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MEDICARE FROM THE CONSUMER'S PERSPECTIVE

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Recorder: NANCY F. NELSON

- A representative from a senior citizen organization will discuss reaction to both indemnity Medicare Supplement policies and the recent Health Maintenance Organization (HMO) Medicare Risk Contracts.
- Representatives from an insurance company and an HMO will discuss how their organizations are addressing the needs of the Medicare Population.

MR. PAUL R. FLEISCHACKER: Over the last several years, there have been several major changes to the Medicare Program at the federal level. These changes have had a significant impact on the health care delivery system and on the structure and availability of Medicare supplement type products for the elderly. Predominant among these are the changes in government payments to hospitals from a cost basis to a prospective payment basis, and the introduction of TEFRA Risk contracts. There has also been a fairly significant volume of state legislation in the area of mandated benefits, and legislated plans

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which also have had an impact on the structure and availability of health products to the elderly.

MR. MITCHELL J. GOODSTEIN: My discussion will focus on Medicare risk contracts. Before moving into this primary topic, I would like to give you a brief overview of the other products available:

Medicare Products

- Indemnity Supplement
- HMO Supplement
- HMO Risk Contracts
- HMO Cost Contracts
- Health Care Prepayment Plan

A Health Care Prepayment Plan (HCPP) is a very unusual type of plan. I am mentioning it now because I will not be going into it later. It is essentially the same as an HMO Cost Contract, in that the Health Care Financing Administration (HCFA) will reimburse the HMO or the providers for their cost. It is not a risk contract; rather, it is a form of a cost contract. An HCPP relates to Medicare Part B only, and the cost contract covers both Part A and Part B.

Let me give you a few contrasts among the products. The indemnity supplements, which are most prevalent and with which you are most familiar, involve complete freedom of choice. In other words, a person who enrolls in the indemnity supplement plan may go to any provider, and any hospital, and will be covered under the plan. Under these policies there is usually some out-of-pocket cost for the subscriber. This is because the policy will only provide coverage up to the Medicare reasonable and customary level and will not go beyond that. Many physicians do not accept assignment, and the charges go well over the reasonable and customary level. Thus, the consumer can be subject to out-of-pocket charges. This is the system that is the least controlled. There is no utilization review system as exists in HMOs; there is no preadmission certification or any other thing along those lines. Thus, it has the highest cost.

I want to discuss cost with you in two senses. One of these senses is the cost to the consumer. What is the premium rate? The other one is the overall cost

of the Medicare program, that being what the insurance company is paying, plus what the government is paying. The indemnity plan has the highest cost in both areas.

The HMO supplement goes a step further in control. The beneficiary will only be covered by going to the providers within the HMO system. One of the key distinctions is that if the subscriber makes an error or consciously chooses to leave the HMO system and go to a nonaffiliated provider, he will still be covered to some degree. He will be covered by Medicare for the basic Part A and Part B coverage. However, the HMO will pay nothing. It is what I call an escape valve for the beneficiary. If the beneficiary decides he does not trust the specialist, doesn't like the HMO, etc., he can go outside of the HMO system and at least have some coverage. The other advantage for the HMO supplement coverage is that all the physicians in an HMO situation will typically accept assignment. Therefore, when a subscriber goes to the HMO physician, coverage is complete.

One of the contrasts between a typical HMO supplement and a Medicare risk contract is that, in the HMO Supplement, there is no contract between the HMO and HCFA. The contract is strictly between the HMO and the beneficiary. The government is not involved in the process.

In a risk contract, however, the HMO does contract directly with the government. The HMO is responsible for providing all care to the subscriber, not just the supplemental care. The government is out of the Medicare business once it has made the contract and has made its payment to the HMO. The HMO is now the Medicare intermediary and the provider for the services. This is the most controlled system. If you are outside of the system, there is no coverage at all. This is a very key issue for the consumer in the Medicare risk contract. Very often the consumer will not remember the rules of the system, may perhaps leave the system and for the first time, as a Medicare beneficiary, find out there is no coverage at all.

The Medicare risk contract is a relatively new phenomenon. Let me give you a very quick history of the contract. In 1978, the Federal government began contracting with select HMOs across the country for demonstration projects. If

you will, that was the guinea pig stage. They tried to work out the details and determine the potential problem areas in the system and how an HMO and the government would contract for care. The demonstration phase ended in 1982, when the TEFRA legislation enabled and authorized HCFA to enter into full risk contracts with HMOs. It wasn't until 1985 that regulations were issued, and during 1982 to 1985 only demonstration projects were in place. In January of 1985, the regulations were released and the contracting began.

We are looking, therefore, at a phenomenon that is really only about a year and a half old. During that year and a half, it has grown tremendously. Twenty-six risk contracts were involved in the demonstration phase. Thirty-five HMOs applied within the first eleven days after regulations were released in January of 1985. In January of 1986, the 100th contract signing celebration was held. I have a report that shows there were 137 HMOs with TEFRA contracts as of June 1986, and I understand as of today, (October 6, 1986) there are over 140 with an additional forty odd applications pending. I believe that almost three quarters of a million beneficiaries are being covered. That is just an incredible amount of growth for such a short amount of time.

In hearing about risk contracts, you may have heard discussion of HMO versus Competitive Medical Plans (CMP). For the most part, I consider the difference between an HMO and CMP (both of which can apply for a risk contract) to be the difference between a federally qualified HMO and a non-federally qualified HMO. If someone asked me for the simplest definition of a CMP, I would say it is an HMO that is not federally qualified. The only real exceptions to that definition are that the regulations are a bit looser, and a CMP can be a line of business for a carrier. Many of the Blue plans work that way. When a CMP is a line of business, it is not strictly a stand alone licensed HMO entity, but in every other way it will resemble an HMO that has not necessarily gone through the federal qualification process.

The benefits for the risk contracts are very rich. All of them cover the basic Medicare coverage; that is, both Part A and Part B services. All of them will waive the Part A and Part B deductibles, and there will not be any Part B coinsurance. A total of 30% of the contracts will cover preventive care, 80% will cover 365 days a year of hospital coverage, and a large majority have very

rich, extensive supplemental benefits. For example, prescriptions, which typically can cost anywhere from $10 to $25 a month, may be covered. We are looking at extremely comprehensive benefit packages over and above the Medicare package.

The way the HMO is paid by HCFA is through a capitation system. Again, I want to emphasize that the HMO is being capitated for all services, from first dollar cost and not as a supplement. The enrollee usually does pay a small premium, but there are several that pay no premium at all.

The mechanism for the capitation payment is called the Adjusted Average Per Capita Cost (AAPCC). The HCFA actuaries calculate the average cost for Part A and Part B separately for each county of the United States, and establish a specific payment rate for the year. The 1987 AAPCCs were released in September 1986 and have increased roughly 2% over the year before. The government saves money in the risk contract by reducing the AAPCC by 5%. It pays 95% of the average cost in the area to the HMO. The theory is that because the HMO is a managed health care system; it can do utilization review, can perhaps secure a discount from providers, and should be able to save at least the 5%. It is not a simple, flat payment; there are actually 120 different AAPCCs. They are adjusted by age, sex, welfare status, and institutional status for each beneficiary, and there are separate figures for Part A and for Part B. When the HMO receives its capitation check from the government, a complete listing of who is covered and their status is provided with the payment.

Therefore, when you are calculating your rates and doing projections to decide whether you do want a risk contract and at what price, you must try and figure out just what kind of demographic mix you'll get, i.e., how many institutional, how many non-institutional, etc. We found that it is relatively stable, although tricky, in that, when you look at the full published number, you must make absolutely sure not to trick yourself into thinking that number is the amount you will be paid. In fact, for Part A you usually receive about 85% of the published figure for the area, and for Part B you receive about 90%.

Of course, the HMO will try to market to a healthy population and try to skim the cream by going for the younger folks, even in the Medicare population. This will bring the age and sex mix of the covered population down and accordingly bring the payment down.

The HMO must compare the premium payment from the government (the AAPCC) to the Adjusted Community Rate (ACR). Essentially, the ACR is a projection of the HMOs cost of caring for the Medicare population.

There is a process which must be followed as part of the application. The ACR calculation must be approved by the HCFA actuaries. There are essentially three steps to the process. The HMO commercial rate charged for under 65 enrollees for the normal commercial package in the HMO is the starting point. The first adjustment is to change the price to reflect Medicare benefits instead of commercial benefits. That is, if I were marketing to an under 65 population and my benefits were the basic Part A and Part B benefits, what would my price be? You then make the appropriate downward adjustment. The biggest downward adjustment is allowing for the deductibles and the coinsurance under the Medicare program. The next step is to convert that under 65 rate to an over 65 rate, reflecting the higher frequency of services and complexity of services that are typically delivered to a Medicare population. These adjustments are called frequency/complexity factors.

In deciding whether or not to go for a risk contract, you basically have to compare the ACR with the AAPCC. The AAPCC is your premium, and the ACR is your expense. If the ACR is higher, the choice is obvious -- do not contract. I do not think it is obvious, however, that you should contract if the ACR is lower. Let's take as an example a situation when the ACR is equal to the AAPCC. That means you project that the payment from the government would be sufficient to cover your costs, but your costs would be for your basic Part A and Part B benefits. I think the marketing people would have difficulty trying to market a product like that, saying, "Please sign here -- it will cost you no money, you will have your regular Part A and Part B benefits, but, by the way, if you leave the system you have no coverage!" The HMO, of course, has to deliver something more than that. Therefore, the ACR not only must be less than your AAPCC, it has to be significantly less. What happens to the

difference when you do have an ACR less than the AAPCC? The government mandates one of two things: either you have to give the money to the government or you have to increase your benefits. I do not believe there is an HMO in the country that gave any money back to the government; they are all increasing their benefits.

The spread between the AAPCC and the ACR is the entire reason why an HMO enters into a risk contract. Essentially, when the HMO applies the savings from the payment for basic benefits to supplemental benefits, it is subsidizing the normal cost of the supplemental benefits with the payment from the government. The illustration below will demonstrate this:

Premium Calculation

Adjusted Community Rate	$180
AAPCC Payment	200
Difference	($ 20)
Additional Benefits	40
Allowed Premium to Enrollee	$ 20

The top line is the ACR; the HMO's projection of its cost. The second line is the payment from the government. The HMO is going to be able to produce the same set of benefits that the government normally does for $20 less. The additional benefits price added $40 to that. The $20 savings from the underlying benefits that is normally not seen is applied to the supplemental benefits. The HMO would charge the enrollee $20 for $40 worth of benefits. If the HMO did not have the risk contract, it would have to charge $40 in order to break even under the program.

Once the HMO has decided what its costs are and what the rate is; it decides on the price. "Cut the rate" is what is happening in the marketplace. The HMO will file its application with HCFA, calculate its ACR, calculate its AAPCC, and therefore calculate its rate, and then immediately cut it. The government really is using the ACR calculation to determine a maximum allowable amount for the HMO to charge. But, what is uniformly happening is that HMOs are cutting the rate. They may calculate $30 or $40 as their actual cost, and

go in with a $10 rate. The marketplace is becoming extraordinarily competitive. What I am not sure is whether it is being done in a rational business sense, or if it is what is called "lemmings to the sea," an attitude that if the other guy is charging $10 then they have to charge $10 also to make it in the marketplace.

The HMO management is then confronted with the issue of how to fund the shortfall once it has calculated the $30 cost and then marketed a $10 premium. Where I have usually seen it come from is the providers of the HMO. They will pay the hospital less, or the doctors less, or both. Mr. Fleischacker mentioned that I had a previous position as the president of an HMO. We were confronted with exactly this situation in our planning process. The HMO I worked for happened to be provider owned and provider governed. When it came down to the final meeting, I explained that the only way we would make it in the market was for the providers to earn less money. Low and behold, we did not cut the contract, and we went elsewhere.

Listed below is a typical profile of prices that the HMOs are charging:

Pricing Profile

$ 0.00	16%
$ 0.01 - $20.00	24%
$20.01 - $38.00	44%
$38.00 and above	16%

It is rather astounding to me that 16% of them are charging nothing, if you consider the benefit package I discussed before. All of them are covering the basic benefits, all of them are waiving the deductibles and coinsurance (which are worth $30 right there). Most of them are providing prescriptions, or eye care, or ear care, etc. We have found at TPF&C that when you are doing filings for HCFA, it is almost impossible to get away with a rate over $40. Somehow, the HCFA actuaries will beat you back down and make you charge something less than $40. So, whether they are willing to go through a price war or not, HCFA makes the prices for these risk contracts extremely low.

The government is pushing this program very hard. First of all, it is saving 5%. I'll say that's a theory, not necessarily a fact, because one of the things that has not been taken into account so far is selection. The various categories of age, sex and institutional status are not necessarily the best indicators for the health of the population under the risk contract. It is very possible that the HMOs are skimming some of the more healthy individuals.

The government is looking at changing the compensation system to have health status as an indicator. The health status over the two years prior to enrollment would be used to determine a factor to set the AAPCC adjustment upon joining the HMO. The government will therefore attempt to eliminate some of the selection problems. The government is obviously in a very strong, aggressive program to shift the risk of the Medicare program to the private sector.

In the HMO that I worked for, I said to the providers, "The government is not really interested in making the providers wealthy from these programs." In fact, what we all think is going to happen is that the government will ratchet that 95% payment down as far as it can until the HMO is charging a lower premium, giving the consumer a better benefit package but making sure that the HMO is not profiting too highly.

I believe there are demonstration projects underway now where the government is paying 85% instead of 95%. The ratcheting process has already begun. Another place where it occurred during this past year was the Gramm-Rudman Act. Once the HMOs began to receive the 95% payments, all of a sudden they were getting 99% of the 95%. One of the HMOs sued the federal government because there was a HCFA contract. The contract said, "We will perform these services, and this is the payment you will make," and then unilaterally the government cut those payments by 1%. The HMO won the suit, and the government is no longer reducing the AAPCC payments by 1%.

The employer based plan is another thing that may be coming down the road. Let me explain a little bit about what they are. Senator Durenburger recently introduced a bill in the Senate called the Medicare Voucher Bill. One of the features of that bill is providing for what is called employer based plans. Essentially, the risk contract process will be broadened in two areas if this

bill passes. For the insurance industry, you will not necessarily have to be an HMO, or even a CMP to enter a TEFRA Risk contract. The bill proposes to broaden the scope of the program to permit commercial indemnity carriers to go into the Medicare risk business. As another aspect, the employer based plan is being introduced. That is, the employer which is providing coverage for its retirees, again usually in a supplement package, will now be able to contract directly with HCFA. The employer will be able to provide the retiree the full scope of benefits, both the underlying Part A and Part B benefits and a supplemental benefit, with the employer being at risk.

I am a little concerned in that I don't know whether once the program goes in that direction if it will ever turn back. We may find the employer community in the United States responsible for the health care of all retirees, and the government may be very quickly getting itself out of the Medicare business.

Consumers are given the deal of the century based on the prices we looked at. They have super benefits and extremely aggressive prices. From that perspective, they are getting the best bang for the buck; better than any other possible supplement product that I have ever seen.

There are a lot of educational problems and other problems involved in taking a senior citizen and putting him into an HMO system. I consider the most important one to be no escape valves. Under the indemnity supplement plans or the HMO supplement plans, if the beneficiary left the system, he was still covered by Medicare. That's not necessarily the case in the HMO Risk Contract. The HMO will deny the claim except by administrative exception. I have seen the biggest problems in the 16% of the HMOs that charge no premium. The marketing force will go into the community and enroll people in the Medicare program. The HMO is delivering super benefits: no deductible, no coinsurance, perhaps prescription drugs, and will just ask the enrollee to sign an enrollment form. Six months later the beneficiary has a health episode. He will go to the emergency room, will go to his old doctor, etc., and he will just flat forget that he ever joined the HMO. He is not receiving a bill in the mail every month reminding him that he is a member of the plan. Yet, he still is, and the government is capitating the HMO instead of paying on the fee for service basis, and the claim is denied.

Another thing I have seen in zero dollar premium situations is that the insurance department will very often get contacted by potential enrollees within the state who are very suspicious. For example they might say, "These people want me to sign a piece of paper. It won't cost me any money, and they are going to give me all these benefits. What's wrong?" Where I came from in Arizona, it happened quite a bit. When the very first HMO opened its door and started its enrollment processes, the phone banks were just blinking everyday.

From the consumers' perspective, under Fallon's demonstration project (Fallon is one of the demonstration HMOs in Massachusetts), we have an extremely high satisfaction rate. The access to care problem, however, came out in the Fallon demonstration project. The provider system and the HMO did not properly anticipate the resource demands which this older population would place on the HMO system. Scheduling for physical exams virtually doubled, scheduling for refractions doubled, and scheduling for routine office visits quadrupled. If the HMO is going to contract, it not only has to be financially prepared, but also must make sure its provider system is prepared. The senior population will place three to four times the resource demand on the HMO system than the HMO is typically used to.

There is also a question in my mind about the overall viability of the risk contracting program. We have seen half a dozen HMOs pull out of the program in the last few months. They were losing money; one of them is bankrupt. I think we may also be seeing sharp price increases coming. We talked earlier about the dollar premium amounts, and I also mentioned that the AAPCC is going up 2% in 1987. Unless the HMO can manage its costs to an increase of 2% or is willing to discount even further, it is going to have a tremendously sharp increase in premium. It is even worse at the $0 premium level. For example, when you go from a bill of nothing to $12, it really impacts the consumer a great deal.

Quality control has also been an issue. We had pretty much of a disaster in Florida last year. Many have called the situation a "Medicare Mill," where an HMO risk contractor was enrolling people left and right, and building up thousands of enrollees, but did not have a system adequate to care for them, did not have a quality assurance program in place and ran into severe financial

trouble with many quality issue questions arising. It will be HCFA's job and Congress's job to make sure that the quality issues are addressed. We hope it will improve in the near future.

MR. JAMES P. HILFERTY*: Is a new AAPCC calculated each year?

MR. GOODSTEIN: A brand new AAPCC is calculated each year. I don't know if that really is a ratcheting process for the HMO, but the formula for the calculation of the AAPCC is based on a five year average. I think in the next couple of years, the AAPCC will continue to go up very slowly, or perhaps go down, because the effect of the DRG system on the Part A benefits is not in the five year average yet. This is just beginning to come into the five year average. If the government truly began to save a lot of money on the DRGs, the AAPCC will go down during a period when costs may go up.

MR. THOMAS R. AUVINEN: We've read in the trade press about many of the HMOs having financial problems with the TEFRA Risk contracts. What is the cause of the problems: is it poor pricing, or poor marketing?

MR. GOODSTEIN: I think the problems are caused basically by three things: the price is too low; the management was not prepared with the systems needed to care for the individuals; and the provider system was not ready. I am specifically thinking about the utilization review systems. Not only is there a greater resource demand on the system, but it is a different resource demand. Even when you estimate that there will be three or four times as much health care delivered, it affects each specialty differently. For example, pediatrics is not included in the equation, so it will impact internal medicine and surgery even more. The Medicare population is the most difficult population for which to control utilization, and frankly I don't think the HMOs were prepared.

MR. RONALD D. HAGEN: I have a few remarks to make about the whole issue of Medicare and Private Supplemental Insurance. I would like to segment these

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into a number of categories. First of all, I'd like to talk about the gaps in Medicare and what the individual Medicare beneficiaries' options are in filling those gaps. I will talk a little bit about what I term "Medicare Myths" and what the beneficiary population believes about the Medicare programs as far as the extent of coverage and the availability of coverage. Then, I'd like to talk a little bit about the Medicare TEFRA Contracts, the risk contracts, and the Cost Contracts. Again, we will look at some of the pluses and minuses that are involved in that approach to supplementing Medicare and providing the Medicare benefit package. Finally, I will talk a little bit about some of the problems that exist currently in the sale, marketing and delivery of Medigap type policies as well as the TEFRA Risk Contracts.

I think Mitch touched on something towards the end of his remarks that serves as a backdrop for what we are saying here, that is, the Medicare DRG reimbursement system used for hospitals. Our association recognizes that the implementation of a diagnostic related grouping (DRG) reimbursement system under the Medicare program has led to substantial fiscal savings for the Medicare program. The savings are due in part to reduced lengths of stays and reduced admissions. At the same time, the DRG system has led to the release of individuals in what we would term a quicker and sicker fashion, into what also can be turned into a no care zone. Typically, these individuals have chronic and disabling conditions, need recuperation and are without any kind of public or private insurance available to care for them once they are released from the hospital. Hospitals also are doing a less than admirable job in providing appropriate discharge planning and case management services.

What are the gaps in Medicare coverage, then? Clearly, the first and foremost, at least in the beneficiary's mind, is that strange Part A deductible. The deductible increased from $404 in 1985 to $492 in 1986, and according to our lobbyist, may be anywhere between $512 to $520 for calendar year 1987. Many people who buy Medicare supplement coverage, buy it on the basis of the fact that it picks up the Part A deductible, i.e., it is first dollar coverage.
Again, increases in the Part A deductible are due primarily to the DRG reimbursement system. This system has had the impact of ratcheting down the average length of stay and thus resulting in a higher per diem cost. The results of the activity on the Hill over the last couple of weeks seemingly

will change this formula and adjust to a per admission as opposed to a per diem basis, which should serve to at least stabilize the increase in the deductible over the coming years.

When we talk about DRGs, we are talking about some 84% of all acute care hospitals in this country being on a Prospective Payment System (PPS). It has had a very substantial impact: the average length of stay for PPS hospitals, is something like 7.6 days. It is stabilizing now. Admissions, at the same point in time, are down some 4.5%. In the last fiscal year (1985), there were about 11 million admissions of persons 65 and older. Admissions are down, the length of stay went down, and the average numbers of days of care are significantly less. Another gap is the coinsurance or cost sharing issue.

We have something called a participating physician program now. Physicians who agree to accept assignment are supposedly given certain other quick payment incentives to do so. Only about 29% of all physicians have agreed to accept assignment in all cases. The government has promised them a more quick and more appropriate indexing of their fees as a result. That is really yet to be seen. There will be another open enrollment period in November 1986, and we hope, as many others do, additional physicians will agree to sign up for this program. However, there is no indication this will necessarily be the case.

Charges above Medicare reasonable charge determinations, or so-called charge reductions, as well as Part B premiums, have also been increasing rather significantly. The Part B premium will be some $17.90 in 1987; an increase of almost 16% over 1986. It has increased over 100% since 1977. The annual Part B deductible (currently $75) represents approximately $100 of actual out-of-pocket costs since only Medicare allowable charges count towards meeting the deductible. The Medicare reduction is approximately 27% on average on each bill right now. Congress has also been messing around with the indexing of physician fees (the medical economic index), which should serve to further depress the increase in physician fees.

The Medicare allowable charges for which the individual beneficiary is responsible at coinsurance rates of 20% have increased more than 100% from 1980 to 1984.

We talked about charge reductions, the difference between actual charges and the Medicare reasonable charge determination. Some $6.9 billion was spent out-of-pocket by beneficiaries in fiscal year 1984. Some $8.6 billion will be spent in fiscal 1985. That averages out as about a 20% reduction in each bill. There is a substantial cost sharing liability to the beneficiary under the current system.

Services not covered by Medicare are obviously another substantial gap. Hospital stays in excess of 150 days (the last 60 days being the so called lifetime, onetime, reserve days) are not covered. Skilled nursing home stays in excess of 100 days are not covered, as are intermediate skilled nursing homes stays in non-Medicare approved facilities. Only about 24% of all nursing homes are Medicare certified. Also not covered are private duty nursing, drugs outside the hospital (unless they need to be administered by a physician), dental care, eye care, etc. The biggest gap is clearly in the area of custodial or personal care services, and long term care services for individuals who have chronic and disabling conditions. A total of 70% of Medicare beneficiaries have some sort of supplemental health insurance, either private indemnity type policies or some other kind of gap filling policy. Still, about 20 or 21% of all beneficiaries have no coverage other than Medicare. The balance is predominately individuals who are dually eligible for Medicare and Medicaid.

I will now address some of the myths of Medicare. AARP has done a lot of market survey research in the process of developing a series of long term care insurance plans that are now available to our members. We have about 5 million insureds in our group health program; it is a very substantial program for the association. Our current underwriter is the Prudential Insurance Company of America. Our program has grown rather significantly over the last three to four years.

Exhibit 1 indicates some of the Medicare myths. The exhibit shows that gaps exist in Medicare coverage, and it shows the perceptions that individuals have as to what Medicare and both group and individual private insurance cover. We looked at individuals who perceive themselves as needing some sort of nursing home or long term care services of a substantial nature (substantial defined as one month or more), and how you would pay for those services. As the exhibit

indicates, 79% of the individuals cited the Medicare program as picking up the custodial long term care and personal care service needs they might have. In fact, the Medicare program actually reimburses only about 1.8% of all nursing home services provided in this country (35 billion dollars in 1985). In fact, private insurance picks up only about 1% of those institutional expenses. About 50% of the individuals indicated that either their group plan at work or some other kind of Medigap or private insurance plan meet those expenses.

EXHIBIT 1

Percentage of Elderly Misperceiving
Who Pays for Nursing Home Care

Perceived Payer	Percent
Medicare	79%
Earnings/Savings	53
Private Insurance	50
Medicaid	17
Children	10
Relatives	2
Other	9
Don't Know	1
Total	221%*

* Exceeds 100% due to multiple responses.
Source: AARP/Gallup Long-Term Care Survey

We also have to keep in mind that about 36% to 37% of the total per capita health spending of the 65 and older population is out-of-pocket right now. About 20% of that is in the form of payments for private health insurance of one sort or another. We did some work with a consulting firm in Washington last year and considered that about 8.5% of all elderly households (65+ households) will incur some form of expense for long term nursing home care. Of those households, the average cost will be about $21,000 a year for that care. Our calculations show that long term care comprises almost half of the total out-of-pocket liability for health care services for elderly persons.

Other myths which exist are the amount which private policies will pay for long term care. About 35% of the respondents said that their current policy will pay for long term nursing home care. We examined those policies, and in every instance they did not pay for the long term custodial and personal care services that would truly be the financial burden that the family would have to bear.

As part of developing the long term care coverage, we have tried to put together an outline of coverage, almost a buyers guide, which would lay out the various services, including both home and community based care services, and the institution based services of the potential gaps. Listed on the left side of Exhibit 2 are the potential sources of payments. These include Medicare, Medicare supplement indemnity plans, and group and individual type coverage, both in the work place and available to retirees. Finally, at the bottom we have a little bit of a marketing pitch which talks about what the AARP Plan specifically picks up which the others don't. We have a major and very significant educational issue of what the private insurance market place currently covers and what Medicare's limitations and exclusions are with respect to Medicare, private health insurance and long term care.

One of the challenges and opportunities for AARP today is of having a major consumer education role and having a group health program with a significant number of individuals participating. Hopefully, we can test and develop products that will allow this kind of risk to be spread and allow people to make intelligent, informed decisions about this kind of coverage.

Other options for filling the gaps in Medicare include a whole series of hospital indemnity and limited benefit indemnity plans. These plans provide fixed dollar benefits. We provide a portfolio of this kind of plan. Every credit card company, every gas company, etc, provides one sort or another of this type of plan. These plans basically leave the individual unprotected against large medical bills, are widely advertised, and are easy to understand by the beneficiary. This is an attractive feature from their perspective. They are less inflation sensitive, and vary significantly with respect to limitations and exclusions. These variations include pre-existing exclusions

OPEN FORUM

EXHIBIT 2

KNOW YOUR HEALTH INSURANCE BENEFITS...

	Custodial Nursing Home Care	Intermediate Nursing Home Care	Skilled Nursing Home Care	Home Health Care
Medicare	$0	$0	In Medicare-approved institutions only -- 100% of eligible expenses for 20 days; all but $61.50/day for the next 80 days; nothing thereafter.	Medicare covers home health care ONLY IF it is part-time, intermittent skilled care, physical therapy or speech therapy... you are confined to your home ... and the provider is Medicare-participating.
Medicare Supplement Plans	$0	$0	Varies from nothing ($0) to the Medicare co-insurance from days 21-100, to a portion of the daily cost beyond the 100th day (for skilled care only).	$0
Group and Individual Health Insurance Plans	$0	Usually pays $0	May pay for very limited post-hospital convalescent care.	May pay for very limited post-hospital convalescent care.
AARP's Nursing Home & Home Health Care Plan	$40.00/day* for nursing home expenses for up to 3 full years, if necessary... a lifetime total of up to $43,800.00.			$25.00 for each Nurse or Therapist visit*; $20.00 for each Health Aide/Homemaker visit — up to 7 visits/week, 365 days in a lifetime, up to an additional $9,125.00

* Benefits begin after the combined total of days in a nursing home and home health care visits equals 90.

and other pricing structure variations. The only thing they really have in common is that they do have to meet the NAIC model for limited benefit plans.

We talked about the cost contracts and the risk contracts under the TEFRA legislation. Our association sees a number of significant advantages to beneficiaries of receiving a full range of health benefits through CMPs or HMOs.

1. Beneficiaries will have the ability to budget predictably for health care expenses.

2. Preventive health care services are provided: physical exams, health education programs, health/wellness life style programming, etc.

3. There is no Medicare assignment problem: the problem of significantly few physicians agreeing to accept the assignment at 100%. This is important because there is a significant cost reduction or differential growing between actual charges and Medicare allowable charges.

4. There are no claim forms or other paperwork burden which is a significant advantage.

5. It is hoped that improved coordination of services, case management assessment, and care coordination will be able to improve the quality as well as the availability of care that individuals receive. The one stop shopping idea does have some advantages in that regard.

6. Less time in the hospital is causing a quicker and sicker discharge kind of problem, but we also have the fact that the hospital is not exactly a healthy or safe place to be. Many of our members have a lot to learn in that regard and we are working on that.

7. Extra benefits reduce premiums; we talked about the difference between the adjustable community rate and the AAPCC. The fact that the differential must be returned to the beneficiary reduces premiums; cost sharing or increased benefits can be a substantial advantage to the beneficiary.

8. One of the traditional benefits or advantages of the HMO has been the ability to assure quality of care. I think that is under some scrutiny now, but we will question whether that is really happening under the current TEFRA risk contracts.

There are also disadvantages to the Risk Contract.

1. There is limited access to providers not affiliated with the HMO.

2. Out-of-area emergency coverage causes confusion.

3. In many cases, we are finding out that the product being delivered is not what the person thought he brought. This is not only a problem in HMOs; it is a problem in Medigap insurance limited benefit indemnity plans as well.

4. The use of physician extenders, physician assistants, and nurse practitioners is a problem. To what extent are people disappointed or confused or less than fully informed about the use of these people by HMOs in providing health care services?

5. Limited HMO locations could be another problem.

6. Limited experience with an older population, the lack of geriatric practitioners, and the lack of physicians with strong skills and experience in the differences that exist between an older and a younger population in delivery of health care services have had a substantial impact on the quality of care that is being provided. As an association, we are working with a number of HMOs around the country in providing some assistance in developing programming in this area.

Currently there are some 143 risk contracts with a little over 3/4 million enrollees. We are also looking at some 47 cost contracts that have been signed with about 103,000 enrollees. This is an area which we will continue to look at very closely. At AARP, we have already seen a number of significant problems starting to emerge. Quality assurance systems are a major issue. In

South Florida, the General Accounting Office just did a report on four major HMOs in the South Florida area that had risk contracts with the Department of Health and Human Services and HCFA. The quality assurance systems that were set up in those HMOs were lacking in many respects. This area needs increased attention and is something we should look at very closely.

With respect to payment of hospital bills, there was an issue of double reimbursement. This is an issue that needs to continue to be reviewed. We need to be sure that the carrier intermediary, at receipt of the capitation payment (including the payment for hospital services) doesn't turn right around and reimburse the individual for the same care that has been provided on an inpatient basis. Marketing practices need to be scrutinized, particularly with regard to prescreening. In South Florida, Medicare looks very closely at lab tests and other kinds of prescreening mechanisms, which in essence could be used to skim or cream the population. There was strong indication that there was a great deal of this activity going on, and that in fact the HMOs in Florida were getting a better than average risk in the Medicare population. This obviously leaves Medicare with a preponderance of the poorer risks.

Financial solvency is another important issue. One of the HMOs in Florida which has some 135,000 of the 750,000 risk contracted Medicare beneficiaries has had and continues to have major financial problems. The issue of financial solvency relates directly to the issue of continuity of coverage. Does the Medicare beneficiary population view these options as being here to stay, or are they a flash in the pan? Beneficiary attitudes will have a very significant impact on the extent to which risk contracting will continue to grow. For success, people must believe this is something that is real and here to stay, and not something the federal government is going to pull out in the next month or the next year.

Medicare has a requirement that no more than 50% of HMO enrollees can be Medicare and/or Medicaid beneficiaries. In one particular case in south Florida, that requirement was waived. This requirement is intended to be a protection for the Medicare beneficiaries, in other words, getting a broader spread of risks by having other than only the Medicare population involved in the HMO.

Biased selection continues to be a problem. Franchising or capitating care management responsibilities to individual providers presents a risk of under-providing services, and compromising the quality of care that is provided, and it also presents a number of financial solvency issues that must be addressed.

TEFRA risk contract "Pull-outs" are another issue. AARP was approached and is considering a situation where a particular HMO in the Chicago area has decided not to renew its TEFRA risk contract. This action leaves some 11,000 Medicare beneficiaries in the Chicago area without health insurance protection. This HMO has asked AARP, Blue Cross/Blue Shield, and I imagine other insurers to waive our pre-existing condition exclusion clause to allow those individuals into our programs. That would be the only limitation on our program since we are a community rated, open-enrollment, guaranteed issue type of plan. We are considering that right now, and are also considering the precedent which may be set for other HMOs terminating coverage. Waiving the preexisting exclusion clause may ignore the potential additional selection that might exist on that population versus the Medicare population as a whole. We will be making a decision very shortly as to whether we are going to do this or not. At the same time we are concerned about whether this is a sign of things to come, or whether this is an isolated instance. To sum up our stance on the TEFRA risk contracts, we are concerned about health policy direction at the federal level potentially compromising the true reform which exists by allowing the individual Medicare beneficiary to enroll in a TEFRA risk plan. Looking for fiscal savings by the continued ratcheting down of the AAPCC will compromise the ability of Medicare beneficiaries to utilize the many advantages of HMOs. This will very likely mean a reduced participation level.

Another issue we have looked at is the idea of geographic capitation. There are a number of areas around the country, where HCFA is looking at the idea of geographically capitating the Medicare program to a single insurer or entity of one sort or another. The most recent example of this is Maryland, with Blue Cross/Blue Shield of Maryland the provider under consideration. We have serious concerns about this relative to the bulk of the organization of the Medicare program. The potential is set up for ratcheting down the payment level and compromising this as a true option that Medicare beneficiaries might have. We also had some serious about concerns anti-trust and have expressed

those. My understanding is that this particular demonstration is not going to be going forward now. But, there are a number of other ones potentially in the works.

There are other private insurance options that potentially could fill the gaps for Medicare population as well as for the 50 plus population in general. The major medical issue is something that we've been enlightened to recently. We have had a number of our members calling and talking to us about the lack of a major medical product under our group health program. In response, we have developed a number of products. What we typically find in the marketplace are products with sizeable up-front deductibles. It is hard for the 65 plus population to buy and keep that kind of coverage. It is possibly inadvisable to begin with, but a pricing issue clearly exists applying to heavily underwritten products as well.

We looked at the fact that almost 38% of the 55 to 65 year old population is currently either uninsured or underinsured. This amounts to a group of about 12 million individuals, 4 million of whom are uninsured, and 8 million of whom are potentially either underinsured or inadequately insured.

We did some work in categorizing the calls we had received and finding out what people were specifically interested in whether it was an affordability or an availability problem. The reasons those people who already had coverage were looking were predominately related to price. Second, they were concerned about the coverage they currently had. About 25% of the folks were retiring and were interested in finding out what kinds of options they had to bridge them until they became eligible for Medicare. Among those without insurance, the reasons were predominately retirement related. About half the people were interested in finding out about coverage because they were retiring and did not have coverage available to them until they reached the Medicare eligibility age. About 38% of the people indicated that they had had coverage within the last 3 months. About 45% had not had coverage for 12 months or more.

We are looking at this whole area through our group health program to see if there are unique or different products that we can design which can possibly meet that need for our under 65 year old population.

The other potential gap filling coverage is a dread disease product. I think there are self-explanatory problems with this type of very limited benefit structure. In fact, several states have outlawed the availability of this kind of coverage. Nevertheless, it is purchased based upon fear, upon misperceptions and other concerns.

In closing, I think despite the Baucus legislation attempting at the federal level to legislate greater policy comparability, compatability, and standardization, and despite the passage by some 47 states of individual Baucus qualifying statutes, there still exists a wide degree of variation in the type of Medigap or indemnity type Medicare supplement plans that are available. The differences are in pre-existing condition exclusions, underwriting, deductibles, rating structure, prescription drugs benefits, and the availability of additional non-Medicare benefits. Skilled Nursing Facility (SNF) benefits also vary to the extent of whether the SNF copayment is available or not.

In AARP's survey, we looked at the various Blue Cross/Blue Shield plans around the country which we believe are our major competitor in the Medigap insurance area. We looked at a number of these categories of differences. As far as choice, 40% of the plans had only one policy available; 25% had three or more. A total of 40% of the Blue Cross/Blue Shield plans had no pre-existing exclusions; the other 60% ranged from six-month accident, six-month sickness to unlimited accident, six month sickness. Those plans had waiting periods. About 40% of the plans used medical underwriting questionnaires. About 81% of the plans covered the Part A deductible; 50% covered the entire Part B deductible. Some 84% of the plans picked up the Medicare copayment, and almost 80% stopped at 100 days of coverage. About half the plans had a prescription drug benefit, but the plans varied significantly with respect to maximums, deductibles, and copayments. Rating structures varied significantly. Sixteen of the plans had step rating versus community rating. In summary, there are still significant differences despite the efforts of the Baucus legislation to standardize and make policies more comparable and to make the decision among the currently available variety of Medigap type policies easier. There are significant regulatory differences between states. For example, in Minnesota and Connecticut, we have recently had some significant problems relative to

mandated benefits. These mandated benefits have had a substantial impact on our ability to make available the products in our group health portfolio.

There continue to be substantial problems in duplicative and overlapping coverages and policies. The felony provisions of the Baucus legislation with respect to individuals who knowingly sell duplicative or overlapping coverages, or who misrepresent certain coverages are not adequately enforced.

We found that some 36% of all the people that have Medicare supplement policies with our program have one or more other Medicare supplement plans. The perception is the more policies held, the better and more comprehensive the coverage.

It will be difficult to turn this perception around. Change must come from a number of directions, including the federal government via the Medicare program, consumer groups, and individual private insurers. Many plan variations and renewability variations are not understood very well by the beneficiary population, for example, the extent to which differences in renewability provisions impact loss ratios and the economic return on policies to the policyholder and the beneficiary. People are also looking at TEFRA cost and risk contracts with respect to financial stability and solvency. They are looking for ways to evaluate both the policy and the company providing the policy.

MR. ROBERT J. MYERS: I've seen hospitals that are advertising the old "waive the initial deductible and the co-insurance." I question whether this is legal or not. I also am a great believer in "There is no such thing as a free lunch." There must be something wrong somewhere; especially with these zero premium products that you mentioned. I wonder if these outfits are really giving good medical care, and I wonder if there is any way of determining whether they just run people in and give several real office visits or just give them a run through. How can you measure the quality of medical care?

MR. HAGEN: We are endeavoring to do certain things on Capitol Hill with some legislation relative to discharge planning, and with some of the quality assurance procedures and practices that the peer review organizations are involved in now. There have been legal opinions on the waiver of the Part

A deductible, and my understanding is that it is permissible. With respect to the Part B coinsurance, I believe there is contrary opinion and that the waiver of the Part B coinsurance is not permitted. I am not aware of any particular efforts to assess the quality of care that is being provided by those providers which waive these cost sharing requirements.

MR. GOODSTEIN: In the HMO industry, it has always been extremely difficult to try to measure quality. Probably, the most systematic way that HMOs have tended to measure quality is in the area of chart review. For instance, was the chart completed properly, was the information properly taken, was the diagnosis appropriate, etc? The other aspects of quality that have been checked are the access, i.e., how long is the waiting time, was the appointment in a timely fashion, were emergencies dealt with quickly? To me, these measures all seem to skirt the issue. No one has really come to a conclusion or a consensus on the proper way to measure quality.

MS. ANNE L. THIEL: I'd like to share with you how we in Minnesota are addressing the Medicare marketplace. The changes we have seen in the last few years such as the state legislated benefit levels and the TEFRA risk contracts have had a big impact for Blue Cross/Blue Shield in Minnesota, and for our affiliate, HMO Minnesota. The areas that I'd like to discuss are the legislative benefit programs and the results that we have seen of those, and the HMO risk contracts and how we have addressed that market in developing competitive products for both our HMO and Blue Cross/Blue Shield. Last, I'd like to briefly share some ideas we have for the future.

The reason behind the Baucus amendment in the early 1980s was to help control the Medicare supplement marketplace. Objectives included eliminating abuse, standardizing benefits, and allowing for good comparison of products between insurers. I think the best illustration to prove how ineffective that has been is to look at a plan we have in Minnesota. The state legislated the benefit program which required full benefits for hospital, physician services and 80% coverage of prescription drugs. The result of this full benefit program can be illustrated by the monthly rates that are charged for the program. While there is no variation in benefits at all, the monthly rates charged by various insurers range from $58 to $149 for exactly the same benefit program. I'm not

aware of any difference in underwriting criteria that can possibly result in this difference of rates. Further problems of confusion exist with the other benefit levels that are offered in this state. The state has four benefit levels, the first being the broad package described. The other plans have only minimum benefit levels. The result of this has been that the commercial insurers have put their standard benefit package into the market and labeled it with whatever number was appropriate. Therefore, while we may have a Plan II that has a mandated minimum level of benefits, the result is that each of the commercial insurers has put its own package in there, and there is no comparability of benefits. The senior citizens cannot possibly compare benefits effectively; the rates are as varied as those illustrated for the full benefit plan. That is what we saw in the early 1980s. Blue Cross/Blue Shield quickly addressed the market by developing products for the four benefit levels needed by the state programs.

In more recent years, we have had greater concern. As mentioned earlier in the program, there were 26 demonstration projects for HMO risk contracts that were developed in the early 1980s. In the Twin Cities, there were three HMOs that participated in the demonstration project. The result of this is that today about 50% of all of the people over 65 are currently enrolled in an HMO risk contract in the Twin Cities. At Blue Cross/Blue Shield this has had an impact in two ways: (1) We have lost enrollment, and (2) one of our concerns is that we are the Medicare Intermediary and are processing far fewer claims now than in past years.

In trying to address this market, this is the type of competition that we have seen. The rates for the different HMOs offered in the Twin Cities range from about $10 to approximately $30. Variations in benefits are attributed directly to the rates, for example, the rates in the $20s also include drug benefits. The prescriptions are only offered in the clinic setting of the staff model HMOs. These HMOs have enrolled about 40 - 43% of the total Medicare population in the Twin Cities. While this is throughout the Twin Cities right now, it is rapidly expanding statewide.

The momentum behind the rapid enrollment is largely due to the advertising used in the Twin Cities marketplace. If you have an opportunity to visit the Twin

Cities today, you can turn on the television and will see advertisements for all of the HMOs, both for under 65 year old plans and over 65 year old plans. You also will hear advertising on the radio, and see it on billboards all over town.

Examples of the advertisements in the Twin Cities Sunday newspapers follow:

1. An ad for the BC/BS HMO introducing its Medicare risk contract into the Duluth area.

2. An ad specifically addressing a particular market, for instance, the Federal Retirees.

3. An ad which points out some of the shortcomings in another HMO's risk contracts. For instance, an individual practice association model pointing out that under a competitors plan more paper must be filed.

4. Ads for specific benefits such as eye care.

5. Ads stressing quality of care.

6. Ads emphasizing freedom of choice.

When we as an organization addressed how we can be competitive in this market, the first thing we felt we needed to do was some market research. It is fairly obvious what our market research found:

1. Our Medicare population wanted payment in full for all hospital bills and all physician bills.

2. These people expected that they could retain their own physician. Because Minnesota has a high penetration of HMOs in our under 65 year old plans, as people age into Medicare, they are very likely to stay with the same HMO and enroll in that HMOs risk contract.

3. They expect low rates. This is evident by the $10 and $15 rates for the HMO risk contracts.

4. When we did an outstate comparison of other risk contracts or of Medicare eligibles, we found that the outstate people who had access to an HMO risk contract were more willing to pay the $30 and $50 a month that a typical Medicare supplement plan charges.

5. The people in the outstate area were far more aware of the benefits which were available to them.

6. They were all looking for long-term care. Of course, none of the programs in the state currently have long term care as part of their base program.

7. They were willing to pay for drug benefits, if not too expensive.

8. Finally, the senior population wanted to ensure that there was no paperwork involved to eliminate the confusion they had had with their Medicare supplement policies.

Based on this market research, our HMO and our Blue Cross/Blue Shield program looked at financial considerations in developing our programs. The first one is really the significant financial risk that can be undertaken. To give you an example, 25% of our HMO enrollment is in our HMO TEFRA risk contract for persons over 65. While only 25% of the enrollment, over half of the premium dollars and claims come from that population. That certainly was a consideration and added considerably to the financial risk of the plan for a very small portion of the enrollment.

One of our biggest concerns is that there can be no health underwriting under the HMO risk contracts. We were part of the demonstration project and under that program we could health underwrite. We had very good experience at that time, and our physicians made a great deal of money. The minute that the health underwriting criteria was lifted, we faced a far less healthy population, and we are now noticing that in our claims experience.

One other area is the federal government's control on the AAPCC, or the capitation. We have recognized that the federal government today and in the future will probably be controlling the capitation more tightly. In our metropolitan area, the capitation is very adequate. However, of greater concern, some of the regions in outstate, rural Minnesota have very inadequate capitation for the risk. In fact, we assume that the capitation is inadequate.

Our HMO did participate in the demonstration project and also currently has a TEFRA risk contract. I will share a little bit about what we have seen and some of the financial results. The benefit design is simple and is pretty standard. It provides 100% hospital coverage, and 100% of the physician bill is paid as long as care is given by the primary care physician. Referrals are paid at 100%; there is 80% coverage for out-of-area emergency services only. Emergency services are defined to be for life threatening conditions only.

To break even on this program, the provider arrangements require the designation of one primary care provider. This simply means that the member has to select a clinic or physician, and receive all of his care from that provider in order to receive payment in full or have coverage in full. We do capitate our program which means we shifted the risk to the physicians. This is working quite well in the Twin Cities. As I mentioned earlier, under the demonstration project we could health underwrite, and the results of that good selection of risk are still there. That is, the physicians are making money in the Twin Cities on their HMO risk contract. As we have moved outstate and also shifted the risk to the rural physicians, we are seeing real problems with utilization, and they are losing significant amounts of money.

Of course, to help protect the physicians, we do have stop losses under the capitation arrangement. That is, any claims over $20,000 or $50,000, e.g., will be the sole risk of the HMO and not of the physician.

We build in some financial incentives for utilization control. Only rarely do the physicians meet the utilization goals required to get back the withholding of the financial incentive. What we do is withhold 20% of all of the capitation dollars. If our plan breaks even as a whole, we will return the with-

holding to the physicians. Breaking even means that the out-of-area and some of the other risks assumed leave us in a positive position. Otherwise, we retain that portion of the withholding needed to break even.

Given these risk arrangements, we looked at how we could be more competitive and how we could establish competitive rates. One of our rating strategies is that we rate by region. We are the first HMO in the United States to do so. As I mentioned earlier, the capitation in certain rural areas is inadequate, especially when compared to the Twin Cities area. If we have a statewide program, that means we have to charge the same rate statewide. We recognized that (1) the capitation level was very low outstate in certain areas, and we (i.e., our physicians) could not get by with our $16 a month premium and come out financially, and (2) the competition was such in outstate Minnesota, where there are no HMOs, that we could in fact charge a far higher premium and still have people enroll in the plan. We moved to regional rating in 1986. We have 10 different rate levels throughout the state that recognize the different capitation levels. We have rates ranging all the way from $16 to $30, and we think that in 1987 we may have some risk contracts closer to the $40 premium rate per member per month.

All of the Blue Cross/Blue Shield programs and most of the commercial plans in our environment rate the over 65 population by age and sex. That is, the 65 to 69 year old rate is less than the 70 plus rate. In addition, women have a lower rate than men at this age. This is not possible under the HMO Risk contract; however, we can adjust our rates in each region for the age of the population actually enrolled.

As the other panelists mentioned, the HMO risk contracts do present some financial problems. The financial problems are largely due to utilization problems. In studying our data, we found a tremendous pent-up demand experienced in the first couple of months that a program is offered. In rural Minnesota, when the under 65 year old health care benefits have been low in the past, it seems that utilization increases dramatically as soon as the risk contract is introduced and full benefits are provided. It is not unusual for us to see about a 200% loss ratio for the physicians under their capitation in the first few months. We have also looked at elective surgery for that population in the first few

months. Cataract surgery and joint replacement are very common elective procedures that occur with extremely high frequency during the first four to six months.

Another item we have noticed with our risk contract is the age of the population. We don't have an explanation for it, but under the Blue Cross/Blue Shield Medicare Supplement, approximately 70% of the enrollment is under age 70. This is approximately true for all the other HMOs in our community as well. However, the HMO risk contracts in our environment have 70% of the enrollment over age 70. We have not figured out how to attract the younger population into the HMO contracts nor have we come up with the answer of why mainly persons over 70 are enrolling in the programs. Our only explanation is that persons 65 to 69 years old are still healthy enough to travel, and therefore need coverage throughout the United States.

Because there are some potential utilization problems, we have tried to develop a marketing strategy to minimize the selection against our program. Some of these are advertising strategies. We advertise in the paper as do the rest of the HMOs, and on television, radio, etc. However, we try to control selection problems, especially in the outstate area, by limiting our advertising to one month per year. That is, we want to expose our HMO only during one period of time, and thus we hope to minimize the adverse selection that goes on. We hope people don't wait until they need the HMO to enroll. We have enrollment meetings during that time period to encourage people to come and learn about the program. An advantage of requiring attendance at a meeting is that the ability to get out of their homes and physically attend the meeting may improve the odds of attracting healthy persons. We have also sponsored some other programs in the past. Minnesota is a very interesting state in that we have a lot of cultures. We have sponsored "proms," or formals in northern Minnesota and at the same time encouraged people to enroll in our program. The thought is that if they can dance, then they are probably healthy enough for us to want them. We have sponsored health fairs as another method for us to try to get a better selection of the population.

We do direct mailing, but we only direct mail to 65 year olds. We try to avoid direct mailing to 70 plus year olds because we recognize that that is where our

current market is and we would like to change that. Our physicians will also promote the HMO. Since they have a risk involved, it is certainly in their best interest to get the healthier population enrolled in the program. This is where our HMO has been; we are addressing the problems again for 1987. We are recognizing that the rapid expansion planned for our HMO TEFRA Risk contract may have to be put on hold temporarily until we have addressed the utilization problems of the risk contract.

That is one side of our business; the other is Blue Cross/Blue Shield. As I mentioned earlier, we have lost significant enrollment to the HMOs in the Medicare population as we have in the under 65 year old population. Also, as the Medicare intermediary, we are very concerned about the future of that part of our business. A total of 20% of our employees must be involved with Medicare claims processing. In the last year, we have tried to figure out how we as a plan can make payment in full, have worldwide coverage, have no risk except possibly for supplemental benefits, come up with rates that are competitive with the HMOs, have no paper work and yet have a program that will sell in the market place. I'd like to share with you what we think will solve all those problems: the product is called Senior Gold.

Senior Gold is another one of the product lines that we have identified by the name gold. I like to think of this more as a preferred provider product than as a strict indemnity program, although we are marketing it under the Blue Cross/Blue Shield indemnity name. The plan design is based around one of the legislated benefit programs.

The first thing we did was to say that the minimum standards within a program represent our non-network coverage. Then, we built a network of hospitals and physicians called Senior Gold. The benefits available are 100% inpatient if the network facility is utilized. If a non-network facility (a hospital that has not agreed to our contract) is used, then there is no payment of the inpatient deductible, and all that is paid is the Medicare allowance. In this case, the patient pays the $492 Part A deductible. We determined that it was important to have 100% coverage for medical emergencies, just as in the case of the HMOs. Since we are dealing primarily with the Minnesota population, we wanted worldwide coverage (not limited as in the HMO) as one of our largest

selling points. We will pick up all of the inpatient deductible for any hospital facility that is more than 50 miles from the state border. In summary, the hospital benefit provides the full benefit within the network or out-of-state; and for non-network facilities in Minnesota, there is no coverage for the inpatient deductible. The physician's side pays 100% of the bill for network physicians. If a non-network physician is used, we pay the 20% that the Medicare does not pay under the Medicare allowance and also the deductible. The latter part of the non-network bill represents about 70 to 75% of the patient's bill. Again, we are providing a financial incentive to use the network providers.

As noted earlier, our market research indicated that members in the 65 plus population want to have drug coverage. In addition, since the HMOs paid for physicals, we have put a $100 per year physical exam benefit into our high option program.

Now, we have a full benefit program within the network for both hospital and physician, and yet we still want to remain competitive with the HMOs. We think we have done this with our provider agreements. What we offered to our contracting facilities was that we would pay $200 of the $492 Part A deductible and the facility would waive the other $292. This was very well accepted in the Twin Cities area. For 1987, we will again pay $200 of the $500 plus deductible, and the hospital will assume the balance. This has worked well in the Twin Cities because waiving the $292 in 1986 really represented only about 3% or 4% of the total reimbursement that the hospitals would receive on a per case basis.

However, outstate Minnesota was another problem. One of the problems we continue to hear about with the DRG payment system is that, in the rural areas, the DRGs are inadequate. In fact, we found that by requesting rural hospitals to waive $292 of the $492 deductible, in most cases we were in effect expecting waiver of about 12% of the total reimbursement that the hospital would receive. Asking the hospital to waive 12% on a case it feels is being inadequately reimbursed in the first place was a real concern. In order to get rural hospitals to participate, we agreed to limit the deductible to 6% of their total DRG reimbursement. This means that if on an average the hospitals

receive $2,000 per case including our deductible payment, then the most that they will have to waive is 6% of that or $120 dollars.

The mechanics for the outstate hospitals work in the following way:

1. On an interim basis we pay the hospital $200 of the $492 Part A deductible.

2. At year end we sum the DRG payment for patients enrolled in Senior Gold including the $200 dollars.

3. The $292 is added in per patient to the amount already calculated, and the percentage of the total it represents is calculated.

4. If the $292 waived is more than 6%, we then pay the difference between the actual amount and the 6% amount to the provider.

Rural hospitals also have many transfer patients who are in for only one or two days. Those initial days are the expensive days with all of the testing, and precede transfer to another facility. Since the rural hospital only receives a per diem in this situation, we waived the deductible on transfer cases. The end result of this provider agreement meant that we are going to be paying very little to Twin Cities hospitals, but in outstate hospitals we will be reimbursing a high percentage of the inpatient deductible.

On the physicians' side, we asked them to accept 80% of the Blue Cross/Blue Shield usual and customary payment as payment in full. We also asked them to submit claims directly to us. Submission of claims directly to us by the providers results in absolutely no paper work for the individual. We have contracted with Prescription Card Service (PCS) to handle all of the drug claims. The pharmacists file for reimbursement directly with PCS.

On the physicians' side, we have done something unique. It is called the indirect payment method. We agreed with the federal government that this would be an acceptable alternative for us. What it simply means is that the physician bills BC/BS for all of the claims; we then process the claims and pay

the physician 80% of the BC/BS usual and customary. That amount is payment in full. The next step is that Blue Cross/Blue Shield files with the Medicare intermediary. This is ourselves in most cases. In turn, we are reimbursed by Medicare. The end result of this is that the payment to the physician is one payment; the member has absolutely no involvement in the program; and there is no paperwork for the member as long as the providers within the network are utilized.

We wanted to have competitive rates, and competitive rates meant that we wanted a program that paid in full for both the hospital and the physician and still produced rates about the same level as the risk contracts,i.e., in the range of $17 to $18 per month. How are we doing this? We health underwrite all of our programs. We currently health underwrite our over 65 year old population, and we are also doing it in this program. By doing this, we are assuring that we have the better risk selection going to Blue Cross/Blue Shield and are taking it away from the HMOs.

For the first time ever, we are developing different rates for our conversion business. In the past, we have had one rate for health underwritten business and used the same rate for conversion business. This is not realistic, but since we had the best rates in the market, at the time it was advisable. However, since at this point in time we want to have the most competitive rates, the conversion rates will be higher than the health underwritten rates.

We are also going to rate by area. The rates in the Twin Cities are going to be less than the rates for outstate Minnesota, even though the health care costs in outstate Minnesota are less. The reason for this is two-fold. All of the Twin Cities hospitals have agreed to accept only $200 of the inpatient Part A deductible. Outstate, you will remember, we have agreed to limit their liability to 6% of their to[illegible] reimbursement. The other thing that we had found was a difference in the Medicare fee profiles. The Medicare fee profile used in the Twin Cities is about 78% of the BC/BS usual and customary schedule, and we are going to pay 80% under our program. Therefore, we have minimal risk of reimbursement to the physicians in the Twin Cities; i.e., the difference between the Medicare profile and ours is small. However, in outstate Minnesota the Medicare profile was only about 65% of the BC/BS usual and customary

profile, and we have agreed to reimburse at 80% of our usual and customary fee schedule. We are going to be paying the outstate physicians relatively more than the Twin Cities physicians. The end result is that we have very competitive rates in the Twin Cities. The rates outstate where the competition does not exist are about 40% higher.

Our underwriting process also had to be reviewed. While we do health underwrite, it has to be in a modified form. There certainly aren't many people over 65 that have not experienced some type of health problem. However, we do not want to guarantee issue any programs and would like to eliminate all of the catastrophic cases. We ask about six questions on our health applications. The objective is to find out what types of catastrophic illnesses they have, and if necessary, we will reject those individuals. We do not add riders to the contracts or exclude specific diseases for this population as it is too confusing to the members. If we feel we cannot assume the risk of some existing illness, then we offer them a lower benefit program instead.

The end result of modifying our health underwriting and eliminating all catastrophic illnesses is that we write about 70% of the business. To us, that is a very satisfactory acceptance ratio.

We have two plan options, one with drugs and one without. One of the questions on the health application is the number of prescriptions taken yearly. We have rated for about 18 prescriptions per member per year. If a member comes in who is currently not taking any drugs, and his health conditions do not indicate he will be taking any drugs, then we offer the drug benefit. If someone is a diabetic and is currently taking high blood pressure medicine and insulin on a daily basis, then he is already over our rating limit. Therefore, he would not be offered the drug coverage option.

We are providing selection towards ourselves in trying to assure that we have the best population covered under our program. Our marketing strategy is that we look at the HMO risk contract and the BC/BS programs to identify which of our products makes the most sense in which marketplace. In each rural area, we consider the capitation available. If the capitation is adequate, we will probably offer our HMO risk contract to the physicians. If we anticipate that

the physicians cannot possibly come out ahead financially in a rural area, then we are more likely to push Senior Gold as a good alternative plan for that area.

We have joined the rest of the HMOs in advertising. Our over 65 year old plans are advertised on television and in the newspaper just as the HMOs do. We have hired Betty White to represent our Senior Gold program. The slogan is "When you're doing 65 or better."

The Senior Gold plan is a plan that BC/BS has designed. It was just introduced in July 1986. We believe it probably will be one of the more effective programs both to compete with the HMO marketplace and to minimize our risk.

We are looking at future developments along with all the commercial carriers. One important area is the long term care insurance market. Most of the programs currently available for long term care are indemnity plans; they pay a fixed amount such as $40 or $50 per day. We are taking the approach of having a managed care plan because of our ability to contract with a limited number of facilities. It will provide payment in full for a limited number of facilities. We only have one problem with that, which is called portability. We are not contracting with any facilities in the Sun Belt, and yet we recognize that is where many of the claims will be incurred. We are working with other BC/BS plans to come up with a method of contracting and managing care in the southern states.

The employer-at-risk programs were mentioned earlier. In these programs, BC/BS would administer a risk contract where the employer would put all of its retirees on the plan. We are considering this as a potential option. In this situation we would again face no risk.

Another area to consider for the future is other services. Before coming here, I called some other BC/BS plans. They are still largely involved with the standard Medicare supplement programs and with the HMO risk contracts. They are looking at associations such as AARP and the other benefits offered through them. I found it quite interesting that one of the California Blue Cross/Blue Shield plans is using its I.D. card almost like a credit card. For example, if

you go to certain travel agencies, there is a discount provided because you are carrying your BC/BS card.

Another California BC/BS idea that was interesting was to advertise service stations or garages as hospitals for your cars, with mechanics as the physicians to your car. These garages have agreed to a 10 to 15% discount to people who are carrying the Blue Cross/Blue Shield I.D. card.

There evidently is a great deal of diversification not only in plans but in concepts of how to buy the market place. I have shared with you how we in Minnesota are trying to address this very competitive market. Certainly in the next few years we expect it to remain competitive, and we are moving quickly with many new product developments and ideas.

MR. WILLIAM J. BUGG, JR.: *Consider an individual who joins an HMO which has a service contract. Is that individual tied to that HMO for life, or does he have an option to change once a year?*

MR. GOODSTEIN: Members certainly can opt out of the HMO. What I meant by the escape valve was that the coverage would be provided if they did not use the HMO providers. The contrast is under a classic Medicare supplement or even an HMO supplement plan. If the patient decides to use a non-contracted, non-HMO provider he will still receive some coverage in that the Medicare program will still pay for the basic benefits. If however, patients are under a risk contract and they go outside of the HMO system, they will receive no coverage at all, including no coverage from the basic Medicare benefits. Certainly they do have the ability to opt out of the Medicare risk contract. I think it requires about 30 days notice to go out of the program. It is a little tougher for the HMO, which has an annual contract.

MR. HILFERTY: Why would BC/BS limit enrollment to one month per year? What does that do competitively?

MS. THIEL: In areas like the Twin Cities where there is competition at all times, we do not limit our advertising and enrollment to one month per year; it is continuous. However, in outstate areas, where we are the only HMO offering

in the town, we recognize there may be some real adverse selection with people joining only the month before they need services. That is why we try to emphasize a one month enrollment or education period in order to enroll as much of the population as possible. It is also practical from a logistic standpoint, since there is a lot of education involved with an HMO risk contract. For example, people must understand the details of selecting a physician and the benefit limitations. Holding enrollment and information meetings is a real resource strain which is another reason to limit the enrollment period.