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TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS
Monthly Report for July 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: July 2005	Change From Previous Month	Same Month Last Year	
			July 2004	Change From July 2004 – 2005
Contracts				
Total	392	+52	292	+100
CCP*	247	+50	149	+98
PPO Demo	34	0	35	-1
PFFS	13	+1	5	+8
Cost	29	0	29	0
Other*	69	+1	74	-5
Enrollment				
Total	5,793,667	+53,663	5,376,650	+417,017
CCP	4,943,668	+37,978	4,634,134	+309,534
PPO Demo	123,418	+1,293	102,634	+20,784
PFFS	119,723	+11,092	37,357	+82,366
Cost	322,341	+488	330,081	-7,740
Other*	284,517	+2,812	272,444	+12,073
Penetration**				
Total Private Plan Penetration	13.4%	+0.2% points	12.5%	+0.9% points
CCP + PPO Only	11.7%	+0.1% points	11.0%	+0.7% points

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

** Penetration rates for June and July 2005 are calculated using the number of eligible beneficiaries reported in the March 2005 State/County File. Penetration rates for July 2004 are calculated using the number of eligible beneficiaries reported in the June 2004 State/County File.

DEFINITIONS: Coordinated Care Plans, or CCPs, include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs) and preferred provider organizations (PPOs). Data from the June 2005 Geographic Service Area File show that HMOs account for 80 percent of CCP contracts and 99 percent of CCP enrollment. The Medicare preferred provider organization demonstration began in January 2003. PFFS refers to private fee-for-service plans. Cost plans are HMOs that are reimbursed on a cost basis, rather than a capitated amount like other private health plans. Other Demo refers to all other demonstration plans that have been a part of the Medicare+Choice / Medicare Advantage program.

A Note on 2005 Monthly Enrollments. The July 2005 report shows a continuation of the previous trend showing increases in contracts and small, but steady, increases in enrollment. The exception was last month (June 2005) when enrollment declined. We cautioned readers then to defer interpretation pending future data, a caution that seems warranted. The reported July 2005 total private plan enrollment is 30,554 higher than reported in May 2005. As indicated last month, monthly enrollment totals are sensitive to the date on which data are captured and the potential for month to month inaccuracies is great during periods when enrollment is growing or contracting rapidly. Therefore, users may want to base their assessment of short-term trends on several months of data.

Pending Applications

- According to the July 1,2005 Medicare Managed Care Contract Report, there are pending applications for 58 MA contracts, 4 PACE contracts, 5 PFFS contracts, 9 cost contacts and 8 other demonstrations.

Summary of new MA contracts announced in June:

CMS's Monthly Managed Care Report (MMCR) for July 1, 2005 indicates that 52 new contracts were signed in June 2005, including 50 new CCP contracts, 1 PFFS contract, and 1 new HCPP contract. The report does not indicate whether new CCPs are HMO or PPO plans. Though the latter have been small in number historically, their number is growing. Because there is a moratorium on new local MA PPOs for two years starting January 2006, applicants wishing to offer these products must get them approved in 2005. CMS's June 30, 2005 press release (noted last month) indicates that 66 new local PPOs were approved in 2005 (www.cms.hhs.gov/media/press/release.asp?counter1497). The 50 new contracts signed were as follows:

- Aetna Health Care, Blue Bell AZ (CCP)
- Blue Cross and Blue Shield of Alabama (CCP)
- Fallon Community Health Plan, Worcester MA (CCP)
- Carolina Health Plan, Columbia SC (CCP)
- Presbyterian Insurance Company Inc., Albuquerque NM (CCP)
- Priority Health, Grand Rapids MI (CCP)
- McKinkley Life Insurance Company Canton OH (CCP)
- United Health Care Insurance Company, Minnetonka MN and affiliates (7 contracts) (CCP)
- Summacare, Akron OH (CCP)
- Metcare Health Plans, West Palm Beach FL (CCP)
- Ods Health Plan, Portland OR (CCP)
- Blue Cross and Blue Shield of Oklahoma, Tulsa OK (CCP)
- Firstcare, Austin TX (CCP)
- Partners National Health Plan of NC, Winston Salem NC (CCP)
- Aetna Health Plan, Hartford CT, Blue Bell PA and affiliates in Georgia (6 contracts) (CCP)

- Humana Insurance Company, Louisville KY (3 contracts) (CCP)
- Mountain State Blue Cross Blue Shield, Parkersburg WV (CCP)
- Blue Cross and Blue Shield of Idaho Health Services Inc, Meridian ID (CCP)
- Hometown Health Plan, Reno NV (CCP)
- Oxford Health Plans, White Plains NY (CCP)
- Arcadian Health Plan, Oakland CA (2 contracts) (CCP)
- Blue Cross and Blue Shield of MA, Boston MA (CCP)
- Atrio Health Plans, Roseburg OR (CCP)
- Honored Citizens Choice Health Plan Inc, Beverly Hills CA (CCP)
- Regence Blue Shield and affiliates in ID, OR, UT, and WA (4 contracts) (CCP)
- Asuris Northwest Health, Spokane WA (CCP)
- Coventry Health and Life Insurance and affiliates, Des Moines Iowa (2 contracts) (CCP)
- Wellcare of Georgia, Marietta GA (CCP)
- Elder Health Texas, San Antonio TX (CCP)
- Avmed Inc, Gainesville FL (CCP)
- Anthem Health Plans of Virginia, Richmond VA (CCP)
- Healthspring, Nashville TN (CCP)
- Blue Cross-Blue Shield of Michigan, Southfield MI (PFFS)
- National Health Plan Network Inc, New York, NY (HCPPS)

In addition, the report indicates approval of service area expansion for 47 plans.

NEW ON THE WEB FROM CMS

Relevant to Both Medicare Advantage and Prescription Drug Plans

- On July 5, 2005, CMS sent a memorandum to all private plans (Medicare Advantage (MA), Prescription Drug Plan (PDP), cost, demonstrations) with Part III of the Medicare Advantage and Part D enrollment and payment systems changes for 2006. (http://www.cms.hhs.gov/healthplans/). The memo provided additional technical detail on the final monthly premium withholding report layout, reporting of RXID/RXGROUP/RXBIN/RXPCN data, enrollment response file layouts, low-income subsidy and late enrollment penalty enrollment, and auto-enrollment.

- On July 7, 2005, CMS released additional guidance on the review process for multiple bids (www.cms.hhs.gov/pdps/BidInst.asp). CMS had previously indicated that it will allow multiple bids if they represent legitimate and meaningful variations (e.g. benefit packages). CMS is reviewing multiple bids that were submitted and may be contacting applicants with questions on meaningfulness of variations. The guidance indicates that co-branded bids (i.e. bids that are identical in every way except plan name) will be accommodated within one plan benefit package. When multiple applications were submitted that are duplicates, separate and identical bids relating to joint enterprise administration/competition will be asked to withdraw duplicate bids if CMS determines they are without meaningful differences. If the difference in multiple bids is limited to cost sharing (e.g. identical formularies, cost sharing differences that vary minimally (e.g. 5-10 percent) or deductibles that vary by $50 or less without other differences), sponsors must justify that differences are meaningful or withdraw duplicates. Similarly, if there are different formularies but no meaningful differences in benefit design or bid amounts sponsors will have to justify or withdraw these.

- On July 7, 2005, CMS released answers to questions on the auto-enrollment process (www.cms.hhs.gov/pdps.BidInst.asp). Full benefit dual eligibles that do not enroll in a PDP or MA-PDP will be enrolled in a plan through a two-step process. CMS will first randomly assign individuals among all PDP sponsoring organizations that offer at least one plan with a premium at or below the low-income premium subsidy amount. Assignments will be equal in number to each plan. Then, within sponsoring organization, individuals will be randomly assigned among all the PDPs, which are eligible based on their premium. Individuals will be able to change their plan if they wish.

- On July 12-13, 2005, CMS convened a Retiree Drug Subsidy Conference in Dallas, Texas. The agenda and presentation materials can be downloaded at http://rds.cms.hhs.gov/events/national/conf.htm. During the first day of the conference, presenters reviewed the materials employers must provide to apply for the subsidy, how they will submit the list of qualifying covered retirees, and various aspects of their interaction with the RDS Center, most of which appear relatively technical and systems related. The materials include the data elements that employers need to submit to CMS. Day two focused on calculating subsidies, providing them to employers, the process for appealing subsidy calculations and oversight of benefit integrity (fraud and abuse). Employers will need to provide information on gross aggregate prescription costs for qualified covered retirees and estimated rebate amounts attributable to the gross costs. Sponsors of insured plans can provide substitute information based on the amount of premium for these costs.

Relevant to Medicare Advantage

- On July 12, 2005, CMS convened a technical user group training call with managed care organizations (MCOs), cost plans, MA plans and HCPPs. The meeting focused on technical details of enrollment and payment, including review of the 2006 Part III instructions (see above) (http://www.cms.hhs.gov/ healthplans/training/).

- On July 20, 2005 CMS posted a notice to procure vendor information for a Medicare Advantage Group's Financial Watchlist project (Federal Business Opportunities, Reference # 765-5-361002). The information sought is on ratings that indicate the ability of the Medicare Advantage Organizations (MAOs) (and their parent organizations) to meet financial obligations for enrollees. The data will be used to help monitor fiscal soundness and to predict those who may be at risk for leaving the program because they no longer comply with the state requirements for fiscal soundness or have unprofitable or limited Medicare beneficiary enrollment).

Relevant to Prescription Drug Plans

- On July 11, 2005, CMS updated its list of parties interested in contracting with Part D applicants. (www.cms.hhs.gov/pdps/Intrstd3rdPartyInfo.asp). The list, now at 99 pages, includes consultants / implementation contractors; pharmacy contractors including those in the areas of home infusion, 340B, FQHC or other safety-net providers; the Indian Health Service; retail; long-term care; mail order, and others.

- On July 21, 2005, CMS released a revised version of the guidance and instructions for submitting pharmacy access analysis (www.cms.hhs.gov/pdps/aug1pharmaccess.asp). The document "August 1, 2005 Submission of Pharmacy Access Analyses" was issued June 30, 2005 and revised July 7, 2005, with clarifications added on July 15 and July 20. Applicants are required to submit the

documentation according to the indicated technical specifications by August 1, 2005. CMS indicates that they will not review information received after 5 PM on that date and that, because of the timing of the MMA, applicants cannot be guaranteed an opportunity to remedy deficiencies in the submitted information. The document also indicates contracts will be signed early September 2005.

Relevant to Special Needs Plans Specifically

- None

ON THE CONGRESSIONAL FRONT

About Medicare Health and Drug Plans Specifically

- None

Broader Medicare Program (in Brief)

- This month marked the 40th Anniversary of the enactment of Medicare and Medicaid. On July 26, 2005, the Kaiser Family Foundation and Commonwealth Fund sponsored a symposium to mark the occasion. KFF showed a documentary (available on CD) on the history, politics and impact of the programs, including perspectives of people involved in its original enactment and implementation. Robert Dallek, presidential historian, gave an historical perspective and Joseph Califano, former Chief Domestic Advisor to President Lyndon Johnson (and former Health, Education and Welfare Secretary), talked about his perspectives as an insider. Former Health Care Financing Administration (HCFA)/Centers for Medicare and Medicaid Services (CMS) Administrators participated in a panel discussion lead by Jackie Judd. Panelists included: Robert Derzon, Leonard Schaeffer, William Roper, Gail Wilensky, Bruce Vladeck, Nancy-Ann DeParle, and Thomas Scully. The webcast and transcript of the session are available at www.kaisernetwork.org/health_cast)

    - On July 26, 2005, Health Affairs published web-exclusive papers from each of the administrators on their perspectives looking back and forward (www.healthaffairs.org).

    - Marking the occasion, KFF released the third edition of the *Medicare Chartbook* Summer 2005 (www.kff.org). It contains detailed statistics on Medicare Beneficiaries, Benefits and Utilization, Supplemental Insurance Coverage and Medicare Advantage, Out-of-Pocket Spending, Medicare and Prescription Drugs, and Medicare Spending, and Medicare Financing and Future Projections. A new Appendix includes a timeline of the Medicare program from 1965-2005.

    - Also, The Commonwealth Fund released a Health Care Opinion Leaders Survey on Medicare and its future (www.cmwf.org). Views varied but the vast majority of panelists from all sectors—academic, health care delivery, business/insurance/other health care industry, and government/labor/consumer advocacy—say Medicare is a successful program and 92 percent say it has been a success in providing stable predictable coverage to guarantee access to basic medical care. Eighty percent credited it with success in providing support for graduate medical education and training. Leaders were least likely to credit the success to the program in the area of home care (41%), using purchasing power to improve

quality (21%) or encouraging preventive care (12%). Opinions were almost equally divided on whether Medicare Advantage or traditional Medicare buys more value for the money spent, with MA favored by business and industry and other sectors split because many were unsure. Looking to the future, panelists favored more use of electronic medical records and health information technology and using Medicare's leverage to reward high quality providers. The panelists also favored undertaking more efforts to encourage beneficiaries to find a medical home and reward providers for coordinating care and prevention.

- On July 27, 2005, the Senate Finance Committee held a hearing on "Improving Quality in Medicare: The Role of Value Based Purchasing" (www.finance.senate.gov/sitepages/hearing072705.htm). Senators Grassley and Baucus have introduced the Medicare Value Purchasing Act of 2005 (S1356), which is designed to shift Medicare from paying for volume to paying for quality. Witnesses at the hearing included: Herb Kuhn, CMS; Mark Miller, Medicare Payment Advisory Commission (MedPAC); Byron Thames, AARP; Nancy H. Nielson, American Medical Association (AMA); Leo Brideau, for the American Hospital Association (AHA); and James Mongan, Partners Healthcare.

    - The CMS testimony reviews CMS's quality measurement and current and future initiatives to promote quality and use of pay-for-performance in Medicare and also summarizes private sector efforts.

    - MedPAC's testimony summarizes the Commission's history of support for the concept and for directing 1 to 2 percent of current provider payments toward this end. It described the criteria it has developed to decide whether conditions in a given setting were ready to move forward with pay for performance, and the conclusions reached about hospitals, physicians, home health agencies, Medicare Advantage plans, and dialysis facilities and associated physicians. With respect to MA, MedPAC notes that pay for performance is ready for implementation in this sector because measures are developed and already collected, room for improvement exists, and risk adjustment is not a factor given the nature of the available measures.

    - AARP's testimony was supportive of pay for performance as part of a new approach which offers rewards for high quality, quality improvement and use of health information technology.

    - The AMA said any value-based legislation must replace the current physician payment system (particularly the Sustainable Growth Rate) with a more reliable stable system and also reviewed features of the bill against the AMA Principles and Guidelines for Pay for Performance attached to their testimony).

    - AHA testimony reviewed their work historically in this area and expressed support for now tying some portion of payments to performance on measures already reported.

    - Partners Healthcare testimony supported pay for performance, especially when coupled with development of information technology.

FROM THE PERSPECTIVE OF BENEFICIARIES

General

- On Friday July 8, 2005, PBS' NOW had a segment on the implementation of Medicare's new drug benefit authorized in the Medicare Modernization Act (www.pbs.org/now/printable/transcriptNOW127_full_print.html). The segment reviewed the different perspectives on the value of this benefit and the sizeable effort now underway to enroll seniors.

- In July 2005, Families USA issued a special report suggesting that the Medicare drug benefit was putting low-income people at risk (www.familiesusa.org). The concern relates to dual eligibles and the "clawback" provision establishing requirements that states pay the federal government for a portion of the costs associated with Medicare coverage for dual eligibles—people whose coverage previously was provided through Medicaid, which is jointly financed by federal and state government. The report says that states (including Florida, Mississippi and Missouri) have already announced proposed cuts in Medicaid coverage for the elderly and disabled (most of whom are dual eligibles). While such individuals may get drug coverage through Medicare, they will not get the extra services Medicaid provides beyond the Medicare benefit package (e.g. hearing coverage, transportation) and their drug coverage under Medicare may not be as complete as it was before under Medicaid. The clawback provision has been controversial among states but Senate Finance Committee aides suggest that the reductions are due less to the clawback specifically than to other factors such as state budgets. (*CQ Healthbeat*, July 7, 2005)

- In a July 17, 2005 *New York Times* article "Officials' Pitch for Drug Plan Meets Skeptics," Robert Pear discusses the Administration's cross-country campaign to enroll beneficiaries in the new 2006 Medicare drug benefit. President Bush flew to Minnesota to open a national "education and outreach tour" that is making stops in many localities to educate consumers and encourage community groups to help people enroll. Though health policy experts say the benefit is a good deal, the article suggests that some beneficiaries are indicating they need more information, may be concerned the benefit is less than ideal or too complex, or may feel they don't need to enroll as they don't use many drugs. Pear writes that officials' ability to respond to questions is limited because crucial details, like monthly premiums and names of covered drugs, won't be available until mid-September.

- On July 19, 2006 Former Senator John Breaux announced the creation of a Medicare Rx Education Network of more than 40 groups focused on Part D enrollment (www.medicarerx.education/org/media-launch.htm). The network includes AARP, Blue Cross Blue Shield, Easter Seals and the American Medical Association and seeks to "eliminate duplication of efforts and maximize the effectiveness of outreach efforts …(also) preempt any confusion…by making sure information disseminated about the benefit is factual and accurate." The network plans a public relations campaign including TV ads, a web site and 24 hour toll-free information and intends to direct beneficiaries to local resources and communities where questions can be answered face to face or in person. Congressional Quarterly's Health Beat (July 19, 2005) quotes AARP's Cheryl Mathias as saying that the fundamental message will be "there is now going to be a prescription drug benefit in Medicare, but it's not automatic". The article also indicates that the original funding for the first TV ad was from the National Association of Chain Drug Stores, the Pharmaceutical Care Management Association (representing pharmacy benefit managers), AHIP and the US Chamber of Commerce.

- On July 25, 2005, USA Today ran "Medicare writing up one complicated prescription" by Richard Wolf. Using consumer education by federal and state officials in Maryland as an example, the article

focused on the challenges that exist in making the program understandable to beneficiaries and the fears that complexity could lead to adverse selection, with enrollees concentrated disproportionately among those with chronic conditions.

Special Populations

- Kaiser Commission on Medicaid and the Uninsured released an issue brief: "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003" by John Holahan and Arunabh Ghosh. The issue brief analyzes data relevant to the almost 7.5 million aged and disabled beneficiaries dually eligible for Medicare and Medicare. Using data from the Medicaid Statistical Information System (MSIS), the authors describe this population and their contribution to Medicaid expenditures by state in 2003. Nationwide, dual eligibles account for 14 percent of Medicaid enrollees and 58 percent of all aged/disabled eligibles. State spending for dual eligibles was $14,114 per capita in 2003 on average and in total it represented 40 percent of spending on state Medicaid programs. While only 19 percent of duals received institutional care, they accounted for 40 percent of all Medicaid spending for duals. The paper examines the fiscal implications for federal and state government of alternative ways of restructuring responsibilities for care of dual eligibles both overall and for the aged and disabled population.

- A story in the *Los Angeles Times* (Ricardo Alonso-Aaldivar, July 12, 2005) headlined "Drug Plan May Hurt Some It's Meant to Help" summarizes advocates concerns that the changes in Medicare under the MMA could hurt people with special needs who are jointly enrolled in Medicare and Medicaid. (www.latimes.com). The concerns relate to the need to choose among a variety of plans with diverse ways of structuring drug coverage versus the current MediCal program in California.

FROM OTHER STAKEHOLDERS

- On July 6, 2005, HealthMetrix Research issued a press release indicating that it had selected 13 Medicare health plans for overall best value based on their 2005 benefits and member cost-sharing. (http://biz.yahoo.com/prnews/050706/clw017.html?v=20). Alphabetically, these are: California Health Plan (Los Angeles), Fallon Community Health Plan (Boston/Springfield/Worcester), Group Health Plan (St. Louis), HealthAmerica (Pittsburgh), Health Plan of Nevada (Las Vegas), Humana (Atlanta, Kansas City), Mount Carment Health Plan (Columbus), Presbyterian Health Plan (Albuquerque), Quality Health Plan (Tampa), Touchstone Health Partnership (New York City), United Health Care (8 locations), Universal Health Care (Bradenton, Sarasota), and WellCare (8 locations).

- On July 6, 2005, UnitedHealth Group announced that it had signed an agreement to merge with PacifiCare (www.unitedhealthgroup.com/news/rel2005/0706PHS_print.htm; *America Healthline*, July 7, 2005). UnitedHealth Group executives said the merger would straighten their capabilities on the Pacific Coast and in western states and add the strength of PacifiCare's Secure Horizons brand and leading market position in Medicare. The merger is expected to be finalized in late 2005 or early 2006. In an *LA Times* article on the merger, firm executives say that the merger would increase competition and provide PacifiCare with technology to allow it to better compete with WellPoint, though some consumer advocates in California expressed concerns (*Los Angeles Times*, July 9, 2005). Jenkins of the *Wall Street Journal* (July 13, 2005) suggests that UnitedHealthGroup's key motivation was to build on PacifiCare's west coast Medicare HMO business before the MMA takes

effect.

- On July 14, 2005, Humana announced that it will offer a co-branded prescription drug card with Wal-Mart and Sam's Club in 46 states and the District of Columbia and will partner with Wal-Mart to inform seniors on the new drug benefit (www.humana.com/corporatecom/newsroom /releases/PR-News; *America Healthline*, July 14, 2005). The partnering involves all 3,600 Wal-Mart, Sam's Club and Neighborhood Market stores nationwide. Humana staff were to visit 500 of them (half in Florida, Texas, and Arizona) over the next 10 days (Prescription Drug Week) to answer questions and to educate beneficiaries on the new drug benefit. Representatives of the Social Security Administration also will be involved. Humana will continue to be available in select locations in August. Further description of the Florida context is included in a July 20, 2005 article by William E. Gibson and Diane C. Lade on "Drug plan providers push to attract Medicare patients" (www.sun-sentinel.com/news/nationworld/sfl-adrug20jul20,0,7660114,print.story)

- On July 14, 2005 *Medicare Advantage News* reported on "CMS Approves MA Products Through U.S., Intensifying Competition in 'Hot Spots' in '05." The article is based on information that *Medicare Advantage News*' publisher, Atlantic Information Services, received from CMS on 2005 approvals in response to a request following the June 30, 2005 press release indicating approval of 143 new MA plans in 2005. While much of the information discussed comes from the CMS Monthly Report whose content is summarized in this tracking report each month, the article discusses the additions by selected markets.

- On July 21, 2005, PacifiCare announced it would sell 5 different private-fee-for-service MA plans in 800 counties in 16 states starting September 1, 2005: Arizona, California, Georgia, Illinois, Indiana, Iowa, Kentucky, Michigan, Missouri, North Carolina, Oregon, Pennsylvania, South Carolina, Texas, Virginia and Washington (www.pacificare.com). CMS approval is pending for an additional 1,500 counties in 33 states. Each of the plans available will vary by county, but PacifiCare says in total there are 5 plans, including 3 with a $0 premium. All have co-payments for office visits to primary care physicians ranging from $5 to $12 and to specialists for $20 to $25. Enrollees can see any Medicare-eligible provider. The offerings are designed to complement PacifiCare's proposed freestanding drug plan to be offered in 2006. Press reports indicate that the other plans will have monthly premiums of $25 to $45 and that hospital costs would be $75 to $175 per day with full coverage after 7 days and a maximum $2,000 to $5,000 out-of-pocket cost—a feature that is not included in traditional Medicare (www.dailypress.com/business/local/dp-53785sy0jul21,1,6693828.story? ctrack=1&cset=true).

NEWLY RELEASED RESEARCH STUDIES NOT PREVIOUSLY DESCRIBED

- **Bruce Stuart, Becky A. Briesacher, Dennis G. Shea, Barbara Cooper, Fatima S. Baysac, and M. Rhona Limcangco "Riding the Rollercoaster: The Ups and Downs in Out-of-Pocket Spending under the Standard Medicare Drug Benefit" *Health Affairs* July/August 2005, pp. 1022-1031.**

  Using data from the 1998-2000 Medicare Current Beneficiary Survey, the authors project quarterly drug expenditures for those signing up for the Part D. They estimate that in the first year, 38 percent of enrollees will have expenses that fall in the "donut hole" and 14 percent will exceed the threshold of spending for catastrophic coverage. They show substantial variation in spending over the course of the year but also persistence in high spending on an annual basis over time. The projections are for

the subgroup of Medicare beneficiaries living in the community and estimated not to qualify for low-income assistance (incomes above 150 percent of poverty) and also not to have full-year employer sponsored drug coverage. This subgroup represents 40 percent of the sample. Among potential Part D enrollees defined this way, 39 percent now have no drug coverage. The paper includes tables that provide information on how characteristics and spending vary for potential Part D enrollees versus all Medicare beneficiaries in the community. Among potential Part D enrollees it also provides estimates that distinguish high spenders and those with catastrophic coverage from the group as a whole.

- **Robert E. Hurley, Bradley C. Strunk, and Joy M. Grossman. "Geography and Destiny: Local-market Perspectives on Developing Medicare Advantage Regional Plans"** ***Health Affairs*** **pp. 1014-1021, July/August 2005.**

  This paper presents analysis from interviews with health plan and hospital informants in 6 of the 12 Community Tracking Study (CTS) communities on key considerations in evaluating whether they can or will offer regional products under Medicare Advantage. The paper discusses challenges associated with entering markets not of their own choosing, the interplay of product and network developments, the uncertainties that relate to product costing and bid preparation which require "leaps of faith", and the implications for cost and care management. Based on the interviews, the authors indicate that the choice of 26 regions, most of which are single states, will bode well for selection including the way these relate to the Blue Cross-Blue Shield regions, but that discussions on local versus regional options and strategic postures of multi-product firms and other factors will also be important in decisions.

OTHER SIGNIFICANT EVENTS

- None