Number 79
October 5th, 2005

TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS
Monthly Report for September 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

Prepared by Marsha Gold, Stephanie Peterson and Lindsay Harris, 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://cms.hhs.gov/healthplans/reportfilesdata/):

Plan Participation, Enrollment, and Penetration by type	Current Month: Sep 2005	Change From Previous Month	Same Month Last Year	
			Sep 2004	Change From Sep 2004 – 2005
Contracts				
Total	464	+38	295	+169
CCP*	302	+28	151	+151
PPO Demo	34	0	35	-1
PFFS	17	+1	5	+12
Cost	29	0	29	0
Other*	76	+7	75	+1
Enrollment				
Total	5,913,280	+62,372	5,420,078	+493,202
CCP	5,024,708	+45,138	4,665,927	+358,781
PPO Demo	125,097	+631	106,174	+18,923
PFFS	147,900	+12,724	41,570	+106,330
Cost	322,434	+391	329,074	-6,540
Other*	293,141	+3,488	277,333	+15,8-8
Penetration**				
Total Private Plan Penetration	13.6%	+0.1%	12.7%	+0.9%
CCP + PPO Only	11.9%	+0.1%	11.0%	+0.9%

*Other includes Other Demo contracts, HCPP and PACE contracts. Please note that the total number of contracts does not add to the total by plan type for this month because the number of other plans is 76 (not 82 as would be expected given the total reported in the MMCC report for September). We are currently investigating the cause of the discrepancy in the file released by CMS.

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

- CMS has almost eliminated its backlog of pending applications as a result of approvals granted over the last several months. According to the September 1, 2005 Medicare Managed Care Contract Report, there are pending applications for 4 PACE contracts and 6 cost contracts. There are no pending service area expansions this month. (These counts exclude regional MA plans that will not be offered until 2006 and could exclude applications for new contracts in 2006. As discussed below, CMS released basic information on 2006 approved contracts on September 23, 2005.

Summary of new MA contracts announced in June:

CMS's Monthly Medicare Managed Care Contracts Report (MMCC) for September 1, 2005 indicates that 35 new contracts were signed in August 2005, including 28 CCP contracts, 1 PFFS contract and 6 demonstration 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 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:

- SDM Healthcare Corporation, Bayamon, PR (CCP)
- Companion Healthcare Corporation, Columbia, SC (CCP)
- ODS Health Plan, Columbia, SC (CCP)
- Empire Healthchoice Assurance, Inc, Brooklyn, NY (CCP)
- Freedom Health, Ocala, FL (CCP)
- San Mateo Health Commission, South San Francisco, CA (CCP)
- United Healthcare Insurance Company, Minnetonka, MN and Warwick, RI (4 CCP contracts)
- Independent Health Benefits Corporation, Buffalo, NY (CCP)
- Universal Health Care, Inc, Saint Petersburg, FL (CCP)
- Care1st Health Plan of Arizona, Phoenix, AZ (CCP)
- Hip Insurance Company of New York, New York, NY (CCP)
- Rochester Area Health Maintenance Organization, Rochester, NY (CCP)
- Arizona Physicians IPA, Inc, Phoenix, AZ (CCP)
- Capital Advantage Insurance Company, Harrisburg, PA (CCP)
- Optima Health Insurance Company, Virginia Beach, VA (CCP)
- Blue Cross and Blue Shield of Ma, Inc, Boston, MA (CCP)
- Familycare Health Plans, Inc, Portland, OR (CCP)
- Blue Cross and Blue Shield of SC, Columbia, SC (CCP)
- Fidelis Senior Care of Michigan, Inc, Livonia, MI (CCP)

- Aetna Life Insurance Company, Hartford, CT (3 CCP)
- Health Net Life Insurance Company, Woodland Hills, CA (CCP)
- Humana Insurance Company, Louisville, KY (CCP)
- Geisinger Indemnity Insurance Company, Danville, PA (CCP)
- PacifiCare Life and Health Insurance Company, Cypress, CA (PFFS)
- Primewest Health System, Alexandria, MN (Demos)
- Itasca Medical Care, Grand Rapids, MN (Demos)
- Healthpartners, Bloomington, MN (Demos)
- First Plan of Minnesota, Duluth, MN (Demos)
- Blue Plus, St Paul, MN (Demos)
- United Healthcare Insurance Company, Minnetonka, MN (Demos)

In addition, the report indicates that 16 contracts were approved to expand their service area.

NEW ON THE WEB FROM CMS

Relevant to Both Medicare Advantage and Prescription Drug Plans

- On September 23, 2005, CMS held a conference call announcing approved contracts for Medicare prescription drug plans (PDPs) and Medicare Advantage-Prescription drug plans (MA-PDs). The information is accessible on CMS's website at http://www.cms.hhs.gov/map/map.asp. The website was updated on September 30, 2005 to correct the naming of one national PDP, show the approval, as of September 27, 2005, of an additional 57 new cost plans and MA-PD plans offering drug coverage, and provide additional information on the specific contracts and benefit packages to be offered in each state. From the language in the release, it appears that additional updates and corrections may occur over the next few weeks. Table 1 that is attached to this release formats the data on available offerings by region and state that CMS released on September 23, 2005, noting additional MA-PD/cost approvals in the 9/27/05 release.

    - Ten insurers have been approved to offer national PDPs. These ten companies will offer stand -alone PDP products that will be available in each of the 34 PDP regions. They are:

        - Aetna Life Insurance Company
        - Connecticut General Life Insurance Company
        - Coventry Health & Life Insurance/First Health Life & Health Insurance/Cambridge Life Insurance
        - Medco Containment Life Insurance Company
        - Memberhealth, Inc
        - Pacificare Life and Health Insurance Company
        - Silverscript Insurance Company
        - Unicare (the 9/30/05 replaces this with its parent Wellpoint and notes that Unicare, Anthem, and One Nation plans will share the collective firm-wide allotment of dual eligible assignees through Wellpoint)
        - United Health Care Insurance Company
        - WellCare Health Plans

    - The total number of PDPs offered per region is 11 in Alaska (Region 34) and 12 in Hawaii

(Region 33). All of the other regions will have 15 or more PDPs. The maximum number of PDPs in any region is 20 in New York (Region 3) and in Oregon and Washington (Region 30); this maximum is a bit lower than the preliminary CMS announcement of a maximum of 23 PDPs. PDP counts include the 10 national PDP contractors and additional contractors that are offering a PDP in just one or a subset of the 34 regions.

- The minimum number of PDPs available to those in the low-income subsidy (LIS) program and auto-enrolled is 5 and the maximum is 14. In most regions, over half of the PDPs available to all beneficiaries will be available to those in the LIS. Availability of free-standing PDPs to those who qualify will be most limited (compared to all available offerings) in Arizona (5 of 18), Florida (6 of 18), Nevada (7 of 17), and California (8 of 18). At least part of the reason for this is that the low-income subsidy amount varies by region based on PDP offerings and also takes into account MA-PD premiums, which are weighted by the level of MA penetration in the PDP region (see August 2005 Monthly Report for a description of these calculations).

- Those wishing to stay in traditional Medicare who want the new Part D benefit must join one of the PDPs described above. Premiums for such plans (if not subsidized by LIS coverage) vary by plan and region. At least one PDP at a premium under $20 will be available in all regions except Alaska (Region 34). While 17 PDP regions have only 1 PDP at this price level, 3 regions have 5 (New York, Region 3; New Mexico, Region 26; and California, Region 32).

- Beneficiaries also can choose to get Part D coverage through an MA plan if one is offered. Such coverage is available through Regional PPO MA plans that provide coverage to all beneficiaries in regions where they are offered or in local MA-PD plans that are available on a county by county basis in selected locales.

  - Regional PPOs will be available in 21 of the 26 MA regions that span 37 states. Regions 1 (Maine, New Hampshire), 2 (Connecticut, Massachusetts, Rhode Island, Vermont), 20 (New Mexico, Colorado), 23 (Oregon, Washington, Idaho, Utah) and 26 (Alaska) will not have a regional PPO offering in 2006. Most regions with regional PPOs will have only one such product. Five regions spanning 8 states will have two regional PPOs offered.

  - Humana has been most aggressive in offering regional PPO products. Their regional PPO product has been approved in 14 regions and thus will be available to beneficiaries in 23 states.[1] United Healthcare is offering such a regional PPO in three regions (Region 2, NY; Region 9 (Florida); and 25 (Hawaii). Aetna is offering a regional PPO in two regions (Region 4, NJ; Region 3, Delaware, Washington DC, and Maryland) as is Anthem (Region 12, Ohio; and Region 13, Indiana and Kentucky). Other BC/BS plans are covering the 7 state region 19, and also California. Sierra is offering a regional MA plan in Nevada (region 22). Instil Health Insurance Company is offering one in Region 8 (South Carolina, Georgia). Health Net is offering one in Arizona (region 21).

  - Local MA-PD plans will be available to at least some beneficiaries in all states but Vermont and Alaska. However the number of such plans varies widely across locales (e.g. according to the September 23, 2005 release, most states have few but Florida has 28 and California

1 A spot check of local listings indicates that Humana also will be offering local MA-PDs in all or most of the states in these regions, some of which will be available to all beneficiaries at zero premium for drug coverage.

and New York each have 19). CMS has not yet provided information on how many of local MA-PD plans are PPOs versus HMOs) and has provided only limited information on the counties in which these plans will be offered. MA-PDs, where available, appear to have a price advantage over PDPs, with some offerings available with zero premium for the drug coverage. Such zero premium products are available in all states except Vermont, Alaska, Delaware, New Hampshire and South Carolina but not necessarily to all beneficiaries since availability varies by county and offerings have historically been more extensively in urban than rural areas and in some urban markets. CMS has not released information yet on the premium MA-PDs will charge for supplemental coverage other than for drugs.

- CMS has not yet released information on the number of MA only plans that are available. This is particularly relevant for private fee-for-service (PFFS) offerings, which are not required to be offering prescription drug coverage. Some national firms (e.g. PacifiCare, Humana) had indicated intent to offer these products in most or all regions. Presumably beneficiaries who enrolled in them could join that organization's PDP or another such offering.

- The September 30, 2005 CMS update on the CMS website updates lists for each state of PDPs and PD-MA plans. The updates include all plans approved by September 25, 2005. The revised PDP tables show not just organizational names (contracts) but also the list of specific benefit plans/products that each organization will offer and, for each, the premium, whether the initial $250 deductible is in place, reduced, or eliminated in that package; whether tiered co-payments are used and whether there is any coverage provided in the "coverage" gap and if so whether it is for generics and brand name drugs or just generics, whether mail order is offered and how many of the top 100 drugs on the formulary the plan covers. The MA PD pages provide the same information for these plans and also indicates the percent of beneficiaries in the state who are in counties where that package is available, the type of product it is (HMO, local PPO, regional PPO, PFFS or cost)

- On September 1, 2005, a press release by CMS reported that Medicare managed care plans will receive $4 billion less in Medicare reimbursements over the next five years. The decrease in payment is due to two factors: 1) a change from the April 2005 budget neutrality payment factor and 2) a technical correction. There has been a change in the budget neutrality adjustment rate due to new estimates that the differences in health status between Medicare managed care plans and traditional fee-for-service plans are smaller than the April estimates. CMS plans to change the reimbursement rate for 2007-2011 but not next year (2006). The press release is available at http://www.cms.hhs.gov/media/press/release.asp?Counter=1544.

- On September 14, 2005, CMS released a memorandum outlining requirements and timelines for data submission for all PDPs and MA-PDs. The memorandum noted that all data submitted must match the plan design that has been approved by CMS. Organizations can submit changes to the data only after approval by CMS. The full list of data submission files is posted on CMS's website (www.cms.hhs.gov). The list includes (1) the formulary file (submitted on a monthly basis), (2) beneficiary cost file (submitted annually), (3) pharmacy cost file (submitted weekly), and (4) pricing file (submitted monthly). The memo also clarified the "opt out" notification. Any organization that chooses not to participate in the Online Enrollment Center associated with the Medicare Prescription Drug Plan Finder on www.medicare.gov is required to notify CMS in writing (via email) by September 16, 2005 at drugplanfinder@cms.hhs.gov.

- On September 16, 2005, a press release by CMS stated that the monthly premium for Medicare Part B will increase by $10.30 in 2006 making the monthly premium $88.50. It is currently $78.20. The press release stated that the primary reason for the increase premium is the continued rapid growth in the intensity and the utilization in Part B services, including physician office visits, lab tests, minor procedures, and physician-administered drugs. The press release is available at http://www.cms.hhs.gov.

- Bush Administration officials including HHS Secretary Mike Leavitt continued their promotional tour on the Medicare drug benefit. This is part of a "100-city tour" to discuss the new benefit with Medicare beneficiaries and senior advocates. The tour is specifically designed to help raise awareness of the benefit and then provide beneficiaries with important dates about when and how to register as well as how those that qualify can apply for financial assistance.

    - HHS Secretary Mike Leavitt held meetings in several areas in Kentucky as well as in Tennessee this month (Yetter, *Louisville Courier-Journal,* September 2, 2005; Harrington, *Knoxville News-Sentinel,* September 2, 2005*).*

- On September 20, 2005, HHS Secretary Mike Leavitt and CMS Administrator Mark McClellan convened a conference call on the Medicare Prescription Drug Education and Outreach Campaign. The conference call included a presentation of the education and outreach campaign strategy and resources as well as a presentation of the new web tools. Secretary Leavitt discussed the three new tools on the Medicare Web site that beneficiaries can use to determine cost savings, comparison of plans and enrollment information. He noted that on September 25, 2005, Parade magazine included an insert of some of the campaign resources to help beneficiaries begin to learn about their options. The entire conference call is available on http://www.cms.hhs.gov/partnerships/ and www.aoa.gov as is information on the resources discussed.

    - The three new web tools include the **Medicare Prescription Drug Plan Cost Estimator**. This tool is to help people considering enrolling in the new prescription drug benefit information on cost-savings. Users can enter in their monthly drug costs and the state they live in to get an estimate of annual savings they could accrue by enrolling in a drug plan. These are general estimates not based on a specific plan but are based on the lowest premium amount offered by a plan in their region as well as on the standard benefit received. This tool is available on http://www.medicare.gov/medicarereform/MPDP_Cost_Estimator.asp.

    - The **Medicare Personal Plan Finder** is designed to help beneficiaries compare benefits and costs related to Medicare Advantage plans (including MA-PDs, special needs plans (SNPs), traditional Medicare plans as well as Medigap plans. It will be released on October 13, 2005, to support open enrollment, which begins November 15, 2005. This tool will be accessible at http://www.medicare.gov/.

    - The third tool, the **Medicare Prescription Drug Plan Finder** will include information on all of the plans that offer prescription drug benefits, including both PDPs and MA-PDs. It will provide people with information including cost sharing for different drugs as well as enrollment information and an online application process. It will also alert users to whether they are already enrolled in an MA, Medicaid or employer-sponsored coverage. This tool will be accessible at http://www.medicare.gov/.

- On September 21, 2005, CMS posted question and answers on rebates and the retiree drug subsidy (RDS). A plan sponsor that qualifies for the subsidy will receive 28 percent of allowable retiree costs (ARC) for each qualifying covered retiree. This information as well as other question and answers regarding the retiree drug subsidy can be accessed via the Retiree Drug Subsidy (RDS) Center website at http://rds.cms.hhs.gov.

    - On September 29, 2005, CMS held a RDS center national conference call. The call included a presentation addressing many of the RDS "hot topics" identified by the plan sponsor community. The presentation is also available via the RDS website at http://rds.cms.hhs.gov.

- On September 22, 2005, a press release by CMS reported that approximately 3 million Medicare beneficiaries have already submitted applications for low-income subsidies that will be available through the new prescription drug benefit. The CMS actuaries projected that about 4.6 million people with Medicare are expected to enroll in the program for extra help by 2006. The press release is available at http://www.cms.hhs.gov.

- On September 28, 2005, CMS conducted a one-day compliance conference for prescription drug plans and Medicare advantage plans. The conference provided detailed information on compliance requirements related to marketing and outreach, data security, licensing and ethics requirements, internal monitoring and reporting of compliance issues to CMS. The conference also provided information on monitoring and oversight and audit procedures as well as an explanation on corrective action plans, intermediate sanctions and referrals to law enforcement agencies. (http://www.cms.hhs.gov).

Relevant to Medicare Advantage

- On September 1, 2005, CMS released a standardized education and outreach letter to all current Medicare Advantage organizations and 1876 cost plans that plans can send to their members. The standardized letter provides members with information regarding their health plan options. The letter includes disenrollment information for current health plan members considering enrollment in plans by different organizations. (http://www.cms.hhs.gov).

- On September 2, 2005, CMS issued a draft of the 2006 Model Evidences of Coverage (EOC) for industry comment. Comments on the draft were due to CMS via email no later than September 14, 2005. The model EOC is a document Medicare Advantage organizations and cost-based plans can send to their members to help educate them on their plan's covered Medicare benefits and related cost-sharing responsibilities. (http://www.cms.hhs.gov/healthplans/marketing/default.asp).

- On September 8, 2005, CMS convened an MA technical user group training call for cost plans, MA plans and HCPPs. The training call focused on MA dual eligibles and enrollment. The agenda is available online at (http://www.cms.hhs.gov).

Relevant to Prescription Drug Plans

- On August 30, 2005, CMS released guidance on PDP eligibility, enrollment and disenrollment. The information included eligibility information, enrollment and disenrollment periods and effective dates as well as procedures and activities required. The guidance is accessible on CMS's website at http://www.cms.hhs.gov/pdps/

Relevant to Special Needs Plans Specifically

- None

ON THE CONGRESSIONAL FRONT

About Medicare Health and Drug Plans Specifically

- The Medicare Payment Advisory Commission (MedPAC) held a meeting on September 8 and 9, 2005 to discuss a variety of issues, including quality of care in Medicare managed care plans. On this topic, Commission members heard testimony and discussed ways in which to introduce pay-for-performance incentives to provide high-quality care. Three panelists, Jack Ebeler, President and CEO of Alliance of Community Health Plans; Dr. Samuel Nussbaum, Executive Vice-President and Chief Medical Officer of Wellpoint, Inc; and Margaret O'Kane, President of National Committee for Quality Assurance briefed the Commission on their experience and the latest approaches to measuring quality in managed care organizations. Key issues addressed included whether or not providers that do not meet the quality standard should be penalized through lower payments. A full transcript of this discussion is available online at: www.medpac.gov.

- MedPAC will hold its next public meeting October 6 and 7, 2005. The meeting will be held at the Ronald Reagan Building in Washington, DC. An agenda will be available approximately one week before the meeting and transcripts will be available approximately 3-5 business days after the meeting ends. Both documents will be available online at www.medpac.gov.

- On September 2 , 2005, an article in *CongressDaily* reported Congressmen John Spratt and Pete Stark announced that their staff had uncovered $750 million in overpayments to Medicare Advantage Plans and that CMS has indicated it will correct the errors. Stark stated that he plans to work with CMS to ensure that the administration sticks to its stated schedule of phasing out the hold harmless payments (*CongressDaily*, September 14, 2005).

- On September 29, 2005, the House Ways and Means Health Subcommittee held a hearing on "Medicare Value-Based Purchasing for Physicians Act" http://waysandmeans.house.gov/hearings.asp. CMS Administrator Mark McClellan was a witness at the hearing. Panel members were Robert Berenson, Senior Fellow, Urban Institute; Thomas Jeven, Practicing Family Physician, Wakefield, Massachusetts; Karen Ignagni, President and Chief Executive Officer, America's Health Insurance Plans and John H. Armstrong, Member, Board of Trustees, American Medical Association.

    - CMS Administrator Mark McClellan testified at the hearing stating that the agency is establishing a system that will allow doctors to voluntarily report quality data in 2006 as a first step toward implementing a pay-for-performance physician reimbursement system. McClellan's full testimony is available at http://www.cms.hhs.gov.

Broader Medicare Program (in Brief)

- None

FROM THE PERSPECTIVE OF BENEFICIARIES

General

- On September 15, 2005, Kaiser Family Foundation began a new weekly column titled Kaiser Medicare Q&A Column that will be distributed by *Knight Ridder Tribune News*. The column will focus on providing Medicare beneficiaries and their families' consumer-oriented information and advice related to the new Medicare prescription drug benefit **(**http://www.kaisernetwork.org).

Special Populations

- A fact sheet released by the Kaiser Family Foundation in September 2005, entitled "Medicare and HIV/AIDS," reported on the impact of the new drug benefit on Medicare beneficiaries with HIV/AIDS. The Kaiser Family Foundation reported that under the new prescription drug benefit, Medicare beneficiaries with HIV/AIDS will have expanded coverage in some areas but that the new benefit will present challenges to some beneficiaries (www.kff.org).

FROM OTHER STAKEHOLDERS

- On September 7, 2005, the *Dow Jones/Wall Street Journal* reported on insurance companies' efforts to prepare for the launch of the new Medicare prescription drug benefit. The article reported that UnitedHealth Group, Humana, Cigna and Aetna are "spending tens of millions" of dollars in preparation activities such as marketing and preparing call centers. It was also reported that some companies are spending more than originally projected and that anticipated earnings for 2005 are lower than anticipated for several insurers. However, the article reported that some analysts predict that this will be short-term and that government subsidies and other cost-saving efforts will eventually increase revenue (Loftus, *Dow Jones/Wall Street Journal*, September 7, 2005).

- On September 11-15, 2005, the America's Health Insurance Plans (AHIP) held its annual Medicare and Medicaid conference. Topics covered in the Medicare sessions included (1) next steps in implementing MMA: views from CMS; (2) beneficiary education and outreach; (3) Part D drug benefit; (4) special needs plans. The full conference agenda is located on AHIP's website (www.ahip.org).

    - CMS Administrator Mark McClellan spoke at the AHIP conference about the new drug benefit. McClellan called upon private health plans to go beyond marketing their own strategy to help educate seniors on the new benefit so that each can "make an informed and competent decision." McClellan also warned that health insurers who provide misleading information would be held accountable (*CQ HealthBeat,* September 13, 2005).

- This month the AARP began a multimillion-dollar educational campaign promoting the new prescription drug benefit. The campaign involved publishing a four-page color advertisement in *Parade Magazine, USA Weekend,* and *American Profile* on Sunday, September 3, 2005, which will reach over 64.5 million households. The campaign also involves distributing millions of free copies of a 28-page booklet about the new benefit. In addition, AARP has thousands of volunteers that will visit senior centers and other places to help seniors fill out applications and answer questions. More information is available on AARP's website at http://www.aarp.org.

- An article in *Medicare Advantage News* headlined "Part D Benchmark Shows Plans Willing to Exchange Price for Volume, Experts Say" (*Medicare Advantage News*, August 25, 2005) described that many managed care plans as well as some industry consultants have signaled reasonable satisfaction with the $92.30 national average monthly bid amount for Medicare Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs) for 2006. The article also described how some plans were disappointed in the limitation of three bids per plan per region.

NEWLY RELEASED RESEARCH STUDIES NOT PREVIOUSLY DESCRIBED

- **Adam Atherly and Kenneth E. Thorpe. "Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries"** ***Blue Cross and Blue Shield Association,*** **September 20, 2005. (http://www.bcbs.com/)**

  In a study funded by the Blue Cross Blue Shield Association, the authors addressed five major questions regarding the Medicare Advantage program: 1) Who enrolls in Medicare Advantage?; 2) What is the value of the Medicare Advantage program to its enrollees?; 3) What is the value of the Medicare Advantage program to the Medicaid program?; 4) What would Medicare Advantage enrollees do if they had to find an alternative to Medicare Advantage?; 5) What are beneficiaries' perceptions of Medicare Advantage plans? The authors used data from the Medicare Current Beneficiary Survey (MCBS), the 2003 Medicare Compare data set as well as enrollment data from CMS to conduct their analysis. The authors found that beneficiaries with under $30,000 in income are more likely to enroll in Medicare Advantage than to buy Medigap (41.8 percent versus 33.1 percent). In addition, the authors conclude that both African-American beneficiaries (40.0 percent) and Hispanics (52.9 percent) are more likely than white beneficiaries (32.7 percent) to choose Medicare Advantage than traditional Medicare services.

- **Dawn M. Gencarelli. "One Pill, Many Prices: Variation in Prescription Drug Prices in Selected Government Programs"** ***National Health Policy Forum,*** **Issue Brief, No. 807, August 29, 2005. (www.nhpf.org).**

  In this article, the author updated a previously released issue brief (2002), titled "Average Wholesale Price for Prescription Drugs: Is There More Appropriate Pricing Mechanism?" The author provided

an update on how the MMA has changed Medicare's use of the average wholesale price (AWP). The article included descriptions of other pricing benchmarks now used such as the average manufacturer price (AMP) and the average sales price (ASP) and the issues that have risen as a result of their use. In addition, the author described how the AWP continues to be used in prescription drug pricing and other benchmarking.

- **Marsha Gold. "Private Plans In Medicare: Another Look"** ***Health Affairs,*** **vol. 24, no. 5, September/October 2005.**

  In this article, the author suggests that while previous efforts by Congress to expand the role of private plans in Medicare have met with limited success, Medicare Advantage is being pursued in a substantially changed political environment that will influence its ultimate fate. The article analyzes the reasons private firms sponsoring health plans may now find participation in Medicare attractive and also reviews the potential long run risks and challenges for the program.

OTHER SIGNIFICANT EVENTS

- None

TABLE

NUMBER OF PDPs, AND MA PLANS BY REGION AND TYPE, 2006

MA Region	PDP Region	State	Medicare Beneficiaries	Number of PDP by Type			Number of MA-PDs by Type			
				Total	LIS Eligible	Premium Less Than $20	Regional PPO	Local MA-PD	No Premium for Drug Benefits	Number additional MA-PD and Cost plans approved between September 15 and 27
Region 1			422,515							
	1	Maine	235,804	16	12	1	0	1	1	0
	1	New Hampshire	186,711	16	12	1	0	1	0	0
Region 2			1,805,085							
	2	Connecticut	536,258	17	9	3	0	4	2	0
	2	Massachusetts	9995,597	17	9	3	0	4	0	1
	2	Rhode Island	176,688	17	9	3	0	2	1	0
	2	Vermont	96,542	17	9	3	0	0	0	0
Region 3			1,845,450							
	3	New York	1,845,450	20	11	5	1	19	10	5
Region 4			1,255,829							
	4	New Jersey	1,255,829	17	10	3	1	6	3	0
Region 5			901,259							
	5	Delaware	125,231	18	14	2	1	2	0	0
	5	District of Columbia	77,195	18	14	2	1	4	2	1
	5	Maryland	698,833	18	14	2	1	4	2	2
Region 6			2,527,088							
	6	Pennsylvania	2,167,299	19	14	1	1	16	4	2
	6	West Virginia	359,789	19	14	1	1	5	1	0
Region 7			2,239,954							
	7	Virginia	981,764	16	14	1	1	7	4	2
	8	North Carolina	1,258,190	16	11	1	1	5	2	1
Region 8			1,655,581							
	9	South Carolina	636,365	18	14	1	2	5	0	1
	10	Georgia	1,019,216	18	13	1	2	8	6	1
Region 9			3,041,852							
	11	Florida	3,041,852	18	6	4	2	28	22	2
Region 10			1,663,097							
	12	Alabama	750,732	16	8	1	1	6	4	0

				Number of PDP by Type			Number of MA-PDs by Type			
MA Region	PDP Region	State	Medicare Beneficiaries	Total	LIS Eligible	Premium Less Than $20	Regional PPO	Local MA-PD	No Premium for Drug Benefits	Number additional MA-PD and Cost plans approved between September 15 and 27
	12	Tennessee	912,365	16	8	1	1	8	3	0
Region 11			1,501,197							
	13	Michigan	1,501,197	17	13	1	1	9	1	4
Region 12			1,784,284							
	14	Ohio	1,784,284	17	9	2	2	14	6	1
Region 13			1,588,640							
	15	Indiana	910,980	16	12	1	2	6	4	1
	15	Kentucky	677,660	16	12	1	2	4	3	1
Region 14			2,555,008							
	16	Wisconsin	834,673	17	13	3	1	7	2	2
	17	Illinois	1,720,335	16	12	1	1	13	8	2
Region 15			1,389,193							
	19	Arkansas	471,368	15	12	1	1	4	3	1
	20	Missouri	917,825	15	9	1	1	8	5	1
Region 16			1,107,824							
	20	Mississippi	457,314	15	11	1	1	3	1	0
	21	Louisiana	650,510	16	10	1	1	3	2	0
Region 17			2,504,912							
	22	Texas	2,504,912	20	14	1	1	12	7	4
Region 18			947,170							
	23	Oklahoma	541,369	16	10	1	1	7	2	0
	24	Kansas	405,801	15	12	1	1	4	3	0
Region 19			1,913,827							
	25	Iowa	496,059	18	11	2	1	5	3	1
	25	Minnesota	702,052	18	11	2	1	7	1	3
	25	Montana	148,409	18	11	2	1	4	1	0
	25	Nebraska	264,491	18	11	2	1	3	2	1
	25	North Dakota	105,887	18	11	2	1	3	1	1
	25	South Dakota	125,645	18	11	2	1	3	2	1
	25	Wyoming	71,284	18	11	2	1	2	1	1
Region 20			778,442							
	26	New Mexico	262,437	17	8	5	0	5	1	0
	27	Colorado	516,005	17	10	2	0	7	3	1
Region 21			769,443							

				Number of PDP by Type			Number of MA-PDs by Type			
MA Region	PDP Region	State	Medicare Beneficiaries	Total	LIS Eligible	Premium Less Than $20	Regional PPO	Local MA-PD	No Premium for Drug Benefits	Number additional MA-PD and Cost plans approved between September 15 and 27
	28	Arizona	769,443	18	5	3	2	16	8	0
Region 22			291,959							
	29	Nevada	291,959	17	7	2	1	6	3	1
Region 23			1764,310							
	30	Washington	811,246	20	12	4	0	8	3	2
	30	Oregon	535,276	20	12	4	0	11	1	2
	31	Idaho	186,976	18	12	2	0	4	2	0
	31	Utah	230,812	18	12	2	0	5	2	1
Region 24			4,257,579							
	32	California	4,257,579	18	8	5	1	19	10	3
Region 25			182,651							
	33	Hawaii	182,651	12	7	3	1	4	2	1
Region 26			42,565							
	34	Alaska	42,565	11	7	0	0	0	0	0