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TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS
Monthly Report for April 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: 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: April 2005	Change From Previous Month	Same Month Last Year	
			April 2004	Change From April 2004 – 2005
Local Medicare Advantage Plans				
Contracts				
Total**	320	+4	286	+34
CCP	182	+3	145	+37
PPO Demo	34	0	35	-1
PFFS	8	+1	4	+4
Other***	96	0	102	-6
Enrollment				
Total**	5,693,625	+59,500	5,315,012	+378,613
CCP	4,880,557	+42,477	4,594,178	+286,379
PPO Demo	120,482	+1,654	94,739	+25,743
PFFS	88,131	+11,023	31,550	+56,581
Other***	496,883	+4,156	485,768	+11,115
Penetration*				
Total MA Penetration**	13.1%	+0.1% points	12.4%	+0.6% points
CCP + PPO Only	11.5%	+0.1% points	11.0%	+0.5% points

*Penetration rates for March and April 2005 are calculated using the number of eligible beneficiaries reported in the March 2005 State/County File. Penetration rates for March 2004 are calculated using the number of eligible beneficiaries reported in the March 2004 State/County File.
** Total MA contracts, enrollment and penetration includes CCP, PPO Demo, PFFS, Cost and Other Demo contracts.
*** Other includes Cost, Other Demo contracts, HCPP and PACE contracts.
DEFINTIONS: Coordinated Care Plans, or CCPs, include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs) and preferred provider organizations (PPOs). PPO Demo refers to preferred provider organization

demonstration plans. 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

- There are pending applications for 128 MA plans, 10 PFFS plans, 4 PACE plans, 2 HCPPS plans and 6 Other Demo plans. Service area expansions are pending for 79 MA plans, 8 PACE plans, 8 PFFS plan, 11 PPO Demo plans, 4 Other Demo plans and 5 Cost plans.

- NOTE: The number of pending applications, particularly for MA plans, is much higher than usual though similar to last month (we inadvertently omitted information on pending applications last month). Last month, there were pending applications for 127 MA plans, 12 PFFS plans, 4 PACE plans, 6 Other Demo plans and 2 HCPP plans.

- Plans were required to submit applications by February 15, 2005 for new coordinated care plans for approval by June 1, 2005 (the 2006-2007 moratorium on new PPOs will apply after that date.) Plans had until March 1, 2005 to apply for MA service area expansion. 2006 Medicare Advantage and prescription drug plan (PDP) applications were due on March 23, 2005. More information on MA and PDP due dates is available online at: http://www.cms.hhs.gov/healthplans/.

- Though there has been some speculation on regional plan applicants, CMS has released no official information on this topic. (Because such applications are not binding at this point, current applications represent an upper, not a lower, limit on plans likely to be offered in 2006.)

Summary of new MA contracts announced in April:

- CMS's Monthly Managed Care Contract Report (MMCC) for April 2005 indicates approval of four new MA contracts in April, 3 for CCPs and 1 for a PFFS. These are:

    - New York Presbyterian Community Hospital Inc, New York, NY (New CCP)
    - Three Rivers Health Plan, Monroeville PA (New CCP)
    - United Healthcare Insurance Company, Minnetonka MN (New CCP)
    - Instil Health Insurance Company, Columbia SC (New PFFS)

- The report also indicates approval of service area expansions for 11 plans.

NEW ON THE WEB FROM CMS

Relevant to Both Medicare Advantage and Prescription Drug Plans

- On April 4, 2005, CMS announced the calendar year 2006 Medicare Advantage Payment Rates which are available at http://www.cms.hhs.gov/healthplans/rates/default.asp. In 2006 the National per capita Medicare Advantage Growth Percentage will be 4.8 percent. CMS received 103 comments on the Advanced Notice of 2006 Payment Rates (issued February 18, 2005) from 19 organizations. (www.cms.hhs.gov/healthplans/rates/2006/cover.asp) In the complete document (which can be

downloaded), Enclosure 1 provides the final estimates of the National Per Capita Growth Percentage for 2006 and Enclosure II summarizes many of the assumptions CMS used in calculating it. Enclosures III contain CMS's responses to comments on the advance notice for Medicare Advantage Plans and Enclosure IV does the same for Part D. CMS reiterates that it has decided not to re-base the county fee-for-service rates in 2006. However, CMS did decide (in response to comments) to delay implementation of the updated and recalibrated CMS-HCC risk adjustment model until 2007 rather than 2006 as originally proposed. CMS also decided not to proceed with recalibrating the Part C risk adjustment models for costs of beneficiaries for whom Medicare is a secondary payer ("working aged") and will instead continue to use the adjustments that are currently in place. CMS received 42 sets of comments on Part D, the majority of which were on the Part D risk adjustment model, the reconciliation process, and the special payment methodology for PACE. The enclosure clarifies that CMS will not be conducting a geographic risk adjustment of the national average bid amount for Part D in 2006. Enclosure V contains the Part D CMS-HCC model risk factors, which will be used in calculating 2006 rates for MA-prescription drug benefits and private drug plans (PDPs).

- On April 7, 2005, CMS issued new guidance for employer/union groups wishing to sponsor Medicare Advantage or free-standing Part D retiree plans when the prescription drug benefit goes into effect. (www.cms.hhs.gov/medicareereform/pdbma/PardDEmpUnionWaiverGuidance04-06-05.pdf.) The guidance waives or modifies selected Part D requirements and elements of the application process. The waivers supplement and modify those issued on February 11, 2005 and the additional guidance on March 9, 2005.

- On April 11, 2005, CMS announced that $31.7 million had been awarded to State Health Insurance Assistance Programs (SHIPS) for 2005 to help inform beneficiaries about new drug coverage (www.cms.hhs.gov/media/press/release.asp?Counter=1426) The release noted that the amount reflected a 50 percent increase over the prior year's funding level. A major emphasis will be on signing up low-income seniors, with efforts beginning in May and including 60,000 local events around the country (Congressional Quarterly Health Beat, April 11, 2005). CMS has been under pressure from Capitol Hill about its efforts to promote the new Medicare drug benefit (*Congressional Quarterly*, April 19, 2005).

- On April 18, 2005, CMS provided an updated specification of its Final Medicare Part D Reporting Requirements as well as a response to the comments it had received on the draft requirements (www.cms.hhs.gov/pdps.PlnRpt_Ovsit.asp). The requirements apply to these areas: enrollment and disenrollment, reversals, medication therapy/management, generic dispensing rate, grievances, prior authorization/step edits/non formulary exceptions, appeals, call center measures, overpayment, pharmaceutical manufacturer rebates, discounts and other price concessions and licensure and solvency. These requirements are in addition to previously indicated requirements for formulary, coordination of benefits, TrOOP, payment and 1/3 audit, employer subsidy, low income subsidy and fallbacks, not all of which have been released. (Table 1 in the Appendix of the Final Requirements provides a Summary of Reporting Elements. Each Part D Sponsor is responsible for providing these data.) MA-PD organizations are responsible for complying with all requirements except those related to licensure and solvency. PACE organizations also are exempted from some requirements.

Relevant to Medicare Advantage

- On April 15, 2005, CMS sent instructions for the 2006 contract year to all Medicare Advantage organizations, cost-based plans, and capitated care demonstration programs currently in the program or expecting to be in by 2006 (http://www.cms.hhs.gov/healthplans/letters/default.asp). Parts I-III of the instruction contain information for renewing contracts and IV and V the non-renewal process. Part VI provides contact information and Part VII key web-page references. The letter notes that much additional information relevant to 2006 has already been distributed and is at http//www.cms.hhs.gov/medicarereform/pdbma.

- On April 25, 2005, CMS notified local MA applicants about how they will respond to requests for additional time to work out issues (e.g. provider contracting). Local plans with pending applications for 2005 will have until June 15, 2005 to submit materials to address state licensure/certification and network adequacy standards. 2006 local MA applicants will have until July 15, 2005. An exception is follow-up pharmacy access analyses, which are due April 1, 2005 in accordance with the Part D application. All other portions of the application must be submitted by June 2, 2005. To keep applicants informed on the status of their review, CMS will issue conditional letters of approval to 2005 applicants by mid May and to 2006 applicants by early June, prior to June 6, 2005 when bid submissions are due. (http://www.cms.hhs.gov/healthplans/letters/Appsmemoandtimeline%20Final.pdf)

- CMS has posted a list of approved Special Needs Plans, with enrollment (where applicable) as of March 2005 (www.cms.hhs.gov/healthplans/specialneedsplans/default.asp, last modified April 14, 2005). The list includes only SNPs serving dual-eligible or institutionalized individuals. Guidance for other kinds of special needs plans will be forthcoming.

- The list of 64 contracts is heavily dominated by a few firms (PacifiCare, UnitedHealthcare, Well Care) and includes requested redesignations of existing plans (e.g. Evercare, PACE) as well as new plans. In an April 5, 2005 press release, CMS indicated that it had approved 48 special needs plans and was reviewing an additional 18 applications for special needs plans to be offered in 2005, with over 100 special needs plan applications submitted to provide services in 2006. (www.cms.hhs.gov/media/ press/release.asp?Counter=1141)

- In a letter dated April 29, 2005, CMS notified potential applicants that it is reopening the window for current and applicant MA organizations who meet specified criteria to submit a SNP application. (www.cms.hhs.gov/healthplans/letters/default.asp) The criteria require that SNP products be consistent with selected features of already submitted or approved products (e.g. formulary) and that bids be uploaded by June 6, 2006. The instructions appear to suggest that CMS will accept proposals targeting beneficiaries with severe or disabling conditions as well as the dually eligible or institutionalized.

Relevant to Prescription Drug Plans

- In April, CMS posted on its web site a list of organizations indicating that they would like to partner with Part D sponsors. CMS is creating this opportunity because it decided (because of the proprietary nature of the information) not to post a list of organizations indicating an intent to apply for a Medicare Part D contract (www.cms.hhs.gov/pdps) The list includes consultations/implementation

contractors, pharmacy-home infusion and I/T/U firms, retail pharmacies, long term care pharmacies, mail order pharmacies, pharmaceutical manufacturers and others, including state Medicaid programs.

- On April 28, 2005, CMS updated the 5 percent Medicare file, which is one of the "Final Drug Plan Bid Data Sets" made available to potential Part D bidders on the CMS web site. Other data on the site include the FEHBP Drug Utilization Index CY 2002, the Distribution of prescription drug expenses based on the Medicare Current Beneficiary Survey (MCBS), the Statistical Compendium on Medicaid Pharmacy Benefit Use and Reimbursement in 1999 and MCBS data. (www.cms.hhs.gov/pdpd/BidInst.asp)

ON THE CONGRESSIONAL FRONT

About Medicare Health and Drug Plans Specifically

On April 5, 2005, the Subcommittee on Oversight of Government Management, the Federal Workforce, and the District and Columbia of the U.S. Senate Committee on Homeland Security and Government Affairs held a hearing on "Monitoring CMS's Vital Signs: Implementation of the Medicare Prescription Drug Benefit. (http://hsgac.senate/gov/index.cfm?Fuseaction=Hearings.Detail&HearingID=223). CMS Administrator Mark McClellan testified and took questions for the first panel. Witnesses in the second panel were Marcia Marsh, Vice President for Agency Partnerships, Partnership for Public Service and Ann Womer Benjamin, Director, Ohio Department of Insurance.

- In his testimony, Dr. McClellan reviewed CMS's short and long term recruiting efforts, including new hires and their characteristics, use of direct hire authority, and improved hiring process referred to as "Extreme Makeover". He also reviewed the reorganization of core units within CMS to accommodate the MMA. The Center for Beneficiary Choices, for example, now has four groups covering: Medicare Advantage, Medicare Drug Benefits, Employer Policy and Operations, and Medicare Plan Accountability. The Agency also has established a Chief Operating Officer as a position separate from the Deputy Administrator. CMS expects that MA plans will be available in 47 states in 2005 and that over 90 percent of all beneficiaries will have access to these plans. McClelland received CMS's strategy for beneficiary education and recent steps to better serve beneficiaries.

- The second panel provided addition operational detail on the Extreme Makeover Project by the group working with CMS on it (Marsh testimony) and on local experience with beneficiaries using Ohio as an example, including the importance of individualized information at the local testimony (Womer testimony). The latter testimony noted extensive cooperation with CMS but also room for improvement and increased efficiencies (e.g. getting materials to train volunteers on a more timely basis; obtaining more timely response from CMS to technical questions).

- According to the April 26, 2005 issue of *Congressional Quarterly Health Beat*, ranking Democrats on three House committees dealing with health issues have asked CMS to stop production of the proposed 2006 "Medicare and You" handbook because they believe the draft is confusing and includes erroneous information (e.g. on the donut whole, on the priority of MA relative to traditional Medicare). CMS staff have responded that the document seen is a draft on which they welcome comments, particularly ones that are specific to parts of the book that are in error. (*CQ Health Beat*, April 26th) The draft (dated April 19, 2005) that was circulated for comment revises the 2005 version to the handbook to reflect the introduction of Medicare Prescription Drug Coverage and Medicare

Plan options in 2006; CMS requested all comments be received by Monday April 25, 2005. The draft refers to Original Medicare as a Medicare Fee-for-Service Plan (a term also including private fee-for-service plans).

- On March 24, 2005, the Congressional Research Service issued a Report to Congress on "Beneficiary Information and Decision Supports for the Medicare-Endorsed Prescription Drug Discount Card" (CRS, Order Code RL 32828). The report, by Diane Justice, reviewed CMS's experience providing information and decision support to Medicare beneficiaries related to prescription drug discount cards and also on transitional assistance through those cards available to low income beneficiaries. The report noted that CMS used an intensified version of many of the same outreach and education methods as in the past but also that there was an increased emphasis on the Internet as a vehicle for information. They found that observers credit the complexity of the decisions, together with the fact that about 70 percent of Medicare beneficiaries make no use of the Internet for any purposes, to the limited program enrollment. (Design features cited as limiting enrollment include the large number of cards, confusing release of initial information, early questions raised on the cards value, and cumbersome enrollment procedures). The report highlights the difficult challenges in reaching low-income beneficiaries with information. The report notes that there are lessons for this for implementing the Medicare prescription drug benefit in 2006, where the decisions are likely to be even more complex and the stakes related to the decision larger. CRS intends to update the report in the future. The full report can be accessed online at: http://kuhl.house.gov/UploadedFiles/medicaredrugcard.pdf.

- The Medicare Payment Advisory Commission (MedPAC) met for its regularly scheduled meeting on April 21 and 22, 2005 to consider a variety of topics relevant to developing its June 2005 Report to Congress, including the consideration of recommendations that it might include. The morning of the first day was devoted to a review of the congressionally mandated study of Medicare Advantage payment areas and risk adjustment and to policy issues related to the Medicare Advantage program.

    - MedPAC staff reported that about 15 percent of the variation in the average adjusted per capita cost rates (AAPCCs) is due to geographic differences in input prices and payments for indirect medical education (IME), direct graduate medical education (GME) and disproportionate share hospitals (DSH). The remainder is primarily due to differences in service use that are affected by provider practice patterns and beneficiaries' preferences. They also indicated that the CMS-HCC model predicts costs better than the demographic adjuster previously used and that is true both for those in good health as well as poor. Staff suggested that payment areas for local plans should be larger than current county definitions. Discussion focused on this last area and a vote on recommendations to be included in the June report.

    - The Commission spent the rest of the time discussing a number of policy issues related to MA that MedPAC intends to address in the June report, most related to the issue of neutrality or a level playing field for MA versus other options and for local versus regional MA plans. Areas discussed and voted on included a recommendation to begin to calculate certain quality measures for fee-for-service Medicare, potential elimination of the MA stabilization fund, what to do about the uneven playing field between local and regional plans and among some regional plans because of disparities on how the benchmarks are calculated, and whether benchmarks should be set to 100 percent of the fee-for-service payment rates in each area. The commission also considered a staff recommendation to redirect a share of

Medicare's savings from the bids below the benchmark to provide rewards for plans based on quality measures. (A full transcript of the session is included on pages 1-95 of the meeting transcript at www.medpac.gov; see also Congressional Quarterly Healthbeat, April 21, 2005 for a discussion of the Commission votes).

- On the morning of the second day, MedPAC focused on monitoring the implementation of Part D. Staff reported on an expert panel they convened to consider how performance measures could be used to monitor the Part D program and to evaluate the performance of participating plans. Performance areas discussed included cost control, access and quality assurance, benefit administration and management, and enrollee satisfaction. Staff reported that CMS will be collecting a large amount of data on Part D, including drug utilization and plan benefit information. CMS intends to develop performance measures with these data though they have not yet been developed. Data will be used both for Congressional reporting and internal CMS use. In the discussion, Commissioners clarified that national PDP plans cannot cross-subsidize by region and that premiums (and potentially formularies) could differ by region. Commissioners noted that the amount and level of information CMS will obtain on Part D is much more detailed (e.g. transaction level) than is currently required for A and B benefits for MA plans. (See pages 274-300 of the transcript).

Broader Medicare Program (in Brief)

- In April 2005, HHS issued its Report to Congress on "Transitioning Medicare Part B Covered Drugs to Part D" (www.cms.hhs.gov/rsearchers/reports/2005/RTC_PtbtoPtD.pdf). The report concludes that it would not desirable to move coverage of most separately billable Part B drugs to Part D although this might be worth exploring for a few categories of drugs. The report also notes that moving drugs from Part B to D at this time would also complicate current implementation challenges. A more extensive summary of the report is included in *BNA's Medicare Report*, April 8, 2005.

- In late April 2005, Senators Grassely and Baucus wrote to Secretary of HHS Mike Leavitt and SSA Commissioner Joanne Barnhart expressing concern about the changes in process for Medicare appeals which will be introduced in October 1, 2005 as responsibility for these appeals shifts from the Social Security Administration to CMS (a shift mandated in the MMA of 2003). The Senators are concerned about the limited number of locations for hearings, the more extensive use of video-conferencing versus in person hearings with beneficiaries, and the adequacy of available support systems at CMS (*Congressional Quarterly Health Beat* April 25, 2005; *American Healthline* April 26, 2005.) On April 24, 2005, an article on this topic by Robert Pear, entitled "Medicare Change Will Limit Access to Claim Hearing," appeared on the front page of *The New York Times.*

FROM THE PERSPECTIVE OF BENEFICIARIES

General

- The March/April 1005 Health Poll Report Survey released by the Kaiser Family Foundation reported that in April 2005 34 percent of seniors still said they had an unfavorable impression of the new prescription drug benefit compared to 21 percent who had a unfavorable view (45 percent were neutral or didn't know). Seniors were more likely than those aged 18 to 64 to have a negative view but 70 percent said lawmakers in Washington should fix the problem as opposed to repealing it (12

percent). The report also showed that two-thirds of seniors said they did not have a good understanding of the benefit or how it would affect impact them personally. Fewer than one in ten surveyed said they are planning to enroll while 37 percent said they will not (47 percent hadn't heard enough to decide and 7 percent didn't know). The Health Poll Report Survey is available at: www.kff.org/healthpollreport /april_2005/index.cfm?Renderfor Print=1.

- On April 13, 2005, the Kaiser Family Foundation released a report by Tom Rice and Katherine Desmond on "Low Income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Assets Test" (www.kff.org). The authors estimate that 14 million low income Medicare beneficiaries would be eligible for low-income subsidies included the Medicare Prescription Drug Benefit law but that 2.4 million of them would be disqualified because of the asset test, which disqualifies individuals with more than $10,000 in assets and couples with more than $20,000 in assets. A large proportion of those disqualified had relatively modest assets (half under $35,000 and 42 percent under $25,000). The authors suggest that the study findings raise serious questions about the equity of the asset test, particularly when Americans have been encouraged to save for retirement, including the possibility of sizeable long-term expenses.

Special Populations

- In an issue brief released by The Commonwealth Fund in April 2005, entitled "Impact of Medicare Prescription Drug Benefit on Home- and Community-Based Services Waiver Programs, Chuck Milligan presents results from a survey of 3,180 Marylanders dually eligible for Medicare and Medicaid who are enrolled in home and community based waiver programs. Overall, they received a total of 220,884 prescriptions in FY2004, or almost 70 prescriptions per beneficiary on average. Overall, 1,645 different (unduplicated) kinds of prescriptions were written. The author argues that in transitioning these beneficiaries from Medicare to Medicaid under the MMA, care is needed to ensure a smooth transition and recommends a number of steps for doing so. The issue brief is available online at: www.cmwf.org.

FROM OTHER STAKEHOLDERS

- At a March 31st policy briefing sponsored by the Alliance of Community Health Plans (ACHP), ACHP advocated stricter requirements for reporting quality information by new regional MA plans. ACHP said Congress will have to re-examine the value of regional plans in comparison to local MA plans, which have more extensive quality reporting requirements. (*BNA's Medicare Report*, April 8, 2005)

- PacifiCare has announced that it expects to offer a standalone prescription drug plan in all 34 CMS regions, along with the drug coverage it will provide in 2006 to those already enrolled in its MA plan. PacifiCare will establish a new division, Prescription Advantage, for the stand-alone product. The product will be supported by PacifiCare's pharmacy benefits management subsidiary, Prescription Solutions (*BNA's Medicare Report*, April 1, 2005).

- On April 28, 2005, the National Health Policy Forum convened a Technical Briefing on "Understanding Medicare Advantage Bidding and Payment: Effects on Plan Choice and Beneficiary Premiums." Marsha Gold, Sc.D., Senior Fellow at Mathematica provided a review of historical trends with private plans in Medicare. Sally Burner, Special Assistant to the Chief Actuary of CMS,

reviewed the methods used in MA bidding and payment. Jack Ebeler, the President and CEO of Alliance of Community Health Plans, described the bidding process as it works on the ground for plans and beneficiaries (e.g. the importance of the overall premium faced by the beneficiary), and the environment now facing MA plans as they consider their bids.

- In April 2004, Kaiser Family Foundation updated its Medicare Fact Sheets, including "Medicare at a Glance", "Medicare Spending and Financing", "The Medicare Prescription Drug Benefit" and "Medicare Advantage".

- On April 12, 2005, the Pharmaceutical Research and Manufacturers Association released a study by Milliman that disputes AARP's analysis of trends, arguing that the actual rate of increase has been below the Consumer Price Index (www.aarp.org). (For the AARP study, see David Gross, Stephen Schondelmeyer and Susan Raetzman. "Trends in Manufacturer Prices of Prescription Drugs Used by Older Americans" Washington DC: AARP Public Policy Institute Research Report, April 2005).1

NEWLY RELEASED RESEARCH STUDIES NOT PREVIOUSLY DESCRIBED

- **Lori Achman and Lindsay Harris. "Early Effects of the Medicare Modernization Act: Benefits, Cost Sharing and Premiums of Medicare Advantage Pages, 2005" Washington DC: AARP Public Policy Institute, April 2005 (#2005-02). (www.aarp.org).**

  In this report, the authors update the trends in MA benefits and premiums through 2005 in response to changes in the payment rates authorized under the MMA. Average monthly premiums declined form $25 to $22 per month between 2004 and 2005, though they remain substantially higher than in 1999. The share of MA enrollees with any drug coverage in 2005 rose to 74 percent (from 71 percent in 2004) and the share with brand-name coverage rose to 36 percent (from 33 percent). There were improvements in MA coverage of Medicare physician and hospital cost sharing. Though MA enrollee out of pocket costs in 2005 declined to 2003 levels, they remain high. Those in good health still spend substantially more than those in poor health; however, the gap between the two has narrowed from recent years. The types of plans available has expanded both under demonstration and non-demonstration authority.

- **Alan Fine. "Employer Monitoring of Changes to Medicare HMOs" *Managed Care Quarterly* 13(2): 18-20, 2005**.

  This article reports on a Towers Perrin survey of 20 Medicare Advantage plans about what they intended to do with the rate increases they received in 2004. Seventy-one percent planned to use the increase to reduce premiums, 30 percent to enhance benefits, 41 percent to strengthen provider contracts and 29 percent to establish a stabilization fund (plans could use it for multiple purposes). However, many employers are not immediately gravitating to the program.

1 This pair of reports updates AARP' s study of changes in manufacturers' prescription drug price lists for about 200 brand name and75 generic prescription drugs widely used by Americans age 50+. The current update analyzes 2004 year-end prices (www.aarp.org)

- **Marsha Gold, Timothy Lake, William E. Black and Mark Smith. "Challenges in Improving Care for High-Risk Seniors in Medicare"** ***Health Affairs*****—Web Exclusive W5-199, April 26, 2005. (www.healthaffairs.org)**

  This article considers the implications of the typically negative findings from demonstrations seeking to improve care for high-risk elders for current efforts to generate such improvements, such as those encouraged in the MMA of 2003. The paper examines the experience of the California Healthcare Foundation's Program for Elders in Managed Care and finds that specific flaws in concept, design, and implementation each make it more challenging for demonstrations to achieve their intended goals, especially those involving cost and utilization reductions. The authors speculate that part of the reason for this is that organizational and political processes lead to fundamentally conservative demonstrations that assume that small amounts of resources directed at incremental change can be effective in generating substantially change in organizations and do so rapidly. They also discuss the implications for new efforts authorized under the MMA.

- **Dana Gelb Safran, Patrician Neuman, Cathy Schoen, Michelle S. Kitchman, Ira B. Wilson, Barbara Cooper, Angela Li, Hong Chang, and William H. Rogers. "Prescription Drug Coverage and Seniors: Findings from a 2003 National Survey" Health Affairs, W5-167, April 19, 2005. (www.healthaffairs.org)**

  In this article, authors report on results of a 2003 national survey of Medicare beneficiaries aged 65 and older. Findings show that more than one-quarter had no prescription drug coverage and that nearly half of low-income seniors in some states lacked coverage. The survey found that 26 percent of seniors said they had not fully adhered to prescriptions because of costs-skipping or splitting doses, failing to fill prescriptions or spending less on basic needs to afford prescriptions; among seniors with no drug coverage, with low income, or with 3 or more chronic conditions the figures respectively were 37 percent, 35 percent and 35 percent. The authors conclude that drug coverage is clearly critical to the health of Medicare elders, that the large number of low-income seniors who lack coverage in many states highlights the enormous potential of the MMA to improve coverage, and that the positive role now played by Medicaid in coverage makes it vital to protect Medicaid enrollees as they move in Medicare Part D plans. They also suggest that reports of complex drug regimens, multiple prescription physicians and pharmacies, non-adherence, and re-importation demonstrate the challenges in integrating seniors' prescription drug care, with monitoring critical to the potential to improve quality.

- **Bruce Stuart, Lindsa Simoni-Wastila, and Danielle Chaucey. "Assessing the Impact of Coverage Gaps in the Medicare Part D Drug Benefit"** ***Health Affairs*** **Web Exclusive, W5-152, April 19, 2005. (www.healthaffairs.org)**

  In this paper, authors use data from the Medicare Current Beneficiary Survey in 1998-2000 from beneficiaries with naturally occurring gaps in drug coverage to estimate the potential impact on out of pocket spending for Medicare beneficiaries under the new Part D benefit who qualify only for that coverage. The authors find that discontinuities in coverage have in the past resulted in sizeable reductions in medication use and spending and that these reductions are magnified in people with chronic illness. They estimate that under Part D in 2006, the average beneficiary who signs up will spend $722 out of pocket; the average for those with diabetes, chronic lung disease, and mental

illness will be $1,581, $1,435, and $1,844 respectively.

- **Cindy Parks Thomas, Stanely S. Wallack and Timothy C. Martin. "How Do Seniors Use Their Prescription Drug Card"** ***Health Affairs*** **Web Exclusive W5-180, April 19, 2005. (www.healthaffairs.org)**

  This article reports on the use of prescription drug cards issued by a major national pharmacy benefits manager in the year before the Medicare discount drug program began. The study included 3.2 million enrollees aged 65+ receiving a discount card free of charge as an added feature of Medigap coverage and 320,000 people who may or may not have had Medigap who purchased the card for a $20 annual fee. The latter group who actively enrolled relied heavily on the card for their purchases. They saved 20o percent overall but still spent more than $1,3000 annually on prescriptions. Fewer than half of the first group (those automatically enrolled) used the card. These seniors either had other options or needed to understand better the value of drug savings card programs and how to use them.

OTHER SIGNIFICANT EVENTS

X None.