speakers focused on how the implication of the MMA has affected costs, quality and access to care for Medicare beneficiaries. More information on this event is available on the Center for American Progress website at http://www.americanprogress.org/site/apps/nl/content3.asp?c=biJRJ8OVF&b=593305&ct=1960193

- The National Academy of Social Insurance held it's 18th annual conference in late January. In the session titled "Implementing Medicare Part D: The First 60 Days" experts examined the new Medicare prescription drug benefit since the start of enrollment in late November. Speakers included Karen Ignagni, CEO of America's Health Insurance Plans; Trudy Lieberman, Director of the Consumers Union's Center for Consumer Health Choices; Marilyn Moon, president of NASI; and journalist Bob Rosenblatt. The audio web cast is available online at www.nasi.org.

- An article in *Business Week* (Gleckman, Howard, January 30, 2006) titled "Plan A: Hook Them with Part D. Humana's low-cost Medicare drug plan is a way to lure seniors into its managed care" describes Humana's approach to marketing their Medicare Health and drug benefit plans. The article states that Humana's goal is to get as many seniors into a drug plan at a modest margin or even no margin in Year one and then try to convert them to a managed care plan. Vice President for Senior Products at Humana, Steven Bruckner, said that he calls their strategy an

"enroll-and-migrate strategy." The article also stated that Humana was paying commissions to their sales staff that are twice as generous for health and drug plans than for drug only plans.

- An article in the *Chicago Tribune* (Jaspen, Bruce, February 24, 2006) reports that the inspector general of the U.S. Department of Health and Human Services will be working with the Centers for Medicare and Medicaid Services to investigate any beneficiaries complaints regarding scenarios in which beneficiaries may have been put into plans they did not specify. The article reported that the OIG investigation came after Congressman Peter Stark (D-California) complained that sales practices are violating the Medicare marketing guidelines because health insurers are using high-pressured sales tactics to push seniors into HMOs rather than drug-only plans, which can bring in six times the revenue.

NEWLY RELEASED RESEARCH STUDIES NOT PREVIOUSLY DESCRIBED

- **Borger, Christine, Sheila Smith, Christopher Truffer, Sean Keehan, Andrea Sisko, John Poisal, and M. Kent Clements "Health Spending Projections through 2015: Changes on the Horizon".** ***Health Affairs Web Exclusive;*** **February 22, 2006, www.healthaffairs.org**

In this analysis of national health care spending projections through 2015, CMS actuaries also examine the impact of Medicare Part D coverage. They conclude that the introduction of this coverage produces a dramatic shift in spending across payers but has little net effect on aggregate spending growth nationwide. Such growth however, is expected to continue to outpace the GDP over the coming decade, accounting for 20 percent of GDP by 2015. The analysis uses assumptions consistent with the Medicare Trustees Report and assumes that 32 percent of Medicare enrollees will be in managed care plans in 2015, compared with 12 percent in 2004. The revision of risk adjustment in 2007 is expected to reduce payments to such plans by 7 percent in that year compared to what the payments otherwise would be.

- **Schneider, E.C., Zaslavsky, A.M, and Epstein, A.M. "Quality of Care in For-Profit and Not-for-Profit Health Plans Enrolling Medicare Beneficiaries."** ***American Journal of Medicine,*** **vol. 118(12): 1392-1400. (www.cmwf.org/publications)**

The authors analyzed performance data from HEDIS submissions on all plans serving Medicare beneficiaries. They used a sample (was this a sample or all who submitted) of 231 health plans and made adjustments for sociodemographic differences. The authors found that for-profit plans scored significantly lower than not-for-profit health plans on the four areas measured: breast cancer screening (7.3 percentage points lower), diabetic eye examination (14.1 percentage points lower), beta-blocker medication after heart attack (12.1 percentage points lower) and follow-up after hospitalization for mental illness (18.3 percentage points lower). These differences persisted after adjustments were made for sociodemographic factors, geographic variables, and health plan differences. The authors then speculated about the differences between the health plans such as in selection of providers, priorities of plan leaderships, and use of effective quality management techniques or tools, such as educational outreach or patient reminder systems. They conclude that the reasons for which these plans differ needs to be better understood before conclusions can be drawn and that while quality of care in for-profit plans may be lower than that in not-for-profit plans, it may still be higher than in the fee-for-service program.

- **Gross, David, Schondelmeyer, Stephen W., and Raetzman, Susan O. "Trends in Manufacturer List Prices of Prescription Drugs Used by Older Americans-third quarter**

2005 update." Washington, DC: AARP Public Policy Institute, February 2006. www.aarp.org

In an update of prior work, this study reports on changes in the prices of generic drug manufacturers charge wholesalers and direct purchasers during the third 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 fell by 1.5 percent in the 12 months ending with the third quarter (July 1 through September 30) 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 third quarter of 2005. Only three of the 75 drugs studied had an increase in price at any time from January to September in 2005, all during the first quarter of the year. This study is the latest in a series examining trends in prescription drugs, also available on AARP's website.

- **This month CMS released its "40 Years of Medicare & Medicaid" issue of *Health Care Financing Review* (winter 2005-2006, vol. 27, Number 2). Some of the articles featured that are relevant to Medicare Advantage include:**

    - Antos, Joseph. "Ensuring Access to Affordable Drug Coverage in Medicare."

This article addresses key issues to whether the new prescription drug benefit will be a success. The author discusses: 1) whether market-based approaches are more effective than direct government intervention in limiting spending; 2) how beneficiaries, drug plans, employers, and States are likely to adapt to the new program; and 3) the balance between cost containment and access to innovative pharmaceuticals.

- Dowd, Bryan E., Coulam, Robert, Feldman, Roger, and Pizer, Steven. "Fee-for-Service Medicare in a Competitive Market Environment."

In this article, the authors examine the advantages and disadvantages of private plans and the government sponsored fee-for-service (FFS) plan. The authors found that while FFS Medicare provides universal access with relatively stable premiums, private plans have a more streamlined decision-making process, they are more nimble and their benefits are more responsive to changing market conditions. They draw two conclusions: 1) Neither FFS nor private plans should be the exclusive provider for Medicare and 2) performance comparisons between the two should not be justification for an open-ended subsidy for FFS Medicare. The authors stated, however, FFS and private plans should compete on equal terms, just not through this type of subsidy.