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TRACKING MEDICARE AND PRESCRIPTION DRUG PLANS
Monthly Report for March 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

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PROGRAM STATUS: PRIVATE PLAN OFFERINGS, ENROLLMENT, AND CHANGE

NOTE: CMS HAS NOT RELEASED DATA FOR 2006. WE SHOW DECEMBER 2005 DATA IN THE PREVIOUS MONTH COLUMN.

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

Plan Participation, Enrollment, and Penetration by type	Current Month: March 2006	Change From Previous Month Column Shows December 2005	Same Month Last Year	
			March 2005	Change From March 2005 – 2006
Contracts				
Total	Not Available	459	316	Not Available
CCP		302	179	
PPO Demo		34	34	
PFFS		17	7	
Cost		29	29	
Other*		77	67	
Enrollment				
Total	Not Available	6,121,678	5,634,125	Not Available
CCP		5,157,629	4,838,080	
PPO Demo		163,787	118,828	
PFFS		208,990	77,108	
Cost		321,555	325,543	
Other*		269,719	274,566	
Penetration**				
Total Private Plan Penetration	Not Available	14.0%	13.0%	Not Available
CCP + PPO Only		12.1%	11.5%	

*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. Penetration rates for March 2005 are calculated using the number of eligible beneficiaries reported in the December 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

- No March 2006 data published from CMS.

Summary of new MA contracts announced in December:

- No March 2006 data published from CMS.

NEW ON THE WEB FROM CMS

Relevant to Both Medicare Advantage and Prescription Drug Plans

- On March 7, 2006, CMS released a Medicare Consumer Alert notifying Medicare beneficiaries to be vigilant of phone scams. CMS stated that no Medicare drug plan can ask a person with Medicare for bank account or other personal information over the telephone. In addition, legitimate Medicare drug plans are not allowed to come into beneficiaries' homes uninvited and cannot ask for personal information on the internet. The Medicare sponsored drug plan is required to bill beneficiaries on a monthly basis by sending the billing information to the beneficiary's home. The press release stated that consumers can report scams to their local law enforcement agencies or by calling 1-877-7SAFERX. The press release is available at http://www.cms.hhs.gov/news/press/2006press

- On March 23, 2006, in a CMS press release titled "More than 27 Million Medicare Beneficiaries are enrolled in prescription drug coverage" CMS indicated that nationwide, there are 6.3 million beneficiaries in stand-alone PDPs. There also are 7 million beneficiaries enrolled in MA plans, including 5.7 million who receive prescription drug coverage through their plan (5.8 million dually eligibles are automatically enrolled in PDPs, with another 600,000 enrolled in MA plans covering prescription drugs). CMS listed state-by-state enrollment numbers in Medicare Prescription Drug Plans as of March 18, 2006. The enrollment numbers include a breakdown of those in stand-alone prescription drug plans, Medicare Advantage with prescription drugs, dual eligibles auto-enrolled, Medicare Retiree Drug Subsidy, and Federal Retirees for each state. The press release is available at http://www.hhs.gov/news/press/2006pres/20060323.html.

Relevant to Medicare Advantage

- None

Relevant to Prescription Drug Plans

- On March 2, 2006, CMS released a fact sheet titled, "Medicare drug coverage provides significant price discounts and savings." The fact sheet provides a summary of CMS's study based on

information from the Medicare Prescription Drug Plan Finder. For freestanding PDPs, CMS developed 16 beneficiary drug "profiles" that included using 100 brand name and generic medications commonly taken by Medicare beneficiaries. CMS then calculated the cost of drugs included in each of the 16 profiles using price data from 35 urban and rural zip codes in 35 states that covered each of the 34 PDP regions. Some of the findings CMS reported were: 1) Beneficiaries enrolling in the lowest-cost plan in their area may save an average of almost 60 percent off the cost of their drugs compared to what they would pay without insurance; 2) Beneficiaries can increase their savings by switching to lower-cost medications and using their plan's mail-order option. The fact sheet as well as a full report (7 pages) and an excel chart (which includes data collected on their Medicare beneficiary "profiles," negotiated drug prices and mail-order prices, Medicaid drug prices as well as the drug plan finder analysis) are available at http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1792

- On March 20, 2006, CMS issued a press release titled "Medicare takes steps to help people with limited incomes and resources take advantage of comprehensive Medicare drug coverage." Letters are being sent to approximately 1.2 million people with Medicare who have not yet enrolled in a drug plan despite (1) have applied for and been approved for the extra help or (2) being enrolled in either SSI or the Medicare Savings Program (which should mean that they most likely qualify for the subsidy). The letter notifies these individuals that they will be enrolled in a Medicare prescription drug plan if they do not take any action to enroll in a plan before April 30. The letter includes a list of all the plans available in their area with premiums at or below the low-income premium subsidy amount. CMS stated that the letter also makes it clear to these beneficiaries that they can choose a different plan in their area rather than the one they will otherwise be assigned to and can call 1-800-MEDICARE for more information about the plans. This press release is available on CMS's website at http://www.cms.hhs.gov/apps/media/press/release.asp?counter=1806.

- On March 31, 2006, Medicare released a fact sheet titled "Transition Fact Sheet." The fact sheet highlights the steps CMS has taken to help beneficiaries have a smooth transition as they start their drug coverage under Medicare Part D. Specifically, the fact sheet describes steps that CMS has taken with 1) the private health plans; 2) physicians and other health care providers; and 3) pharmacists. For example, the CMS fact sheet outlined the communications it has had with private plans such as asking the plans to provide beneficiaries with a temporary supply of medically necessary, non-formulary medication during the initial 90-day period. The CMS fact sheet also described how it has provided extensive outreach to health care providers and held "Open Door Forum" sessions with pharmacists to provide health care provider and pharmacy-specific information. This fact sheet is available at http://www.cms.hhs.gov/apps/media/press

Relevant to Special Needs Plans Specifically

- None

ON THE CONGRESSIONAL FRONT

About Medicare Health and Drug Plans Specifically

- The Committee on Energy and Commerce Subcommittee on Health held a hearing on March 1, 2006 titled "Medicare Part D: Implementation of the New Drug Benefit." Witness testimony included:

- Panel 1: CMS Administrator, Mark McClellan. In his testimony, McClellan stated that because of strong competition in the prescription drug marketplace, "drug coverage is costing much less for beneficiaries, taxpayers, and the states than anticipated" and those beneficiary premiums are expected to average 25 dollars a month in 2006. The estimate for premiums in July 2005 was 37 dollars. McClellan stated that these savings result from "lower than expected costs per beneficiary."

- Panel 2: Ms. Susan Rawlings, President, Senior Services, WellPoint; Mr. Dennis Song, Flower Mound Herbal Pharmacy on behalf of the National Community Pharmacist Association; Mr. Tom Paul, Chief Pharmacy Officer for Ovations, United Health Group; Mr. David Lipshutz, Staff Attorney, California Health Advocates; Mrs. Jude Walsh, Special Assistant, Governor's Office of Health Policy and Finance; Mr. Earl Ettienne, Senior RX Supervisor CVS/pharmacy; Mr. Marcus Hickerson and Mrs. Anne Dennison.

CMS Administrator Mark McClellan's testimony is available on CMS's website at http://www.cms.hhs.gov/apps/media/?media=testm. The agenda for this session is available online at: http://energycommerce.house.gov/108/Hearings/03012006hearing1787/hearing.htm (and transcripts for this session will be available in 60-90 days from the date of the hearing).

- The Medicare Payment Advisory Commission (MedPAC) held a public meeting March 9-10, 2006. Three sessions focused on Medicare Advantage and prescription drug plans, reviewing preliminary results of analysis in preparation for the June 2006 report to Congress.

  - The session titled "Part D plan offerings for 2006" focused on the staff's preliminary analysis of Part D benefit offerings for 2006 for their June Report to Congress. MedPAC provided basic information on what plans are offering and the benefit structure of those plans. Some of the findings for stand-alone prescription drug plans included: 1) There are over 1,400 stand-alone PDPs available across the 34 regions; 2) about 17 organizations account for the vast majority of stand-alone plans and in most cases these organizations are offering the same two or three benefit designs; 3) Most plans are not using the Part D standard benefit design and instead are using tiered cost sharing; 4) Many stand-alone PDP plans are avoiding the standard $250 deductible; 5) Prescription drug benefits offered by MA plans are more likely to offer enhanced benefits than stand-alone PDPs; 6) In parts of the country with higher MA penetration, organizations offering stand-alone PDPs are more likely to have lower premiums. Some of the findings for Medicare Advantage prescription drug plans included: 1) As mentioned a larger portion of the MA-PDs are offering enhanced benefits (64 percent versus 43 percent) compared with stand-alone PDPs; 2) A large portion of MA-PDs are charging no premium for their prescription drug portion of the benefit; 3) MA-PDs are also more likely than PDPs to charge no deductible in their benefit structure (80 percent versus 58 percent of PDPs).

  - The session titled "Medicare Advantage plan: bids and availability" summarized preliminary staff analysis about how plan payments are determined by the plan's bid and the payment area's benchmark as well as plan availability. Some of the key findings of MedPAC's analysis so far include: 1) bids tended to differ by plan type: Besides Special Needs Plans, local HMOs were the most able to bid below the benchmark and had the largest average rebates (98 percent were able to bid below the benchmark and the average rebate was roughly 80 dollars per month); 2) About two-thirds of plans that received rebates typically

used at least part of their rebates to lower cost sharing on Medicare non-drug benefits; 3) The most widely available plan type is the regional PPO reaching 88 percent of the Medicare population.

- The session titled "Special Needs plans" summarized the additional requirements for SNPs as compared to regular MA plans. The session also summarized SNPs goals and strategies for the future, characteristics of SNP organizations and their relationships with states. MedPAC has conducted interviews with various SNP organizations and some of the findings to date include: 1) SNPs' goals and strategies for the future vary with some holding off on expanding their service areas and increasing enrollment and others considering expanding their service areas right now; 2) SNP relationships with states varied with some having very close and long-standing relationships and others having no relationship at all; 3) Those SNPs that do contract with Medicaid have noted many conflicts between the Medicare and Medicaid rules; 4) SNPs marketing efforts to date have mostly been very targeted rather than broader efforts.

- MedPAC will continue to analyze these topics for their June 2006 report to Congress and provide another summary of findings at its next public meeting April 19-20, 2006. (In addition, MedPAC is currently working with CMS to receive enrollment data to supplement these findings however they stated is unclear when they will be receiving the data at this time). An agenda for the April meeting 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 March 8, 2006, the House Appropriations Subcommittee on Labor, HHS, Education and Related Agencies held a hearing on the Department of Health and Human Services FY 2007 Budget. HHS Secretary Mike Leavitt testified at the hearing. Secretary Leavitt commented on the new Medicare prescription drug benefit stating that enrollment in the prescription drug plans is up (Rooney, *CQ HealthBeat*, March 8, 2006). The full transcript for this hearing is available online at: http://appropriations.house.gov/index.cfm?FuseAction=Hearings.Detail&HearingId=668&Month=3&Year=2006

FROM THE PERSPECTIVE OF BENEFICIARIES

General

- This month, FamiliesUSA released a report titled "Expectations Shrinking for Medicare Part D Enrollment." The report states that since January 2005, the Administration has scaled back its projections on the number of beneficiaries who would have drug coverage with the implementation of the prescription drug benefit in 2006. The report stated that in January 2005, the Administration stated in the *Federal Register* that 39.1 million beneficiaries would have drug coverage in 2006. FamiliesUSA reported, however, that in December 2005, the Administration projected that only between 28 and 30 million would have coverage in 2006. In addition, the report breaks down the enrollment figures CMS made available as of January 17, 2006. The report stated that of the 24.3 million Medicare beneficiaries CMS stated now have drug coverage, an unknown number of them likely had some coverage beforehand and that many of those that needed the new drug coverage the

most still do not have coverage. The report states that there are at least three major consequences that are likely to result if low enrollment persists in Medicare Part D: 1) Many beneficiaries will still not be getting the prescription drug coverage they need; 2) Beneficiaries who do not enroll face higher costs later on (because of late penalties to sign up for the benefit as of May 15); 3) Continued low enrollment in Part D could jeopardize the long-term health of the program especially if a high proportion of those enrolled are those that need coverage the most. The full report is available online at http://www.familiesusa.org/resources/publications/.

- This month, *Consumer Reports* released a report titled "Helping Medicare Beneficiaries Lower Their Out-of-Pock Costs Under the New Prescription Drug Benefit." The study analyzed three states by selecting one zip code in a major city in each state (Sacramento, Califonia; Atlanta, Georgia; and Minneapolis, Minnesota) and using the Medicare Plan finder tool to analyze the annual costs of five categories of drugs. The five categories of drugs included statins (high cholesterol); calcium channel blockers (high blood pressure); ACE inhibitors (cardiac); NSAIDs (arthritis pain); and antidepressants. The report identified plans with both a *Best Buy* drug and an appropriate drug that is therapeutically equivalent and often prescribed instead of the *Best Buy* drug but more expensive. The report describes that beneficiaries have the potential for saving hundreds or thousands of dollars each year by switching to the lower-cost drugs identified by *Consumer Reports* as *Best Buy* drugs. For example, the findings for California included that a Medicare beneficiary in Sacramento would save over 2,500 dollars a year by switching to *best buy* drugs in all five categories and enrolling in the lowest cost plan available in the region. The report is available at www.CRBestBuyDrugs.org.

- On March 27, 2006 *New York Times* (Pear, Robert) did a follow up of its March 1, 2006 article that reported that many Medicare beneficiaries that have recently switched drug plans are now actively enrolled in two plans. The original article stated that this has created confusion and problems for both patients and pharmacists and that it placed many beneficiaries at risk of being charged two monthly premiums as well as incorrect co-payments. The article stated that the Bush administration acknowledged the problem in a recent memorandum to insurers stating that when a beneficiary chooses to join another plan the [government] processing systems has not always sent the correct enrollment and disenrollment information to the appropriate plans. In some situations this has resulted in beneficiaries with low-income status to continue to receive bills for premiums they do not owe. CMS stated that it is working with insurers to resolve these enrollment discrepancies. The follow up article on March 27, 2006 reports that private insurance companies using government letterhead have begun sending out notices on green paper to Medicare beneficiaries. The notice are intended to clear up confusion and state that if beneficiaries take no action they will be removed from the plan they were originally enrolled in but they will continue to have coverage in the second plan.

Special Populations

- None

FROM OTHER STAKEHOLDERS

- On March 13, 2006, America's Health Insurance Plans (AHIP) released results of two polls conducted March 6-11, 2006 on seniors who are enrolled in the Medicare prescription drug benefit.
    - The first poll was conducted March 6-9, 2006 on 408 self-enrolled seniors selected randomly

from a listed sample targeting households with members 65 years and older. The margin of error was 4.85 percent. The findings include that: 1) three-fifths of the seniors polled reported that they are saving money with the new benefit compared to their previous costs; 2) Nine out of ten of these seniors reported taking a prescription drug on a regular basis, and four out of five of them say the drugs they need are covered; 3) More than four-fifths of these seniors stated that they had no problem with signing up for the plan and eighty-five percent reported having no problems using the plan.

- The second poll was conducted March 6-11, 2006 on 401 seniors automatically enrolled in Medicare Part D through Medicaid. In addition, potential respondents that reported annual incomes higher than $30,000 were excluded from the sample. The margin of error was 4.89 percent. The findings were very similar to the poll above: 1) ninety percent of these seniors report no problem using the benefit. 2) More than four out of five automatically enrolled seniors polled say they regularly take a prescription drug, and 3) four out of five of them say the plan covers the drugs they need.

The polls were conducted by Ayres, McHenry, & Associates for AHIP. The survey questions as well as the summary report and a PowerPoint presentation on the results are available online at http://www.ahip.org/content/pressrelease.aspx?docid=15332&pf=true.

- This month, the Kaiser Commission on Medicaid and the Uninsured released an issue brief titled "Medicare-Medicaid Policy Interactions." The issue brief summarizes two policy interactions between Medicare and Medicaid: 1) Medicare Part B premium and 2) the establishment of the Medicare Part D prescription program. The authors use these two policy interactions as examples to describe how changes in one program affect spending in the other. The authors provide a table that illustrates four areas where such changes in one program affect the other: 1) Medicare premiums and cost-sharing; 2) eligibility and enrollment; 3) benefits and coverage; and 4) provider payments. In each of the areas, the authors highlight the potential impact on both Medicaid and Medicare spending as well as the potential impact on both full-benefit dual eligibles and Medicare savings plan beneficiaries. The authors recommend that more attention be focused on these interactions and their full ramifications before future policy changes are implemented. The issue brief is available at http://www.kff.org/medicaid/7468.cfm.

- This month the Kaiser Commission on Medicaid and the Uninsured also released an issue brief titled "An Update on the Clawback: Revised Health Spending Data Change State Financial Obligations for the New Medicare Drug Benefit." The issue brief provides a description of the "clawback" payments –that is the contributions states are required to make monthly to the Medicare program to help offset the cost of the new Medicare prescription drug benefit. (The rationale for the clawback is that states have accrued savings because Medicare assumes responsibility for drug costs for the elderly and disabled, some of whom had been previously paid for by state programs). The issue brief describes the formula for determining state contributions (as established by the Medicare Modernization Act) as well as the update in this formula now that CMS has 2006 National Health Expenditure data. The new data include revised projections in the growth rate of health expenditures. The result is a lowering of the required state contribution to Medicare by over 700 million dollars or 9.7 percent (from 7.3 billion to 6.6 million). This issue brief is available online at http://kff.org/medicaid/7481.cfm

NEWLY RELEASED RESEARCH STUDIES NOT PREVIOUSLY DESCRIBED

- **White, Chiquita; Hinshaw, Elizabeth; Sprecher, Eli; and Blum Jonathon. "The Medicare Drug Benefit: How Good are the Options?" California HealthCare Foundation, March 2006.**

In this issue brief, the authors examined California's dual-eligibles drug coverage with the Medicare prescription drug benefit compared with the state's Medicaid program, Medi-Cal. In the first section of the issue brief, the authors compare coverage of four classes of drugs – antipsychotics, antiretrovirals, antihypertensives, and anticholesterols within the two programs to determine if dual-eligible coverage is better or worse under the new benefit. In the second section of the issue brief they analyze differences among the various Medicare prescription drug plans dual eligibles in California have been auto-enrolled in to determine if there are any differences between these plans. The authors used Avalere Health's DataFrame tool to capture data from CMS's Medicare plan finder website (as of October 22, 2005), the CMS formulary finder and information on plan websites for the analyses. The study found that in three of the four drug classes the new Medicare drug plans offered a lower number of medications than Medi-Cal (in the fourth class, antiretrovirals, both programs covered the same number of medications). The authors concluded that drug coverage with the new benefit is inferior to Medi-Cal. However, the authors also conclude some positive findings in their issue brief including: 1) Medicare beneficiaries in California have a wide array of drug plans to choose from; 2) Federal protection among two of the four drug classes (antipsychotics and antiretrovirals) has led to better coverage in all the new prescription drug plans. 3) the new prescription drug plans that are at no cost offer similar drug coverage to other similar Medicare plans. The authors also conclude that the transition is likely to cause dual-eligibles to experience disruptions in coverage, however, many dual-eligibles are likely to find their Medicare drug plan provides adequate coverage. The authors provide a number of policy recommendations including that 1) California legislation should consider offering wrap-around services as dual-eligibles transition and 2) CMS and the state should monitor the impact of random assignment on drug coverage for, and utilization of other services by, dual-eligibles since there are a significant number of differences between the new plans.

- **Morden, Nancy; and Garrison Jr, Louis. "Implications of Part D For Mentally Ill Dual Eligibles: A Challenge For Medicare."** ***Health Affairs,*** **Vol, 25, no. 2 (2006): 491-500.**

In this article the authors address the challenges and policy concerns of dual eligibles with mental illnesses transitioning from Medicaid prescription drug coverage to the new Medicare prescription drug benefit. The article first describes the characteristics of dual eligibles with mental illnesses. The article states that 59 percent of dual eligibles under 65 have a mental illness while only 37 percent of other Medicare beneficiaries have a mental illness. Of those over 65, 25 percent of dual eligibles have a mental illness while only 2 percent of other Medicare beneficiaries have a mental illness. The article goes on to describe drug coverage for this population before the new prescription drug benefit and the unique concerns this population now faces as they transition to the new benefit. Such concerns include potential access restrictions and discrimination and adverse selection and the potential that the new drug benefit could increase beneficiary out of pocket costs as well as health disparities. Finally, the article describes implications for psychotropic purchasing and pricing, raising concerns that prescription-only insurers have financial incentives to limit access, which could increase morbidity in the mentally ill dual eligible population as well as increase the use of nonprescription care. The authors argue that policymakers must

ensure timely and sufficient quality monitoring for this vulnerable population so that quality of care is not undermined.

- **Gold, Marsha. "The Growth of Private Plans in Medicare, 2006." Kaiser Family Foundation. March 2006. (www.kff.org).**

In this article, Gold describes the different types of Medicare private plans offered in 2006 including Medicare Advantage plans (such as HMOs and PPOs) and private-fee-for-service plans. In 2006, all Medicare beneficiaries will have access to at least one type of private plan (as compared to 2005 when 77 percent of beneficiaries had access to a private health plan). The increase in access to private plans is largely due to regional PPOs being offered as of January 1, 2006 and the increase in private-fee-for-service plans. The issue brief notes that these two plan types are the most common plan type offered in rural areas, however, the most common plan type for urban beneficiaries is still local HMOs. In 2006, there are also special needs plans available to at least some beneficiaries in every state except for nine (with a total of 164 contracts). Most of the SNPs are for dual eligibles, however, 32 are for institutionalized beneficiaries and 11 are for those with chronic conditions. The article also describes the new prescription drug plans being offered. Key findings include: 1) with the exception of beneficiaries in Alaska and Hawaii, each beneficiary has at least 15 sponsors they can choose plans from; 2) Because each sponsor typically has more than one plan type, beneficiaries actually have many more options to choose from (there are at least 40 different plans are offered in most areas in the country).

- **Gold, Marsha. "The Landscape of Private Firms Offering Medicare Prescription Drug Coverage in 2006." Kaiser Family Foundation. March 2006 (www.kff.org).**

This issue brief provides a description of the organizations offering the new Medicare Part D prescription drug benefit and analyzes select features of the market. The analysis is based on narrative information as well as public data available on the Center for Medicare and Medicaid Services (CMS) website. Key findings from the analysis include: 1) the number of organizations sponsoring PDPs is relatively small (10 organizations are sponsoring a national PDP, which accounts for 62 percent of all PDPs nationwide); 2) Seven of the ten organizations sponsoring a national PDP are based in commercial insurance firms with substantial MA experience. The other three of the national firms are in the pharmacy benefits management (PBM) and services sector. All ten of these organizations except for Wellpoint either offered a prescription drug card or partnered with an organization that did; 3) Most of the organizations that historically provided MA plans expanded their benefits in anticipation of 2006; 4) The diversity of firms sponsoring MA and PDP plans is consistent to the complexity of the existing Medicare supplemental market and means that firms in the market may be orienting their products to diverse subgroups of beneficiaries for a combination of defensive and proactive reasons ; and finally, 5) The marketing strategies of the different firms depends on their targeted market segment. For example, those firms that are trying to maintain their current membership are not likely to participate in direct marketing and advertising. Those seeking new enrollees may be relying on a diversity of strategies including direct to consumer advertising, relationships with insurance agents and brokers, leveraged relationships with affiliated pharmacies, and beneficiary responses to CMS and other information sources.

- **Stuart, Bruce; Simoni-Wastila, Linda; Baysac, Fatima; Shaffer, Thomas; Shea, Dennis. "Coverage and Use of Prescription Drugs in Nursing Homes: Implications for the Medicare Modernization Act."** ***Medical Care,*** **March 2006.**

In this article, the authors analyzed drug coverage of nursing home residents using data from the 2001 Medicare Current Beneficiary Survey as well as data they collected on nursing home residents from medical records and nursing home staff interviews. The authors estimate that one-fifth of the nation's nursing home population does not have prescription drug coverage. Of these individuals, one-third have incomes below the federal poverty level and another one-third have incomes between 100 and 200 percent of poverty the study reported. The authors also found that residents used a mean of 5.7 unique prescription drugs per month (which did not vary significantly when the authors took into account drug coverage status). Because of the high drug utilization rate among residents, the new prescription drug benefit should provide financial relief to many of these residents. However, the authors also conclude that the new drug benefit will efforts to control spending (through formularies, mandated prescription drugs etc) and drug therapy in nursing homes, which in some cases may reduce access to specific medications.

OTHER SIGNIFICANT EVENTS

- None