

# TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS

## Monthly Report for November 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: Nov 2005	Change From Previous Month	Same Month Last Year	
			Nov 2004	Change From Nov 2004 – 2005
<b>Contracts</b>				
Total	459	1	300	159
CCP	302	0	154	148
PPO Demo	34	0	35	-1
PFFS	17	0	6	11
Cost	29	0	29	0
Other*	77	1	76	1
<b>Enrollment</b>				
Total	6,058,667	70,414	5,472,313	586,354
CCP	5,120,705	43,071	4,701,396	419,309
PPO Demo	126,487	521	109,778	16,709
PFFS	189,502	24,031	47,494	142,008
Cost	321,279	-574	330,783	-9,504
Other*	300,694	3,365	282,862	17,832
<b>Penetration**</b>				
Total Private Plan Penetration	13.8%	+0.1%	12.8%	+1.0%
CCP + PPO Only	12.0%	+0.1%	11.3%	+0.7%

\*Other includes Other Demo contracts, HCPP and PACE contracts.

\*\* Penetration rates for November and October 2005 are calculated using the number of eligible beneficiaries reported in the September 2005 State/County File. Penetration rates for November 2004 are calculated using the number of eligible beneficiaries reported in the September 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 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**

- CMS has almost eliminated its backlog of pending applications as a result of approvals granted over the last several months. According to the November 1, 2005 Medicare Managed Care Contract Report, there are pending applications for 2 PACE contracts. There are no pending service area expansions this month. Since a year ago, the total number of contracts has increased by 159 from 300 to 459. Most of these have been CCP contracts though the number of PFFS increased almost 3 fold from 6 to 17. Enrollment has increased much more slowly though penetration has increased from 12.8 percent to 13.8 percent.

### **Summary of new MA contracts announced in November:**

CMS's Monthly Medicare Managed Care Contracts Report (MMCC) for November 1, 2005 indicates that no new contracts were signed since the September 1, 2005 MMCC Report. This report covers only approval of contracts for 2005. CMS had previously indicated that all new MA contracts for 2005 had to be approved by September 1, 2005. CMS has released information listing contracts to be available in 2006 ([www.cms.hhs.gov](http://www.cms.hhs.gov), see Landscape of Local Plans). Though this does not include statistics on the total number involved and how that differs from the past, CMS has released a fact sheet that provides information on this topic. (See September 2005 report discussed under CMS items relevant to Special Needs Plans).

### **NEW ON THE WEB FROM CMS**

#### **Relevant to Both Medicare Advantage and Prescription Drug Plans**

- On November 2, 2005, CMS held a "Medicare Prescription Drug Coverage Ask the Experts (Session II)" webcast. The webcast was intended for CMS partners, such as local area agencies on aging and state health insurance assistance programs as well as volunteer organizations and counselors who assist people with Medicare. CMS answered commonly asked questions that they have received on the new Medicare drug plan. The questions and answers focused on how the new Medicare drug plan affects 1) Original Medicare; 2) Employer or union coverage; 3) Medicaid; 4) Medigap; 5) Medicare Advantage. The webcast also provided information on training resources available on Medicare.gov. The agenda and the archived webcast is available <http://www.cms.hhs.gov/partnerships/news/mma/webcasts.asp>.
- On November 7, 2005, CMS issued a press release announcing that the Medicare Prescription Plan Drug Finder now provides more detailed information for beneficiaries to compare drug plan features. Beneficiaries can choose up to three plans within the same zip code to compare 34 different categories of information including 1) drug premiums; 2) a plan's annual costs; 3) co-payments for list of different types of drugs. The press release as well as the Drug Finder tool is available at [www.medicare.gov](http://www.medicare.gov).
- On November 10, 2005, CMS held a webcast on the Medicare Prescription Drug Plan Finder tool. The webcast was intended for CMS partners, such as local area agencies on aging and state health

insurance assistance programs as well as volunteer organizations and counselors who assist people with Medicare. The focus was to demonstrate how the tool works by presenting an example of someone helping a beneficiary sign up for a prescription drug plan. The archived website is available at <http://www.cms.hhs.gov/partnerships/news/mma/webcasts.asp>.

- On November 10, 2005, CMS reported in a press release that its Medicare fee-for-service error rate in payments has declined this year by half (from 10.1 percent in 2004 to 5.2 percent in 2005). at <http://www.cms.hhs.gov/media/?media=pressr>. In conjunction with the press release, CMS released a fact sheet titled “Medicare strengthens oversight in payment for Medicare Advantage and prescription drug plans.” The fact sheet describes the series of steps CMS is taking to try to minimize the number of improper claims payments. These steps include: 1) designing data measures and developing data standards that identify trends in payment as well as outliers; 2) creating a team within CMS to monitor new payment systems to insure they are meeting agency requirements; and 3) working with Medicare Rx Integrity Contractors (MEDICs), who are responsible for investigating fraud complaint and unusual activities surrounding enrollment and delivery of the prescription drug plans. The fact sheet is available at <http://www.cms.hhs.gov/media/?media=facts>.
- On November 15, 2005, enrollment in the new Medicare Advantage-Prescription Drug plans (MA-PDs) and stand alone prescription drug plans began. Open enrollment is from November 15, 2005 to May 15, 2006 and coverage is scheduled to begin on January 1, 2006. Beneficiaries can enroll as late as December 31, 2005 to receive coverage starting on January 1, 2006. Coverage for those beneficiaries who enroll between January 1, 2006 and May 15, 2006 will start on the first of the following month.

### Relevant to Medicare Advantage

- On November 8, 2005, CMS convened an MA technical user group call for all Medicare managed care health plan providers. The call focus was to provide an opportunity for organizations to discuss pre-implementation and pre-enrollment issues. The agenda for the call is available at <http://www.cms.hhs.gov>.
- On November 22, 2005, CMS convened an MA technical user group training call for all Medicare managed care health plan providers. The focus of the call was on Part C marketing issues and included MA/PDP best practices as well as a question and answer session. The agenda for the call is available at <http://www.cms.hhs.gov>.

### Relevant to Prescription Drug Plans

- Starting the first week in November, Medicare began mailing letters to the 5.5 million beneficiaries who are dually eligible for Medicare and Medicaid informing them of the Medicare prescription drug plan they would be automatically enrolled in if they decide not to join another plan by the end of the year. The information was sent out on yellow paper and highlighted: 1) that starting January 1, 2006, Medicare will help pay for their prescription drugs instead of Medicaid; 2) what plan Medicare will enroll them in if they do not choose a different plan; and 3) their costs in the auto-enrolled plan. The notice also included two pages of questions and answers about the Medicare prescription drug benefit. The questions included among others: 1) What is the Medicare prescription drug coverage? 2) What should I do now? 3) What are the differences between Medicare and Medicare? 4) What if I don't want Medicare prescription drug coverage? and 5) Can I keep my Medicaid drug coverage?

The notice is available at <http://www.cms.hhs.gov/medicarereform/Enrollment-Q&A-10-20-05-with-cover-sheet.pdf>. In addition, a fact sheet describing the mailing of the auto-enrollment notice is available at <http://www.cms.hhs.gov/media/press/release.asp?Counter=1705>.

- On November 11, 2005, CMS released additional guidance for PDPs receiving auto-enrollments. The information answers questions on what PDPs should do when they are assigned dual eligible beneficiaries with addresses that indicate they live outside of the PDP's region, what procedures to follow when beneficiaries live in territories, deadlines for sending required materials to beneficiaries and what to do if materials sent to an auto-enrollee is returned as undeliverable. This information is available at <http://cms.hhs.gov/pdps/>.

### **Relevant to Special Needs Plans Specifically**

- On November 8, 2005, CMS released a fact sheet on special needs plans (SNPs). CMS has approved 275 special needs plans to operate in 2006 (an increase of 150 plans from 2005 and 264 from 2004). Of the 275 plans operating in 2006, 226 are designed for those dually eligible for Medicare and Medicaid. Thirty-six plans will enroll residents in long-term care facilities and thirteen are for beneficiaries with chronic conditions. The fact sheet also provides information at the contract level including that CMS has signed 164 contracts, which offer one or more special needs plans and that these contracts represent 90 distinct corporate entities. Regional PPO contracts for SNPs are offered in Hawaii, Florida and New York. The fact sheet also provides basic information on what special needs plans are and specific information on the three groups of beneficiaries eligible to enroll in a SNP (The three groups are: 1) Individuals institutionalized or expected to reside in a long term facility for 90 days or longer; 2) Anyone eligible for both Medicaid and Medicare; and 3) Beneficiaries with chronic conditions such as diabetes, mental illness or HIV/AIDS). The fact sheet is available online at: <http://www.cms.hhs.gov/media/?media=facts>.

## **ON THE CONGRESSIONAL FRONT**

### **About Medicare Health and Drug Plans Specifically**

- On November 7, 2005, the Alliance for Health Reform together with the Kaiser Family Foundation presented a program on "Making Sense of Medicare's Drug Benefit: Information and Resources to Help Beneficiaries." The session's focus was on helping Congressional staff better respond to constituency questions and identify resources available to help nationally and in communities. Moderated by Ed Howard of the Alliance, the panel included Tricia Neuman of KFF, Julie Goon of CMS, Beatrice Disman from the New York region of the Social Security Administration and chair of the Social Security-Medicare Planning Task Force and Jack Vogelsong, Pennsylvania Department of Aging. As part of her presentation, Julie Goon indicated that CMS is promoting November 25th (the day after Thanksgiving) as a National Day of Conversation by families about the new Part D benefit. She also noted that the home page at [www.Medicare.gov](http://www.Medicare.gov) had been revised to make it easier to use and that revised drug pricing information would be available on the Prescription Drug Plan Finder later that day. The session was simultaneously webcast to reach Congressional offices. The transcript, associated material, and webcast are available at [www.kaisernet.org](http://www.kaisernet.org).

- The Medicare Payment Advisory Commission (MedPAC) held a meeting on November 15-16, 2005 to discuss a variety of issues, including the Medicare Advantage program and the new drug benefit ([www.medpac.gov](http://www.medpac.gov)).
  - The session titled, “An early look at Part D: plans and benefit designs” focused on a work plan staff have prepared to analyze detailed information about benefit offerings. The staff presentation (as presented in the transcript for the meeting) also covered some preliminary analysis. There are a total of 82 separate PDP sponsors nationwide, 10 offering products in all 34 regions. Staff will be distinguishing between basic plans (standard benefit or actuarially equivalent coverage) and enhanced coverage (basic plus supplemental coverage) though they were unable to do so fully now. Only 9 percent of PDPs and 15 percent of MA plans with a prescription drug benefits are “standard plans”. For example, tiered co-payments are being used by 82 percent of basic PDPs and 67 percent of basic MA plans with a prescription drug benefit. Deductibles are eliminated in 60 percent of basic plans (including both PDPs and MA plans). Gap coverage is limited. In the discussion, a commissioner noted that “first dollar aversion” is a big deal for beneficiaries that could lead them to prefer choices that remove the deductible even if their overall costs are likely to be lower if they choose a plan that includes a deductible but has lower cost sharing. They also discussed the potential way instability would be handled if, for example, some plans drew limited enrollment in 2006 (John Berko, an actuary on the Commission from Humana suggested that plans with perhaps only 800 members could decide that Part D was not a good business for them.) The Commissioners discussed the plan and what information would be available for the June 2006 report.
  - The session titled, “The Medicare Advantage program for 2006” provided information on MA plan offerings for 2006. Scott Harrison summarized the different plan offerings in 2006 and his preliminary analysis. His data show that in 2006, virtually all Medicare beneficiaries will have some kind of MA plan available compared to 84 percent in 2005 and 77 percent in 2004. (Availability is more limited in Alaska and some New England counties). Zero premium MA plans will be common—73 percent of beneficiaries will have access to MA-PD plans at no premium. Thirty-one percent will have access to a zero premium plan that offers drug coverage with some coverage in the gap (including 15 percent having access to some brand coverage in the gap). Zero premium plans with drug coverage are even being offered by PFFS plans—25 percent of beneficiaries will have access to such a plan. Harrison speculated from their data on average regional bids as a percent of the regional benchmark that the richest benefit packages would be offered to beneficiaries in Florida, Hawaii, Nevada and New York. The most common regional plan design, he said, was a \$100 deductible for in-network services and \$250 for out of network with an out of pocket limit ranging from \$1,000 to \$5,000 per year and out of pocket limit of \$5,000. In the discussion, Commissioners sought clarification on the PFFS offering and how it differed from a regional PPO offering. The agenda and a full transcript for the sessions are available online at [www.medpac.gov](http://www.medpac.gov).
- MedPAC will hold its next public meeting December 8 and 9, 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](http://www.medpac.gov).

**Broader Medicare Program (in Brief)**

- On November 17, 2005, the House Committee on Energy and Commerce Subcommittee on Health held a hearing on “Medicare physician payments: How to build a more efficient payment system.” CMS Administrator Mark McClellan was a witness at the hearing. Other panel members were Chairman Glenn Hackbarth, MedPAC; Frank Opekla, American College of Surgeons; Nora Super, George Washington University Medical Center; Vineet Arora, American College of Physicians; Elizabeth Davis, Alliance of Specialty Medicine; and Duane Cady, American Medical Association. (<http://energycommerce.house.gov/108/action.htm>.)
  - CMS Administrator Mark McClellan testified at the hearing, stating that CMS does not have statutory authority to make changes that would increase Medicare physician payments. Under the current payment system, Medicare physician payments will be reduced by an estimated 5.6 percent in 2005. CMS anticipates that physicians will experience a continual reduction in payment for the next six years. (The current system is based on a statutory formula established in section 1848(d) of the Social Security Act). McClellan noted that even if CMS had authority to increase payments, this would only increase Medicare costs and beneficiary premiums without reducing unnecessary spending. Instead, McClellan suggests moving toward a new payment model that is more efficient and rewards quality care. McClellan describes Medicare pay-for-performance demonstrations already underway such as demonstrations that use pay-for-performance systems to support physician efforts to coordinate care and execute effective patient management for Medicare beneficiaries with chronic illnesses. The full list of panel members and their testimony is available online at <http://www.cms.hhs.gov/media/?media=testm>.

**FROM THE PERSPECTIVE OF BENEFICIARIES****General**

- On November 10, 2005, Kaiser Family Foundation and the Harvard School of Public Health reported results from a survey conducted on a nationally representative sample of 802 respondents 65 years of age and older between October 15 and 31, 2005. The survey examined the views and experiences of these seniors prior to open enrollment of the new Medicare prescription drug benefit but after the start of the education and outreach campaigns. The survey included questions such as how well they understand the drug benefit and whether or not they plan to enroll. Of those surveyed, 61 percent said they understand the drug benefit “not too well” or “not at all.” In addition 43 percent of the seniors surveyed reported that they do not yet know if they will enroll in a drug plan; 37 percent say they do not plan to enroll and 20 percent say they plan to enroll. Other survey questions included whether seniors had seen or heard advertisements about the benefit (45 percent reported they had seen advertisements) as well as if they had heard of 1-800-MEDICARE and Medicare’s website: [www.Medicare.gov](http://www.Medicare.gov). While half of the seniors had heard of the 800 number only 35 percent had heard of the Medicare website. The complete results of the survey as well as the questionnaire are available online at [www.kff.org/kaiserpolls/med111005pkg.cfm](http://www.kff.org/kaiserpolls/med111005pkg.cfm)

- On November 8, 2005, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) released, “Temporary Medicare-approved drug discount card: Beneficiaries’ awareness and use of information resources” (OEI-05-04-00200). The OIG reports findings of a survey on a nationally represented stratified sample of 550 beneficiaries enrolled in the drug card as of August 1, 2004 and 620 nonenrolled Medicare beneficiaries. The survey found that 37 percent of enrolled beneficiaries needed help with the enrollment process. They most frequently needed help in completing the enrollment form or applying of extra help. The OIG report states that enrolling in a drug plan will likely be more complicated and therefore recommends that CMS expand its efforts in helping beneficiaries with the new drug benefit. This report is available at <http://oig.hhs.gov/new.html>
- On November 29, 2005, *USA Today* ran a story indicating that there was a computer data problem in the Medicare Prescription Drug Finder causing drug prices to be artificially inflated for at least two drug plans. Gary Karr, CMS, reported that CMS is working to fix the problem. The article is available at [http://www.usatoday.com/printedition/money/20051130/1b\\_medicare30.art.htm](http://www.usatoday.com/printedition/money/20051130/1b_medicare30.art.htm).

### Special Populations

- Kaiser Family Foundation (KFF) released a chartpack providing demographic data on African Americans, Latinos and Whites with Medicare. The data used in the chartpack were obtained from the 2002 Medicare Current Beneficiary Survey (MCBS) cost and use file. The chartpack provides information on each group by age, living area (urban /rural), poverty level, percent in fair/poor health, source of prescription drug coverage (e.g. Medicaid, private or other) and percent without drug coverage. The KFF findings include that six in 10 African-American and Latino beneficiaries have incomes below 150 percent of the federal poverty level, as compared with 32 percent of white beneficiaries and that the proportion of beneficiaries with a permanent disabling condition before age 65 is higher among African-Americans (26 percent) and Latinos (19 percent) than whites (12 percent). The final section of the chartpack describes how these findings (and others) present both opportunities and challenges in providing outreach and education on the new prescription drug benefit to these populations. The chartpack is available at <http://www.kff.org/minorityhealth/7435.cfm>
  - The information in the chartpack was used for several recent briefings. On November 14, 2005, KFF, co-sponsored with the National Caucus and Center on Black Aged, held a briefing on African Americans and the New Medicare Drug benefit. On November 16, 2005, KFF and the National Alliance for Hispanic Health held a telephone briefing for journalists to highlight how the new Medicare drug benefit will impact seniors. This information is also available at <http://www.kff.or/minorityhealth.cfm>
- On November 29, 2005, Center for Medicare Advocacy, Inc (CMA) held a web based seminar titled “Part D Plan Analysis: Issues for People in the Community, Nursing Homes and Assisted Living.” The web seminar focused on the following four questions: 1) What will Part D plans offer? 2) How can the plans be analyzed? 3) What are beneficiaries’ enrollment options and obligations? 4) How can I guide beneficiaries to make the right decisions? CMA attorneys, Judith Stein, Vicki Gottlich and Toby Edelman, conducted the web seminar: ([www.medicareadvocacy.org](http://www.medicareadvocacy.org)).

**FROM OTHER STAKEHOLDERS**

- On October 26, 2005, *Medicare Today* (representing a broad based partnership of organizations representing seniors, patients, health care groups, employers and others), released “Curtailing Catastrophe: Medicare’s Rx for Catastrophic Drug Costs”, a study prepared by analysts at PricewaterhouseCoopers. Using data from the U.S. Census Bureau’s March 2004 Current Population Survey and the Medicare Current Beneficiary Survey, the analysts found that currently 52 percent of Medicare beneficiaries have coverage for catastrophic drug costs (defined as more than \$4,000 in annual out-of-pocket drug costs). The study concludes that when the new prescription drug benefit begins, nearly all (98 percent) Medicare beneficiaries could have catastrophic coverage, therefore decreasing the number of seniors who pay catastrophic drug costs from 1.5 million to 160,000 nationwide in 2006. The analysts also conclude that with the new prescription drug benefit, seniors who already have catastrophic drug coverage and enroll in a prescription drug plan are likely to have additional savings on drug costs. They estimate these additional savings would be around \$400 per year. ([www.medicaretoday.org](http://www.medicaretoday.org)).
- On November 18, 2005, the National Health Policy Forum held a session on “Medicare Advantage Special Needs Plans: A New Opportunity for Integrated Care?” The session focused on opportunities and challenges special needs plans present, an update of the SNP marketplace, interaction of SNPs with states as well as the potential for SNPs to integrate Medicaid and Medicare services. Speakers also discussed their SNPs, the populations they serve and experiences in becoming a SNP. Speakers from the forum included Jonathan Blum, Director, Medicaid Practice, Avalere Health; Richard Chambers, Chief Executive Officer, CalOptima; Mary Kennedy, Vice President, Business Development, Evercare; John Gorman, President and Chief Executive Officer, Gorman Health Group, LLC. The forum agenda as well as slides from the presentations are available for download at <http://www.nhpf.org/index.cfm?fuseaction=Details&key=591>. More information on this topic is also available in a recently released issue brief titled “Medicare Advantage Special Needs Plans: A New Opportunity for Integrated Care? (www.nhpf.org)” (see also below for summary).

**NEWLY RELEASED RESEARCH STUDIES NOT PREVIOUSLY DESCRIBED**

- **Gross, David, Schondelmeyer, Stephen W., and Raetzman, Susan O. “Trends in Manufacturer List Prices of Generic Prescription Drugs Used by Older Americans-Second Quarter Update.” Washington, DC: AARP Public Policy Institute, November 2005. ([www.aarp.org](http://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 second 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 0.9 percent in the 12 months ending with the second quarter (June) 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 found that none of the 75 drugs studied had an increase in manufacturer list price over this time period (only three had increased in list price during the first quarter of 2005). This study is the latest in a series examining trends in prescription drugs, also available on AARP’s website.



- **Provost Peters, Christie.** “Medicare Advantage SNPs: A New Opportunity for Integrated Care?” *National Health Policy Forum*, Issue Brief, No. 808, November 11, 2005. ([www.nhpf.org](http://www.nhpf.org))

This issue brief examines Medicare Advantage special needs plans (SNPs) and the potential for SNPs to provide a next step in providing coordinated care for certain special needs populations. The author provides background information on special needs plans, dual eligibles and past barriers to successful care coordination. The author also provides information on previous steps that have been taken to coordinate care such as through demonstrations (e.g., PACE and Evercare) as well as certain state waiver programs (e.g. the Minnesota Senior Health Options (MSHO) and Texas Star+Plus). The author then presents opportunities and challenges SNPs present from 1) the plan perspective; 2) the beneficiary perspective; and 3) the state perspective. The author concludes that for some plans and states, SNPs provide an immediate opportunity to enhance better coordination of care in a cost-effective way. However, for other states and plans that are not currently involved in dual eligible managed care programs or demonstrations, the author concludes that observing how some of the risks and uncertainties play out before deciding to participate may be wise.

- **Super, Nora and Biles, Brian.** “Displaced by Hurricane Katrina: Issues and Options for Medicare Beneficiaries. Washington, DC: The Henry J. Kaiser Family Foundation, November 2005.

This issue brief provides policy options to address potential problems the roughly 200,000 Medicare beneficiaries who were displaced by Hurricane Katrina may now face in receiving needed healthcare. The authors divided these beneficiaries into three subgroups: 1) beneficiaries in traditional Medicare; 2) beneficiaries enrolled in a Medicare Advantage (MA) plan; and 3) beneficiaries with unique needs including dual eligibles and nursing home residents. The authors’ recommend the following options for beneficiaries enrolled in Medicare Advantage plans: 1) an active effort by CMS to locate and inform displaced MA plan members about the role of their plan and their options; 2) an explicit requirement that MA plans pay for out-of-network services for a specific period of time; 3) a clear Medicare policy on the amounts and conditions that MA plans should follow in paying out-of-network providers; 4) a clear Medicare policy regarding the new residency status for those that reside outside the designated area of their MA plan for lengthy periods; 5) a new policy that would allow displaced MA plan members to enroll in Medicare supplemental policy without pre-existing condition limitations; 6) a waiver of MA plan annual lock-in for 2006. In addition, the authors also provide policy options for all Medicare beneficiaries who were displaced by Hurricane Katrina as the transition to the new prescription drug plan benefit begins. These policy options include an extension of the initial enrollment beyond May 15, 2006 (possibly until the end of 2006) and a clear statement on the role of the 10 national PDP on monthly premiums and benefits for those displaced beneficiaries that live in multiple regions in 2006. The issue brief is available at <http://www.kff.org/medicare/7437.cfm>

## OTHER SIGNIFICANT EVENTS

- The Second National Medicare Prescription Drug Congress held a three-day forum, October 31, 2005 through November 2, 2005, on the new Medicare Prescription Drug benefit. Keynote speakers included Tom Scully, Nancy-Ann DeParle, John Iglehart and Dan Mendelson. Sessions included:
  - “The Beneficiaries Perspective on the New Medicare Prescription Drug Program”. Presenters included Tricia Newman, Kaiser Family Foundation; John Rother, AARP and Bruce Stuart, University of Maryland.

- “MMA, Private Plans, and Competition: PDP v. MA/PDP” Mark Rubino of Aetna presented on business challenges that may result through the different types of plans participating in part D since each type (PDP v. MA/PDP) is likely to offer vastly different options.
- “Private Plans, and Competition: The Future of Medicare Advantage.” This session focused on regional and local managed care plans, the new competitive bidding process and how presenters view the MA plan will evolve. Presenters included Francis Soistman, Coventry Health Care and Janet Newport, PacifiCare Health Systems.
- “Medicaid and MMA Administrative Challenges: Special Needs Plans.” This session focused on policy challenges and regulations facing SNPs. Presenters included Sandra Bastinelli, CMS and James Verdier, Mathematica Policy Research.

The full agenda as well as presentation material for each session is available to download at <http://www.medicarecongress.com>.