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Medical Products for Medicare Beneficiaries

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Summary: Panelists present current developments in both Medicare risk programs and Medicare supplement products. The Medicare risk discussion includes identification of critical success factors, comments on risk selection, marketing considerations, and anticipated future developments. The Medicare supplement presentation includes comments on implementation of minimum loss-ratio provisions, preferred portfolio designs, distribution alternatives, and product outlook.

Ms. Jean M. Wodarczyk: David Wille is going to talk about Medicare risk products and his experiences with them, including selection issues, what plans can do in response to selection, marketing topics, and the spillover effects of Medicare risk products on the balance of the business. Donna Novak will be our second speaker, and she will be addressing Medicare reform issues and how these might affect products. I will speak on customers and their view of managed Medicare as well as the Medicare products that are available.

While many of us work on the development of products, pricing, reserving, and working with employers on Medicare risk products, there's another side, a personal side, to Medicare products and Medicare developments. If you're like me, you're getting older and you're facing the looming Medicare scenario for yourself. We

have elderly parents that are ever increasingly distraught about their health care programs and offerings and managing their health care as part of their day-to-day life.

What I'd like to do is share some of the experience I have had over the last couple of years with both my parents and my in-laws. My mother-in-law and father-in-law were born in 1919 and 1918. They've been struggling more and more with health care issues as they age. They live in the Mecca of Medicare products, Phoenix, Arizona, so the offerings have been increasing in that particular area. They're covered by a union retiree medical plan, and it has become more expensive for them over the years. The first call I got went something like this: "What do you know about these new health plans, you know, health maintenance organizations? They don't let you go to your own doctor, do they?" These folks were very negative about HMOs and managed care and anything that was different. We talked through the issues: how important is your doctor, what has he been doing for you, what are your concerns? We looked at the HMO offerings that were being publicized, and their doctor was not a part of that network. So they decided that this was something they didn't want to have any part of that year.

A year later their premium went up, and I got my next phone call. They asked, "Do you know how much those HMOs cost? They pay for prescription drugs, but I hear you don't get very good service." Again, they were negative, but the cost issue was beginning to drive them to look at health care from a cost perspective. For the second time, we looked at the options, and they decided not to move to the HMO that year.

The next year I got yet another call, and it was "We're changing to that HMO. You know, we're now each paying $120 per month and that's with the union plan. The HMO will charge $16 each." And so they made the switch, but they were nervous about it. They hadn't called me to talk about the doctor situation. I think we talked about it so much that they were uncomfortable admitting that they were willing to switch after all that discussion.

The next year, which was just this spring, they had actually rationalized their decision: "That new doctor is closer, and do you know what? He checked all my prescriptions. I was using the same prescription drugs for the last 20 years, and that can't be right, can it? This new doctor is reassessing my medical care." I don't know whether my in-laws have better care, but I do know they're rationalizing by concentrating on the positive aspects of the decision.

Now, my parents are a little bit younger. They were born in 1922 and 1924. They've retired in another retirement area, Hot Springs, Arkansas, which is not as

popular as Phoenix. They are also covered by an employer retiree medical plan that is increasing in cost. This year I got that first call again. My mom called and said, "What do you know about HMOs? You don't get to use your own doctor, do you?" I can see the pattern's going to happen all over again in their area. I don't know whether the scenario is the same or different. When you're facing these issues with your own parents, be supportive, help them through the decision-making process, and assess, as you would for yourself, the offerings and their concerns. The biggest challenge is to help them through change. I think change in health care is going to be a continuing saga for the elderly, and one that they find very difficult to deal with. So with that I'm going to turn it over to David to talk about some of the more actuarial issues associated with product design and development.

Mr. David W. Wille: I'm going to start with a quote from one of our salespeople. He said, "Complex ratio formulas are not easily presented to customers even though algorithms that employ change of natural log expressions may make an actuary's heart flutter."

Isn't that great? That's what we're doing—making the actuaries' hearts flutter. I have an issue here that should make some actuaries sit up and take notice—the issue of risk selection and risk segmentation with Medicare risk offerings.

Medicare risk products are funded by the Health Care Financing Administration (HCFA). HCFA pays the Medicare risk plans 95% of its estimate of what the cost would have been in the fee-for-service sector. That figure is called the adjusted average per capita cost (AAPCC). HCFA wants to take its 5% savings off the top and let the Medicare risk plans live with reduced income. What happens if the people enrolled in the HMOs do not have typical risk characteristics? It could go either way. If the plans enroll too many people who are in good health, they will be overpaid. If the plans enroll too many people in poor health, they will be underpaid because the people in the HMO are not the same as those assumed in the overall average that HCFA uses in determining the AAPCC. There are two different enrollment outcomes and two schools of thought regarding selection within each of the outcomes.

One theory states if someone is in poor health and a high user of medical care, they'd want to buy Medicare risk in order to get the extra benefits: the extra drugs or the extra coverage, the co-payments, etc., which would be something on top of what they normally would have had. There's another theory that states if people are under active treatment with a particular doctor, they will resist changing to an HMO plan because they'd have to change doctors and upset their current treatment. Based on the second theory, the HMOs would attract the people in better health.

You could argue it either way, but perhaps the better solution is to measure costs and see what actually happens.

Some of the earlier researchers attacking this issue looked at prior use. The first study looked at what the fee-for-service Medicare benefits paid in the year prior to enrolling in a Medicare risk plan. Based on this study, it was fairly clear that the people in better health were enrolling in Medicare risk plans. There was a difference, but that study did not really answer the question because it goes back only to this prior year. Over a period of time, you'd expect the selection to wear off and regress back to the mean. After some time, maybe the risk would even out. So what you really want to do is look at the health status of people enrolled right now in Medicare risk plans and compare their health status to that of a comparable fee-for-service population. That's exactly what Mathematica did on behalf of HCFA.

The Mathematica Policy Research Company did a study in 1992. They conducted telephone interviews with Medicare risk and fee-for-service beneficiaries in the same locations. They asked questions on health status, prior use of medical care, self-evaluation, activities of daily living, and several other questions in order to classify people. The conclusion from Mathematica was that the Medicare risk plans enrolled people in better health. Again, the Medicare risk plans are overpaid based on the people that they have enrolled.

While the Mathematica study seems to be a valid study, there was a study that went in the other direction. Price Waterhouse did a study in 1996 that came to the opposite conclusion. This study found that the health status of Medicare risk beneficiaries was very close to fee-for-service beneficiaries' health status. However, that study relied on a small sample size, and it had some other problems. For these reasons, nobody really believed it. What's most important is that government regulators didn't believe it either, giving the study little credibility. It seems like the earlier study from Mathematica made a valid point—Medicare risk plans are enrolling people in better health.

What should plans do about it? What action should the government take? A solution came up in the President's Budget that was submitted earlier this year. One proposal was to cut Medicare risk funding from 95% of estimated fee-for-service costs to 90% by the year 2000, a kind of rough way to bring it back in balance. The proposal has been removed from the bill at this point, but it may come back again. It's really not the best way to do it. It just makes an arbitrary cut for every Medicare risk plan regardless of risk selection. It's better to actually measure risk selection or risk factors and cut reimbursement only if plans actually enroll people in better health. This is a way that's more fair to the government and

more fair to the HMOs. That's why we need more research on risk adjustment and more precise risk adjustment methods.

There are a couple of ways to get there. There's the diagnostic cost group, the ambulatory cost group, and the SOA risk adjustment studies and review, but we have a long way to go. There's more research to do before a practical risk adjustment method is found that will work.

So the way to address risk selection is to bring costs down to an even level. Just get Medicare risk funded on the same basis as fee-for-service Medicare. I believe you don't have to bring Medicare risk down lower than fee-for-service Medicare because even if they're just equal, the government saves. The savings come from another area—the spillover effect. The spillover effect refers to physician practice patterns in both fee-for-service and Medicare risk plans that are changing due to enrollment in Medicare risk plans. When doctors belong to Medicare risk plans, they become more accountable for the quality of care and the cost of care. They are more judicious in their use of care and think of the cost of care, resulting in a change in the practice of medical care that spills over into their fee-for-service practice. They do things a different way. They do it for all their patients, and it has an impact on the rest of the business. So that's the theory. We should measure it, so we can determine if this actually happens. Is it true that there's a spillover effect?

Next, I'll talk about four different studies that took place at different times; however, they all look at the same issue and come to the same conclusion that, yes, there is such a thing as a spillover effect. The first one refers to HCFA's AAPCC numbers that are used for Medicare risk reimbursement. It shows, in the top 20 metropolitan areas from 1992 to 1996, that the areas with high Medicare risk penetration experienced a 7.3% annual compound growth in fee-for-service Medicare costs. Those areas with low Medicare risk penetration experienced 9.1% annual compound growth in fee-for-service costs. The difference is a major savings to the government. It's enough to make a difference, and it certainly shows this correlation between Medicare risk enrollment and reduced fee-for-service cost.

The second study was done by Pete Welch of the Urban Institute in 1991. This study showed that 10% growth in the HMO market share would decrease fee-for-service costs 1.2% in the short run and as much as 3.9% in the long run; once again, we come to the same conclusion.

The third study was done by Darrell Gasgan and Jack Hadley of Georgetown University. It was published in July 1995 and was entitled *The Impact of HMO Penetration on Hospital Cost Inflation*. They studied hospital costs in fee-for-service Medicare, in particular, inflation from 1984 to 1991. They found that in areas with

high Medicare risk penetration, the growth of fee-for-service hospital costs was 8.26% per year, and areas with low Medicare risk penetration experienced a growth of 11.2% per year. Once again, we come to the same conclusion and see the same kind of spillover effect onto fee-for-service Medicare.

The fourth study is by Dr. Laurence Baker of Stanford University. It was entitled *Can Managed Care Control Health Care Costs? Evidence from the Medical Experience*. This was written for the Institute for Health Care Management in June 1995. This study shows that a 10% increase in HMO market share is associated with a 1.8% decrease in fee-for-service Part A expenditures. It also shows a 0.8% decrease in fee-for-service Part B expenditures. So we again see the same conclusion.

Now that we understand how the government saves on the spillover effect and comes out ahead, this understanding should drive the shape of the government policies. If the Medicare risk program is a good program and it benefits society and the government, we need to market it more. There should be a government policy to encourage marketing. There are a few marketing issues that I wanted to go through. I'll explain some of the things that are important to us, at least in terms of marketing Medicare risk.

As an introduction, Humana has 374,000 Medicare risk members right now. We offer the program in 15 markets across the country, but most of the business is in Florida, Texas, Arizona, and Illinois.

We do marketing through full-time agents. We have full-time Humana employees who learn the business and do nothing but market Medicare risk. They get leads mainly through telemarketing, but there are other sources as well. After they get a lead, they visit with the seniors, explain the program, answer their questions, tell them about the program, and bring in new business. They market this on a year-round basis.

One of the laws that has been proposed and is in several draft bills before Congress is an annual open enrollment petition. These bills say there ought to be a fixed period of time, for example a 30-day period per year, during which people can enroll in one of the Medicare risk plans. Or it could be the 30 days around their birthday, but in any case it is a fixed period and it is the only time people can come in. The reason for doing this is to stabilize the enrollment period and make it more standardized. But I feel it is the wrong thing to do mainly from a marketing perspective. First, it will reduce enrollment in the Medicare risk plan. If people can join during only one month a year, marketing efforts will be less productive. The second reason it is wrong is because it gives poor service to seniors. The seniors

may have many questions like, “What is an HMO, what is it all about, or what do I have to do when I join an HMO?” They may want to check into it, talk to people who have been there before, and get many questions answered. These may be people who never had access to an HMO when they were actively employed. Well, it's all new to them, and you may have to go through several questions and several discussions with people before they're ready to sign up. You can't do that if there is only a 30-day enrollment period. You have the pressure to either join or not join, and that's probably not what the senior wants. They want to have their questions answered, and when they're ready to make the move, they will.

Ms. Wodarczyk: It takes a while.

Mr. Wille: Another reason it serves the seniors poorly is because their situation may change. For any number of reasons their financial situation may get worse, and they might not be able to afford the Medicare supplement premium anymore. There have been several studies that have looked at who buys Medicare risk and who is enrolled. There are more low-income people enrolled in Medicare risk compared to the fee-for-service population, so one’s financial situation is an issue. It does make a difference who buys this plan. The third reason is that these annual open enrollment rules will remove the agents from the picture. If there's only one month per year to enroll, there is no need for a full-time agent. Do you care if the agents are involved? Well, I think we should care because the agents do bring some value to the picture. They have the personal contact, explain things, answer questions, want to talk to people, and bring value to the health plan. It serves the seniors better if agents are involved.

There's another issue that has been coming up that also causes problems. One of the proposals in several bills is to have a lock-in. Once people are enrolled in Medicare risk they have to stay. They can't disenroll for a one-year period or for some other fixed period. The reasoning behind this is because it makes the program more stable. You could argue that it's better for the HMO to know who's in, whether enrollees will stay, and that they will be a more stable population. It's better for fee-for-service because it's more stable. You don't have them moving in and out. There's an advantage on that side. Overall, I think a time restriction on enrollment is a powerful sales barrier. If you tell someone, “It's a great program, we think you'll like it, but once you enroll you're stuck and you can't get out for a year,” it will be much harder to make the sale. They've created a big barrier to getting the sale in the first place. I think it would be a mistake to pass this kind of bill.

The third restriction on marketing is HCFA’s review of advertising, which is nothing new. We've been doing this for years. We have to submit the ads for prior

approval before they are allowed to run. One of the things that came up recently is a restriction on advertising drugs. HCFA says if you say anything at all about drug benefits, then you must list all the exclusions, all the restrictions, and all the details on drugs. That can create a great deal of paper. You end up with a huge ad or very tiny print, which defeats the purpose of having an ad. There's a better way to do it, and that's to keep the advertising direct without too many words. It should just generate enough interest to get people to ask questions so they will call back to ask more. Then an agent can give a full risk description. So it's important to remove some of these HCFA restrictions and let the marketing go forward.

I guess that covers the marketing side. I'm going to switch to a different topic now because we also wanted to cover Medicare supplements. I just have a few short comments on the Medicare supplement business. Humana writes Medicare supplement as well, and one of the rules we have to live with, as everybody does, is the minimum loss-ratio requirements that every state has put together. We have to measure actual loss ratio by product, and by state every year. If the loss ratio is too low, we have to give a refund. So far we haven't paid anybody any refunds, so I guess that's good. It means that we're paying out enough in claims, but it means that the loss-ratio issue, at least for us, has not caused a problem in terms of the refund.

Before I finish, I want to leave you with just one thought, which is that 12% of the Medicare population is currently enrolled in managed care. This compares with 74% of the under-age-65 insured population currently enrolled in managed care according to KPMG. There is a big gap between 12% and 74%. We have a long way to go. There's room for much growth in Medicare risk enrollment. There is room for the business to expand tremendously, and as it does, we think there will be major savings for the government.

Ms. Donna C. Novak: What I'm going to be speaking about is the reform that is going on in Washington, DC and how it will affect the over-age-65 market, including Medigap reform. There are bills that are being debated very hotly right now. I will be speaking about the testimony being prepared on these two bills. There are two bills, but there's a variable difference between them, so I'll be speaking about them as if they're one. Also, the Health Insurance Persistency Award (HIPA) and the Kennedy-Kassebaum bill have some effect on the over-age-65 market that I will talk about. I'll also discuss the Medicare reform, something for which the AAA has been asked to provide assistance and evaluation.

The first thing we're going to look at is the Chafee/Johnson bills. There are four aspects of these two bills. The first one is portability. It's not totally portable, as is the Kennedy-Kassebaum bill for those under age 65, but it offers some limited

portability. Second, there is a limitation of pre-existing conditions during the open enrollment period. A third aspect is extending open enrollment to the under-age-65 population, and that's what I'll be speaking about the most because I think it has the largest impact. Fourth is the availability of information on Medicare risk and supplemental policies.

Portability refers to guarantee issue within 30 or 63 days, depending upon the bill, of specified events. There has to be notification by the organization that previously covered the individual or administered the coverage for the individual. Again, this bill has a Kassebaum-Kennedy feel to it because there is a portability provision.

Let's discuss the situations under which this guaranteed issue would be available. You would have guaranteed issue within 30/63 days if you move outside your service area, if your plan goes bankrupt, if there is a termination or nonrenewal of a contract, bankruptcy, or insolvency, or if you have an employer plan that greatly reduces benefits.

Finally, there is the one that has drawn the most attention. David was just saying he thinks the government should encourage individuals to get into risk contracts. There's a provision in both bills that within the first 12 months of enrollment in a managed care plan, individuals would have guaranteed issue back into the Medicare supplement marketplace. That's the first time that they enroll in a Medicare risk plan. Of course, the idea is to encourage individuals to try Medicare risk contracts if they are concerned that the doctor they're used to going to isn't in the plan, or if they are concerned about coverage, or what kind of service they'll get. They've been reading the articles that are aimed at the senior market, which I'm sure Jean's in-laws and parents have been reading. There are some concerns about going into Medicare risk, so this is a try-it-and-see-if-you-like-it option. A number of estimates have been done of what the cost effect is going to be on the Medicare supplement marketplace because of this provision. Those estimates are based upon some of the studies that David alluded to. They're very sensitive to the cost of those that are opting into the Medicare risk and the relative costs of those disenrolling and coming back into the marketplace. We in Medicare risk are currently going from 10% to 15% or, in your case, from 12% to 15% or 16%. We're looking at an increase of somewhere between 1% and 3% in the Medicare marketplace or the Medicare supplement marketplace from some of the estimates being done right now. As I say, it has drawn some attention from testimony in Washington, DC.

Let's move on to pre-existing condition limitations during the open enrollment period. Basically, there would not be any pre-existing condition limitations allowed during the open-enrollment period. It has been estimated that there will be very

little effect from this, primarily because many insurers do not have pre-existing condition limitation provisions in their Medicare supplement policies, and even if they do, they don't always enforce them. So this is a provision that is not being resisted very much by the trades right now.

The under-age-65 Medicare population is what's drawing most of the attention in these two bills. There would be a six-month open enrollment period from the time an individual became eligible for Part A and enrolled in Part B. There would be a transition period at the time of enactment of the bill for a six-month period, and the secretary would notify all eligible individuals that they did have a right to guaranteed issue.

Most of the under-age-65 Medicare eligibles are disabled or have end stage renal disease (ESRD). Because the relative cost of ESRD is seven times more than the cost of those without ESRD, there is a concern that this will have a tremendous effect on the over-age-65 Medicare supplement rates. What Johnson and Chafee and Rockefeller are saying is that this is important because of the relative proportion of those with ESRD (256,961) and the disabled population (4,043,039) in general to the total Medicare population (33,000,000). But the cost of these individuals will not be borne by the total Medicare population, but rather the Medicare supplement population. And there is a slightly different relativity here if we look at the size of the Medicare supplement population (10 million) to the under-age-65 disabled population (4.2 million).

There is quite a difference between the relativity to the Medicare supplement population. If you look at the size of the ESRD population, and if all of those individuals are going into the prescription drug plan, which is a possibility because they are very high users of prescription drugs, you will know that your relativities change significantly. When the AAA testified in Washington, they felt that one of the concerns was that if the under-age-65 disabled are guaranteed issue into all of the plans and are given the best available rate or the lower rate, that could drive prescription drug plans out of the marketplace. They would become so expensive, and many of the carriers that now offer them would just continue offering them. Although these very high users of benefits are a small percentage of the population, if you start looking at the part of the Medicare population that would have to share costs with them, you can see that there could be a significant effect in the over-age-65 marketplace. This is still being debated. As I said, the Academy testified, the HIAA has testified, and I believe Blue Cross/Blue Shield Association will be testifying on these issues.

Regarding the availability of information, I think this one is interesting. HCFA was going to provide grants to prepare information on Medicare risk and Medicare

supplement policies. Insurers would have to provide information to the organizations receiving these grants, and insurers would have to pay for the grants. I just thought it looked like taxation without representation to me.

I want to talk briefly about two other effects of reform that are going on right now. There's the Health Insurance Portability and Accountability Act (HIPAA), which I think everybody is aware of. One of the parts of HIPAA is the guaranteed renewability to the individual marketplace. The guaranteed renewability does not stop at age 65. When this first came out, the NAIC was talking to HCFA and asked if, in fact, they had intended this or if the Kennedy-Kassebaum bill had intended that individual coverage duplicate Medicare at age 65. After some review, HCFA has said, in their most recent statement, that policies can coordinate with Medicare if, in fact, they coordinate at the time that the policy is issued and, therefore, is renewed in the same state (not the state of the Union, but in the same condition). Therefore, if a policy is written so that it coordinates with Medicare, it can be renewed past age 65. But if it is not written for the coordination, it would duplicate coverage at 65 since it has to be guaranteed renewed and this is the individual marketplace only.

How many people here come from carriers that write individual coverage at this point? How many of you are rewriting current policies to take this into consideration? Regulators I've talked to expect to see many filings of forms in order to structure them to take this into consideration. A couple of attorneys I've talked to had some concerns about being able to do that on current policies. So it's something that a pricing actuary might need to talk to the legal staff about to find out what's going on and to get this priced. Actually this is effective at the beginning of July 1997.

Pete Stark, who is a House Ways and Means minority member, has asked the AAA to do some estimates of proposed changes to the funding and to the benefits of Medicare. The Academy is looking into putting a model together that could help out not only the House Ways and Means Committee, but any other group that is currently looking at what can be done in order to save Medicare. The most recent estimate now is that the fund is going to go bankrupt by the year 2001. One of the proposals Stark is looking at is, instead of just looking at one solution, what if we combine solutions and, therefore, protect the fund for at least another 75 years. He asked the Academy to model out a combination of increased deductibles and co-payments for Medicare beneficiaries. Of course, this is going to then affect the Medicare supplement marketplace and some of the standard plans.

The AAA also has another project underway that is looking at the effect on Medicare of first-dollar coverage for Medicare supplements, and whether there will be some upward pressure on the whole cost of Medicare because of first-dollar

coverage. The study that's being done does show some proof that there is some effect and that maybe first-dollar coverage for a Medicare supplement isn't the way to go. This hasn't all played out yet, but one possibility is that the increased deductibles and co-payments would not be covered by Medicare supplement policies; therefore, the retirees would have some out-of-pocket costs that possibly could help control utilization.

There are two possibilities on the funding side. One is to reduce provider payment. The first letter that we got at the Academy spoke of ways to reduce increases in provider payments so that increases coincide with the gross domestic product and are not a result of any medical inflation. So, again, we're going to squeeze the provider side and, of course, increase the employer-employee taxes by a couple of percentage points. The Academy's going to be working with Representative Stark and possibly some other groups to put some estimates together to see what can be done. As you can see, whatever they come up with the next year will affect the Medicare supplement marketplace. With that I will segue back to Jeannie who will talk about the Medicare supplement marketplace.

Ms. Wodarczyk: It's always interesting to be in this area because you can count on change and you can count on demand for actuarial work, so that's a good thing. I'd like to talk about the customer perspective. I work with both insurance companies and many employers. I would say the bulk of my work is with employers who are looking at solutions to the health care program issues, retirees being a big issue and an increasingly difficult one for them to deal with. Many employers that I see are more often looking at Medicare managed care. This increased interest is not just with employers, though. Retirees are becoming interested as well. The retirees are coming to employers asking, "Why can't I have an HMO option?" I have a number of clients who have only had an indemnity option for their retirees and actually extricate them from an active HMO and put them into an indemnity program when that individual retires. They realize now that's not particularly smart, and they are trying to address those programs.

I also believe that the government is increasingly interested in managed Medicare as a solution to the health care problem. We see the government sometimes acting very psychotic. On one side, they have to be very concerned about quality and quality issues. So every once in a while you'll see them raise the banner of quality as it relates to limitation of services. On the other hand, they can't abandon managed care and go back to the old fee-for-service environment for everything and stay afloat at the same time. So we're going to see a great deal of balancing going back and forth in trying to ensure quality in almost a regulatory mode, as well as encourage more and more managed care alternatives. Plans are also increasingly

interested in this market, particularly plans that are out in front and finding it to be a profitable market to operate in.

Why are employers interested in managed Medicare, and, by the way, I use the word *managed* on purpose. I think Medicare risk is a financing mechanism. It happens to be the current hot financing mechanism, but there are going to be many more financing mechanisms floated over time. Clearly, a driver is reduced accounting liability. Many of you know by now that employers have to account for the full liability of health care for the lifetime of their retirees when they've made these kinds of promises. Many organizations put in plan design features to limit those numbers on their financial books. Some organizations put in features like capped plans, which means they will pay no more than X dollars, and when it goes above that it will pass all the costs on to the retirees. These organizations are beginning to face the day that burden is a reality. Many employers felt that, ultimately, there would be some sort of change in the system that would relieve them of having to face this ultimate change in plans. But, no mega change in the system has occurred; and reality is right around the corner.

Another equally important, if not more important, driver that I see day in and day out is the reduced cash cost. Cash is king, cash is important, and anything you can do to improve a cash position of a company is highly valued. Moving people to a medical program that is much less costly is a very important strategy for many of these employers. Oftentimes this move is accompanied by increased benefits, and that makes it very desirable to go to your retiree marketplace. Oftentimes you can put in a choice plan and allow the retirees to make the choice to move in. You're not perceived as the bad guy, and you win all the way around. When those situations occur it's a lightning rod to change.

Managed medical care is often consistent with the overall company's benefit strategy, and that, too, is a driver. If you're moving your active employees into managed care and they're comfortable with it, carrying that strategy forward into retirement status is important. Increased flexibility with your programs, establishing options moving people, and getting them used to change is part of the strategies and part of the overall motivation. These programs are available for large employers that have retirees who go to Florida, Arizona, and so on. There are more of these programs and more acceptance. In their hearts, many of these employers believe well-managed retiree care can be better quality care. There are many studies that show that retirees who just go to the system and use a variety of physicians who aren't coordinated actually have worse care. Getting prescription drugs from multiple doctors is one simple example that happens very often. These patients have medical complications because certain drugs are not meant to be taken

together. This kind of thing happens all the time, so the hope is that we can provide better care, higher quality care in a managed environment for the elderly.

Retirees are interested also. Increased availability is clearly a driver. The television ads, the newspaper ads, and the magazine ads all talk about managed medical care. They get more and more comfortable with this. They also see the opportunity for some increased benefits. Oftentimes some additional benefits are thrown in, in order to cover the government regulations as it relates to the AAPCC. Increased comfort with managed care is another reason why retirees are looking more toward managed retiree medical care and reduced cost for themselves. I gave you one personal example, and those were real numbers and real people who are trying to live in a real world and take care of their health care. Reduced paperwork is often a consequence of getting into one of these programs. Dealing with retirees and paperwork is a complex event in this world. So any time we can eliminate paperwork, it eliminates stress and problems for retirees. The increase in the snowbird flexibility that we're beginning to see in these programs shows that people have opportunities to spend time in different geographies and know that they're not out on a limb without health care. That has been a big barrier to retirees jumping into these programs, but we're seeing more and more snowbird plans.

It isn't the panacea, however, and there are many roadblocks on the way to making employers and retirees totally comfortable. With employers I see four main areas that they have concerns about before launching into group managed care programs for their retirees. First, there are transitions, and by that I mean life transitions. Second, the benefits and the benefit structures often cause some difficulty. Third, the whole mode of administration is often different from what they currently have in place. Fourth, the processes of managing these programs can cause some difficulty.

Let me talk briefly about each of these areas. With regard to transitions, when retirees move from active to retiree status, plans change, the programs change, and the offerings change. Whether or not a managed Medicare program is one that they can offer to retirees or offer to actives and retirees in a way that's comfortable becomes an issue. Also, what happens when you have a spouse who's in Medicare and a spouse who's not in Medicare? Can they be in the same health plan? Can they be in the same health care program? These decisions are often made jointly by couples, not by individuals based on their Medicare status.

The snowbird issue has been one that occurs along with the movement of an individual from pre-65 status or non-Medicare status to post-65 or Medicare status. Can they stay in the same HMO? Can they smoothly move from one age category to the other without much disruption, filing of forms, changing their benefits, etc.? That becomes an area of intense confusion among the retirees. Remember that

many of these retirees are in plans where that transition is by and large invisible to them, and this is a major hurdle.

In terms of benefits many of the managed Medicare program offerings have limited drug coverage, either caps on the coverages or designs that really constrain the amount of prescription drugs that are covered in the program. Most of the employer plans are very robust in the prescription drug arena, so this can be a problem.

There are issues in comparing the benefits you're offering to your retirees as compared to the benefits for your actives. Now, this is a lose/lose situation. If the benefits are more robust than what you have for your active employees, you have to explain to your active employees why it is that the retirees have better benefits. If, on the other hand, the retiree benefits aren't as good as the ones that you offer your active employees, you have to explain why, when people retire, they have to take a haircut in the area of benefits and why it is that retirees are not being treated as well as the active employees. So this is really a tough one and a heavy duty employee communications issue.

Finally, many of these employers, particularly the ones I work with in the Midwest, have very strong union agreements in which every *i* is dotted and every *t* is crossed as it relates to the benefits that you're providing both actives and retirees. If the program benefits that are being offered in this managed Medicare supplement or enhancement policy are not in accordance with the union, then it will be very tough to sell these programs to the union.

There are a couple of areas related to administration. First is retiree communications. Who's going to communicate to the retirees and how? They're very sensitive about the public relations issues. On the other hand, the HMO must communicate with retirees when they move into something like a Medicare risk program as it relates to making sure they understand the benefits and making sure they've signed all of the forms. Enrollment and disenrollment requirements by the federal government imply that the plan has to do a certain amount of communication. So coordinating with that employer to make sure that the communications package isn't one that is going to blow up in the organization's face is very important. Also, there's a requirement that the retirees get full evidence of coverage documents each year. This isn't something that employers are used to doing. They're used to getting summary plan descriptions. The confusion will occur when the retirees get this blow-by-blow description. You should determine who is going to make sure that they're comfortable in understanding all of that.

There's also a requirement to track the working agent. Who's going to do that? Is the plan or the employer making sure that's covered? And these are all regulations,

that the government has put on the plan that make it more difficult for everybody to work together in this arena.

In terms of program management, there are special needs of the elderly. You can't just go sign up with any HMO. Many of the HMOs that were originally designed were designed around acute care status. They are networks that looked at well-baby-care issues, which aren't the issues that the elderly have to deal with. So it is very important to select a plan in which the providers truly know how to manage geriatric care, which is often a chronic care issue. Also, be sure that there's continuity in the network. An individual going from active status to retired status or retired status to Medicare status creates a network change. What can happen is that the doctor someone has been going to isn't part of that managed Medicare network. The person then has to make decisions that he or she didn't know about or doesn't want to make. These people become concerned. Are the geographical limits different? Perhaps they now live in an area in which you're not licensed to have a managed Medicare program. Finally, there are retiree satisfaction issues. There's nothing worse to an organization than having a little old lady appear on television talking about the horrible Medicare services that she had and that it was in that employer's plan or she was confused, and so on and so forth. Retiree satisfaction is a very important issue to plan sponsors.

Retiree concerns are often reflections of the employer concerns. Changing a medical provider, whether you're an individual purchasing this coverage or whether you're in an employer plan, is a traumatic event. These people are used to stability, used to selecting a provider, respecting a provider, and trusting that provider with their personal health care. I've seen that many people almost feel that it's a betrayal when they decide to move to another provider, so that's a major hurdle for them. Cost, however, is a big issue for retirees, and many of them on fixed incomes are extraordinarily stressed with health care costs, especially when prescription drug costs are a big piece of their health care expense.

The reputation of the plan or the providers is extremely important. Retirees often get ideas about the reputation from their neighbors, their friends, television ads, or newspaper ads. Travel is a concern. Many retirees travel, particularly in their early retirement years. This tends to be less of an issue in later retirement years. They want to know what happens if they have a medical problem when they are traveling. Many of them have chronic problems that need to have continuous care, even when they travel. They need to be assured that they can have those needs taken care of.

The benefit level is an issue—are they getting what they need? Do they have a choice? What happens if they want to change either the coverage level or programs? Finally, what is the "perceived quality"?

In summary, I'd like to say that I expect that there will be increased government experimentation with design, funding, and financing of these programs. New products will continue to emerge as plans determine how they're going to make offerings that are attractive to this market. It's a market that's growing. You and I are moving into this market very rapidly, and there's going to be a significant group of people in the market, so it's going to create its own demand for products. Employers will continue to migrate to managed care. They are attempting to figure out every way they can get their retirees to be comfortable in these programs. I believe retirees will continue to accept management of their health care over time. I think this is going to continue to grow and be an acceptable form of health care in the future.

From the Floor: We offer Medicare supplement and Medicare risk. What concerns me is HIPAA and the individual product being guaranteed renewable; when the person becomes eligible for Medicare we have to continue with that product in some fashion. The federal government has required various Medicare supplement model bills to be enacted or promulgated by the states. It seems like this is in direct conflict with what the federal government has required us to do prior to HIPAA.

Ms. Novak: Most definitely. You don't just have the standard plans in a state. You have the standard plans, plus all the individual coverage that's written in the state covering your retirees. There are no restrictions on the rates that you have to charge right now at the federal level for those policies. I know that many carriers are just not planning on pricing them competitively.

From the Floor: I'd like to take issue with the statement that Donna made. I'm not sure if I heard it quite right. If I didn't, I apologize. It had to do with Medicare supplement plans, and how they integrate with Medicare. There's an allegation being made that Medicare supplement plans increase Medicare utilization; therefore, there's a hidden subsidy and some argue a hidden subsidy of Medicare supplement plans. The Academy is evaluating that issue. I'm on a committee that's looking at some of the evidence that's being presented largely by academics on the issue. At this point I think there's fairly clear evidence that people who have Medicare supplement plans have higher Medicare utilization. What's missing is the element of what causes what. Are people who perceive a higher expected utilization going out and then buying Medicare supplement plans or are they high utilizers because they have full coverage? Is that causing the higher Medicare utilization? It's a somewhat important issue because there are policymakers who

would like to outlaw Medicare supplement plans or tax Medicare supplement plans for that reason. The other half of the issue is it does make sense that people who don't have any co-payments might be less disinclined to get medical care. Is the issue that the people who have to pay the co-payments out of their pockets are not getting necessary care and eventually are increasing the overall care that they get?

Ms. Novak: Because they don't get the care soon enough?

From the Floor: Right.

Ms. Novak: I'll be interested to see your paper when it's done, but the people I've talked to in the group obviously were on the other side of the table.

From the Floor: There are a number of people that are trying to make the point convincingly.