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Moderator: MICHAEL GERARD STURM
Panelists: RICHARD S. FOSTER
DAVID O. THOEN
CLIFTON I. MAZE†
Recorder: MICHAEL GERARD STURM

Summary: The reforms that have been evolving in the Medicare program, the participation of the Health Maintenance Organization and insurance industry in the managed Medicare market, and the response of Medicare enrollees to these programs are discussed. Both Medicare Risk and Medicare Select programs are addressed.

Mr. Michael Gerald Sturm: David Thoen from Deloitte & Touche and Cliff Maze from the Health Care Financing Administration (HCFA) are joining me today. I'm going to start out by talking briefly about Medicare in review and then get into managed Medicare products, the Risk and Select, and some trends. Then Dave's going to follow up and talk about the Balanced Budget Act and how Medicare's been impacted. Finally, Cliff is going to talk about the new payment rate methodology under Medicare Risk contracts through the Balanced Budget Act.

Just as an informal survey, how many have had or are familiar with the Medicare program? I would imagine everyone is. How about Medicare Risk contracts? So, a good number of people are familiar with Medicare Risk contracts, which means that I'm going to go even faster over the first five slides. Briefly, Medicare eligibility for Part A is anyone 65, disabled, trouble with your kidneys, or voluntary—I think the voluntary premium is about $300 per member per month (PMPM) right now.

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†Mr. Maze, not a member of the sponsoring organizations, is Director of the Capitation Staff at the Health Care Financing Administration in Baltimore, Maryland.

The structure and benefits of the Medicare program. Part A is a compulsory program. About 1.45% of your payroll is deducted to fund the program. Benefits are mainly facility-based, inpatient hospital, a skilled nursing facility, home health care, cost sharing, no premium. There's a deductible and coinsurance. Part B is a voluntary program funded through general revenues and premium, 75%/25% currently, but it's going to be changing under the Balanced Budget Act to 50% a piece. Benefits are mainly ambulatory, physician, outpatient hospital, cost sharing, etc. The premium that I mentioned is going to double, and then, of course, you have the deductible and coinsurance.

The current distribution of enrollees is by option. Most of the enrollees right now are in the fee-for-service plan with a Medicare supplement. I have 62%, but I think that's actually a little bit understated. Then there's your fee-for-service without supplement, and, then, of course, you have Risk contracts, 14% of the 38 million beneficiaries. Risk contracts are growing very fast right now, as most of you know. Then there are Medical Savings Accounts (MSAs), which were passed with the Balanced Budget Act. They'll become effective in 1999. There's also a few other programs, cost contracts, health care prepayment plans, and demonstration programs. I'm not really going to focus on them because cost contracts have been terminated under the Balanced Budget Act and have been out of favor for some time with HCFA. Demonstration programs are HCFA's way of testing new ideas. I imagine a small percentage will always be around. As I've mentioned, risk plans are growing very rapidly, between 25–35% a year. Absolute growth is a little over one million beneficiaries per year out of 38 million. So, they're growing very fast.

I think there's a little bit of confusion out there about trust funds. There are four of them. The first one is cash benefits. It's funded through 5.6% of your payroll, disability income, and of course, Medicare, Part A and Part B, trust funds. The Part A trust fund, as you know, has been in the press a lot lately because of its impending bankruptcy. They will become medical expenses of Medicare and income. These two lines are diverging, creating a larger deficit each year, causing the assets to come down bankrupt at about the year 2000. However, with the Balanced Budget Act the projection was redone and it's now the year 2010, so you can see the Part A trust fund is in quite a bit of trouble. Why? Well, you will have more enrollees coming into the system. Right now there are about five workers per beneficiary. By the year 2030 that's going to decrease to two. So, you can see that, since this is a pay-as-you-go system, there are some real problems here including general inflation and, of course, unexpected changes in utilization and price intensity. For the Part B trust fund, everything looks rosy. Income is matching expenses. For the most part your assets are going up, although this is a bit deceiving because of the way it's funded. Again, when Part B runs out of money

the government just keeps adding cash to the fund. Part B costs are growing at about 9% a year, which is 22% faster than the gross domestic product.

Risk contracts. I'm just going to talk briefly about what each player's perspectives are on risk contracting. As I mentioned earlier, the Part A trust fund is running out of money real fast. That's threatening the government's ability to balance the budget, or it will in the future. The government wants to transfer all the risk to the HMOs. They say, we're going to give you a fixed payment amount PMPM. From the HMO side, they take the risk. They may subcapitate that risk to their physicians or hospitals. Sometimes they'll offer extra benefits beyond Medicare at a fairly reasonable premium. There can be no premium in some markets. So, they're making significant inroads on the Medicare supplement policies right now.

From the provider's perspective, they may assume some risk. Technically, when they sign up with the HMOs, competitive medical plans oftentimes are asked to practice care management techniques under the HMO's utilization review policies. And oftentimes the HMOs will tie them into the bottom line through some sort of risk-sharing mechanism. The HMO will develop an actuarial cost model, which just details your medical cost by line item. That'll serve as a budget for the HMO. To the extent that hospital inpatient costs come in below budget, they'll refund some of the money to the physicians. So, they have an incentive to manage care well. From the enrolled's perspective, with fee-for-service Medicare, they can see any doctor they want. If they sign up for a risk contract, they have a limited set of doctors. However, the advantages are many. They oftentimes pay less premium, have less paperwork, and do not necessarily compromise quality.

Let's compare commercial plans with Medicare Risk contracts. Commercial plans. Your plan sponsor is generally your employer. In Medicare plans it's the government. The relative cost level for Medicare costs is about 3.5 times commercial plans. Of course, your payment rate for the government will reflect that. There's a wide variation of benefits levels on the commercial side. The insurance company comes to market with whatever they think is popular, but on the Medicare side they force the HMOs or competitive medical plans to offer a base set of benefits, at least Medicare's benefits. Then they can offer additional benefits if they wish. Premium levels for commercial are set by the insurance company. For Medicare they're set by HCFA through the Adjusting Average Per Capita Costs (AAPCCs).

Are Risk contracts profitable? As in any profit analysis, you need to analyze your revenue and expenses. On the revenue side you have the government payment and any enrolled premium that you collect. On the expense side you have medical costs, administration, and your development costs. The key is to develop an

internal rate of return that you can do in just about any spreadsheet program, Lotus or Excel, which analyzes your cash flows, including your initial investment up-front. As you become profitable throughout the year, the key is to grow as fast as you can and to get as many members as you can to cover your fixed costs as soon as possible.

Let's have a closer look at the government payment, known as the average payment rate (APR). The APR equals the AAPCC times the demographic factor. It's an amount the government comes up with by taking historical fee-for-service costs, turning them forward and then multiplying them by 95% because they want to save some money, that 5%, in paying the HMOs. The demographic factor is based on whether you're in a hospital or not, your age, your gender or your Medical status. . The AAPCCs have been reformed under the Balanced Budget Act, although I'm not going to get into that here. That's Cliff's territory.

Then there's your enrolled premium. As I said, there can be no premium in some markets. The average is about $30 PMPM. I've seen it get as high as over $100 PMPM in areas such as Minneapolis where the historical fee-for-service costs have been quite low compared to the rest of the nation. The amount of the enrolled premium you charge really depends on the competition in your marketplace and the level of care management. There is one HMO Risk contract in Milwaukee right now, which happens to be where I practice. It's a $0 premium, $10 office visit copay. Another carrier is thinking about getting into the business. I was talking to them the other day, and they told me that they were going to offer a $30 premium plan with a $0 office visit copay, which kind of surprised me, I guess, because it could be inviting a little bit of antiselection. Whom do you think's going to go and pay a monthly premium for a $0 office visit copay? It's going to be the people who are going to be using the care. So, you have to be careful in what type of market you're dealing with and the risks that you're attracting and price appropriately.

On the expense side you have medical costs. This formula comes as no surprise to health care actuaries—just your number of services times your charge per service. You have to adjust for copays. You've have your degree of health care management, which you adjust for, your age and gender of your beneficiaries, the type of office visit copay and cost-sharing features you have, and, of course, you have to trend them and adjust for your geographical area. One thing that you cannot do as an HMO in Medicare Risk is underwrite your enrollees. You still may get selection, and I'll get into that a little later, but you can't get it through underwriting.

Back to the additional benefits offered through Medicare Risk plans. Most plans include physicals and immunizations. Some plans will go as far as to include glasses, prescription drugs and point-of-service (POS).

Let's talk about the adjusted community rate (ACR) filing you have to do with HCFA. It's basically HCFA's way to determine whether or not you excessively profit through Risk contracts. What they have you do is take your commercial HMO experience, your utilization, and your charge per service, and adjust them for volume complexity factors which are published by HCFA. Then you add in your extra benefits. Essentially, at that point you're providing to your cost, or what you're providing, to the beneficiaries. What you need to do then is compare that to the average payment rate—the AAPCC times the demographic rate that the government gives you—and if it's less than that, you either have to refund the government money or you have to add benefits. If it's more than that, you can either charge a premium or you have the option of waiving the premium as carriers do in $0 markets. One thing to note about the ACR is the experience that you develop is generally reflective of what you're going to see of your population. So, you have to be careful. We strongly suggest doing a realistic analysis with numbers that are more representative of the population.

Let's shift gears and talk about Medicare Select for a minute. Medicare Select started out as a demonstration program in 15 states. It has recently been expanded to all 50 states. Again, it's a supplement. It's different from a Risk contract in that the government still retains the risk on the base set of Medicare benefits. In a Risk contract, if you go out of network, you don't get any benefits. In a Medicare Select policy, if you go out of network, you're still going to get Medicare's payment. However, your Medicare supplement carrier likely won't pay. I refer to it as managed care lite because when the government originally established this they thought that Medicare supplement carriers were going to go out and actively manage care in the community. That really isn't happening for a few reasons, one of them being that Medicare supplement dollars that they're reimbursing just aren't large enough to justify going out and developing the systems to do utilization review and that sort of thing. Most often what happens is local hospitals will waive the Part A deductible, which can save you anywhere between 5–20% of claim costs, and then you can pass on the savings to your enrollees. There are about 500,000 of Medicare's 38 million enrollees in Select policies right now, many of them in 2 of the major carriers, Blue Cross and Blue Shield of Minnesota and Blue Cross and Blue Shield of California.

Let's look at Medicare Select from a carrier's perspective. Again, I said they can charge lower premiums, 5–20% lower, and they really don't manage care. Another reason why they don't manage care is that Medicare supplement carriers reimburse the Part A deductible, the $760, and when you start looking at managing care the first thing you want to go after, a proverbial low-hanging fruit, is the in patient days. If you manage care on an inpatient basis, all the savings are going to accrue to Medicare because you're going to pay that $760 on day-1 whether it's a 3-day

length of stay or a 2-day length of stay. In addition, Medicare has peer review organizations that determine medical necessity. So, to the extent that you have a large utilization review in-house and you're trying to determine medically necessary services, there's a law of diminishing returns.

There are also some regulatory issues under Medicare Select in that you have to file reports as to network access, quality assurance, and that sort of thing, which typical Medicare supplement carriers might not be used to filing. On the flip side you have to file your experience, which is more typical of what insurance carriers file, like loss ratio experience and that sort of thing, whereas HMOs, especially staff model, might have a tough time getting that experience because they're not used to reporting that information.

From the provider's perspective hospitals may or may not waive the Part A deductible. It really depends on what market they are in. Physician networks are less common, and because the government has released anti-kickback rules that say that you can't negotiate discounts with physicians on Medicare patients. In addition, I don't think Medicare supplement carriers really want to go and limit the physician panel because when you start talking about directing patients to a hospital, it's generally not as emotionally charged as when you tell somebody they can't use a certain physician. The carriers that do have physician networks, (like Blue Cross and Blue Shield of Minnesota of which 98% of physicians in their state are network), aren't really limiting the provider or patient at all. From the consumer's perspective it's kind of a no-brainer. They get lower premium. If you have a certain affinity towards a hospital that's not in the network, Select is not for you.

Finally, let's get into a few marketplace trends. Of course, risk contracts and select contracts are both growing, risk contracts probably at a little faster rate. Another marketplace trend is that self-referral plans are becoming a little more popular, as opposed to gatekeeper, where you need to go and see a primary care physician to get a referral. I think broader networks are the trend. I think it's an effort to give the beneficiary more of what they want as opposed to trying to steer them to a certain set of providers. It also helps to get market penetration a lot faster. As far as HCFA's perspective, they're really a consumer advocate. They want to have a lot of choice out there for the consumer and inform them well. They passed a lot of things in the Balanced Budget Act with respect to that. Another trend for HCFA is competitive bidding. It says in the law that the Secretary of Health and Human Services has to have, I believe, seven competitive bidding plans by early next century. Many of you are probably aware of the Baltimore and Denver fiasco. The providers are bucking pretty hard at this point. And then there's the health status adjustment, which has also been written into the law. As opposed to all the

numbers that I put up earlier about the demographic factors, what they're adjusted by, HCFA wants to work in health status. It's been argued for a long time that Medicare Risk contracts have gotten better health or select.

Mr. David O. Thoen: I'm going to talk about the implications of the Balanced Budget Act of 1997 as they relate to Medicare Plus Choice plans and Medicare Risk plans and also Medicare Risk POS plans, which are kind of a hot topic right now. I work for Deloit & Touche in Minneapolis, and I've been working on Risk plans for about the last three years, mainly in the ACR filing capacity, as well as feasibility studies. I've done some Medicare Select work and also pretty extensive Medicare supplement work. I've seen a pretty big variety of Medicare-type plans over the last three years.

I'm going to talk about some of the goals of Medicare. I'm also going to talk about the types of plans that are available to Medicare and will be available to Medicare enrollees-in some of the benefits and the protections that are built-in. As far as the payments go, we're going to skip that so Cliff can talk about that. I'll talk about some other transitional rules in regards to contracting with HCFA for being a Medicare Plus Choice carrier. In regards to the POS plans, just some general information, data, and some of HCFA's requirements, and then probably the most interesting thing here, since we are actuaries, the pricing of Medicare Risk POS plans.

As far as background in the Balanced Budget Act of 1997, it was Public Law 103–33. It has 11 major sections and was signed by President Clinton on August 5, 1997. Many of the provisions in the Act are effective January 1, 1998, but not all, so you need to look closely at the act to make sure that you're complying with certain timeliness. Title IV of the Act is the Medicare, Medicaid, and Children's Health provisions section. The Medicare portion of that establishes the new Medicare Part C or Medicare Plus Choice. Before I go any farther I want to put out a couple caveats. One is that I'm not going to be talking about Medicaid or Children's Health provisions. Also, one big part of the Medicare portion of this Balanced Budget Act has to do with changes in payments to providers, the Diagnostic Related Group (DRG) system, and the Resources-Based Relative Value Schedule (RBRVS) system. I will not be addressing that. Finally, since this is an act that's been passed, and there are various interpretations of the act, this represents my interpretation. Yours may be different. And, as we speak, HCFA is currently putting together their interpretation of the Act and making public policy.

The main goal of the Balanced Budget Act of 1997 obviously is to reduce federal government expenditures. Another main goal is to provide managed care alternatives for Medicare beneficiaries and, in relation to that, privatizing Medicare,

putting the risk on other carriers and expanding the program. Probably one of the more important things is standardization of all the laws and rules in regards to Medicare. They want all carriers to follow the same rules. Some other ones are making sure the consumer is aware of their options and protected, and, finally, to reduce fraud and abuse, and penalize those carriers and providers who are abusing the system.

If you're going to be a Medicare beneficiary in 1998 and going forward, now is probably a good time to be there because you're going to have a slew of options to choose from. You have your traditional fee-for-service Medicare, which is Part A and Part B—Part A being hospital, Part B being the Supplementary Medical Insurance (SMI) portion,—but the Balanced Budget Act established Medicare Plus Choice plans or Medicare Part C, and there's going to be a number of options available for beneficiaries, one being HMOs, which we're currently familiar with that have Medicare Risk plans. HMOs are still going to be allowed to have POS options in order to compete with some of the out-of-network, or the more open-access, systems. Preferred provider organizations (PPOs) will be an option. Provider-sponsored organizations (PSOs) are addressed in the Act as being a new option for a Medicare enrolled, MSAs, and private fee-for-service. We're going to talk about the last three for just a few minutes since they do have special words in the act in regards to what they are.

A PSO is defined in the act as a public or private entity operated by a provider or affiliated providers (providers being hospitals, physician groups, or some combination thereof), providing a substantial proportion of services and sharing in a substantial financial risk with respect to the provision of those services. Like all other Medicare Plus Choice plans, PSOs must be licensed under state law as a risk-bearing entity able to offer health insurance. But if it's determined by a PSO or if it's felt by the PSO that they are not, the state is not acting quickly enough or a state has greater restrictions as far as financial or solvency, a PSO can get a waiver from HCFA to go above the state and get a federal approval. This is quite interesting because there might be some power struggles between who has control here.

The financial solvency and capital requirements are due on April 1, 1998, and those will take into account basically three things: the delivery system of the PSO, the other protections such as letters of credit and reinsurance, and, probably most importantly, it'll also take into account the NAIC risk-based capital requirements. HCFA expects between 800 and 2,000 PSOs to apply for Medicare contracts over the next few years. HCFA's goal is to get more providers to offer Medicare Plus Choice plans, and this is one of the ways they're doing it, through PSOs.

MSA is a demonstration program that will be available on January 1, 1999. It has a limited period of enrollment, either until they reach 390,000 individuals or the date of December 31, 2002. It must be offered in conjunction with some sort of high deductible insurance plan. The annual maximum deductible in 1999 is $6,000. There are a couple of special rules. Only HCFA can contribute to the MSA. So, a person who enrolls in an MSA plan cannot put his or her own money in there, and withdrawals are nontaxable if they're used to cover Medicare-approved benefits. Otherwise they're subject to high tax penalties.

A private fee-for-service plan is a Medicare Plus Choice plan that reimburses provider's fee-for-service. The providers are not at financial risk. There's no restriction among selection of providers, and I view this as a Medicare major medical-type plan. As you can see, HCFA's goal to get more options out there for Medicare beneficiaries will occur through the establishments of all these different types of plans. There's other enrollment information and beneficiary information and protections as well. One of the other main programs that HCFA is going to have to take care of starting in 1999 is to get to the Medicare beneficiaries a very detailed annual listing of all the plans available and all the options available of the different types of plans to a beneficiary in their area. They're going to cover all the Medicare Plus Choice plans, the Medicare Select plans, and Medicare supplement plans. That's going to be a big project that HCFA has to put together by 1999, and the Medicare Plus Choice plans also will be charged a fee for that service.

Also, under the Balanced Budget Act enrollees are open to continuous enrollment and disenrollment. This is a monthly thing. A beneficiary can enroll between traditional fee-for-service Medicare and a Medicare Plus Choice plan or anywhere within the Medicare Plus Choice plan monthly, and that goes on until 2002. Like the current regulations, enrollees have guaranteed coverage and renewal, and then plans must also get approval of their marketing materials.

As far as the benefits are concerned, if you're in a Medicare Plus Choice plan, you must offer all benefits and services available under Part A and B, and, if you wish, you can also offer some supplemental benefits or approved optional supplemental benefits which are rider-type benefits.

As Mike mentioned earlier, some of the typical benefits that we've seen are ear and eye exam, physical exams, and prescription drugs. Sometimes in the very high AAPCC markets you're seeing fitness packages, etc. Enrollees must also get an annual detailed plan description from the plan in which they enroll that describes everything about the plan that they'd ever want to know, and there also must be very good access to services for the enrollees, including continuity of care, medically necessary coverage, out-of-network coverage at all times (access to

specialists is very important here), and coverage of emergency services, which is the current situation for Medicare Risk plans. One of the interesting things about the Balanced Budget Act is its description of an emergency service. Sometimes there's a little discrepancy as far as what is considered an emergency service. Emergency service under the Balanced Budget Act is a service as determined by a prudent layperson. Whether that takes away the controversy or not, I'm not sure.

Some other protections under the Act must be quality assurance programs, grievance mechanisms, coverage determinations and reconsiderations, and confidentiality of patient records. The coverage determinations might be interesting. As I said, there's a continuous enrollment and disenrollment until the year 2002. So, determining which plan is liable for a beneficiary's services might be a big issue. As far as the providers go, they're also protected under the plan, or have some protections. They must be given rules of participation, how it works, written notice on any adverse decisions affecting them and procedures on how they can appeal. The physician incentive plans are being designed such that there can be no inducements in the risk-sharing agreements. By the way, risk-sharing agreements with providers are an OK thing under the Balanced Budget Act, but there can be no inducements to reduce or limit services in any way. Providers must be offered stop-loss or have the chance to purchase stop-loss insurance if they feel they want it. And Medicare Plus Choice plans must also survey their members annually to check on the provider quality.

This was a very, very quick look at the options available to beneficiaries, some protections or benefits, etc. If you look back over those, and those of you familiar with Medicare Risk plans, you'll note that a lot of the items here are similar to what's currently required for Medicare Risk plans and for commercial HMOs. For HMOs going forward it probably won't be difficult to comply with these regulations. However, it might be a different story for PSOs. It'll be interesting to see what happens. HCFA, as I said, has estimated between 800 and 2,000 PSO plans. It will apply for approval in the next few years, but I've seen studies that it'll take between 12 and 18 months for a PSO to get up and running with a Medicare Plus Choice plan at a cost of $2–7 million. It remains to be seen whether the PSOs will be able to get themselves up to par to be a Medicare Plus Choice carrier.

Moving onto the payments, my comments here are going to be like Mike's. The payments, the AAPCCs, have changed. Let's discuss the premiums and the timing. Those of you who do Medicare Risk filings know that the ACR is due November 15. The AAPCCs in the past used to come about September 15 or sometime in the first couple weeks of September. Going forward, starting in 1998, the capitation rates or the area-specific rates are due March 1 of each year, with the ACR due on May 1 of

each year, so in 1998 the May 1, 1998 filing will be for a January 1, 1999 renewal. That's a big change for those of us who do ACR filings.

If you're contracting with HCFA to be a Medicare Plus Choice plan, there are a couple special rules. First, you must be able to prove that you will have a minimum number of enrolled lives depending on whether you're an urban or a rural carrier. Second, you must prove if you're a PSO or not, and that can be waived by HCFA. Some final comments. The 50/50 rule will be eliminated on January 1, 1999. The 50/50 rule says that no more than 50% of your enrollees can be Medicare or Medicaid. That rule will be eliminated on January 1, 1999, as I said. Health care prepayment plans (HCPPs) are going to be phased out between 1998 and 2002. No more will be approved after June 1, 1998, and all current Medicare Risk plans will be rolled into Medicare Plus Choice plans by December 31, 1998.

The Balanced Budget Act. There will be seven demonstration projects that are going to take place over the next five years. There's been a special commission that's been set up to get these demonstration projects going. The preventative initiatives. There are several new preventative benefits covered under Medicare or fee-for-service Medicare. Since they're covered under fee-for-service Medicare, you also have to cover them as a Medicare Plus Choice plan. Some of those benefits are PAP smears, mammogram, and diabetes management. If you're doing an ACR filing for 1998, you need to consider the additional cost of those benefits. There are some rural initiatives going on. HCFA really wants to push some of the rural Medicare beneficiaries into a managed plan. As I mentioned earlier, for the fraud and abuse measurers, three strikes and you're out, or if the first strike is bad enough, you're out. Improvements in program integrity. The expected savings under Title IV, the Medicare portion, is $115.1 billion. Many of the savings are due to the changes in the payments, the DRG payments, and the RBRVs payments over the next five years. That concludes my remarks on the Balanced Budget Act. As I said, there's a lot of information there, and it's open to a lot of interpretation, but HCFA is currently working on interpretation of that law.

The next thing I want to talk about is Medicare Risk POS plans. These were first approved in 1996, and, like a commercial plan, they create an out-of-plan benefit option for a Medicare Risk or Medicare Plus Choice HMO. Essentially, they provide choice and flexibility, which is very, very important with the Medicare population because market research consistently states that seniors are not likely to choose a new plan if they have to change doctors. Seniors would possibly consider a Medicare Risk plan, but they don't want to have to change doctors. Also, the same market research shows that seniors would consider a new plan with an out-of-network option so they could keep their physician. The most interested group in a

POS plan is what we call the aging population, the 62–65 year olds coming off a commercial type, POS plan, who are used to POS. That also presents a very good risk for an HMO, which has a young, fairly healthy population.

As far as the data goes concerning POS plans, they're growing rapidly. In 1996, the first year they were available, there were less than ten POS or Medicare Risk HMOs who had POS options. In 1997 there were 58, which represents approximately 20% of the Medicare Risk HMOs. In 1998 it's estimated that between 30% and 40% of the Medicare Risk HMOs will have POS option. As you can see, the POS benefit is growing rapidly. The annual benefit is anywhere from $200 to unlimited. The data issues are great in a POS plan. The number of enrollees is not available, nor is utilization data available. It has made HCFA pricing of a POS benefit quite challenging.

There are four ways to offer a POS benefit, and these all fit in with the ACR filing. The first way is as an additional benefit, and you can do this if your APR is greater than your ACR, which means you've generated some savings. You're getting more premium than you are offering benefits. You can use the savings to offer a POS plan. The second way is as a mandatory supplemental benefit where you can charge a premium. Everybody who takes this Medicare Risk package gets the benefit. As an optional supplemental benefit, this is more of a rider-type situation where they take your plan. They have an option to take a POS benefit or not. Finally, as a unique employer group benefit. The reason that it's interesting and very important to know the difference as to how this benefit is being offered is because of the adverse selection issues. The adverse selection is going to be very different if you're offering a mandatory supplemental benefit versus a rider. There is a greater spread of risk in a mandatory benefit versus a rider benefit, you need to know how the benefit's being offered.

Some of the plan advantages have a POS very similar to commercial. They reduce some barriers and soften the lock-in. That lock-in's very important because in the year 2002 we do have the lock-in. We have the lock-in where we have continuous enrollment and disenrollment until that point. You need to have your POS if you're going to have one, available by then so a beneficiary can test it out. Its competitive advantage. Everybody's doing it. You've seen the growth in POS plans. It's very important to have one in your portfolio of products. It nicely complements your commercial POS products. If you have a commercial POS plan, a Medicare plan is a natural progression for an aging person. Finally, one of the most interesting things about POS plans is that there's great flexibility in your design and your pricing of the plan. There's no ACR-type document to fill out. You can design the benefits as you want to. You can determine the service area, any limits on the benefits, and however it's priced, and the precertification rules.

As far as requirements are concerned, you have to submit a detailed POS business plan with many different things you have to comply with. More importantly, though, concerning our experience with getting approval on the POS plans, there are really four different areas that need to be considered. Since there is great flexibility in the POS benefit as far as pricing in the benefits, etc., HCFA was very concerned that plans are not being approved and disapproved consistently. They put together a commission to review all POS benefits. Going forward, all POS benefits with Medicare Risk plans will be approved or disapproved consistently. Second, precertification rules. They do not like when you have precertification on your out-of-network benefit that's exactly the same as your in-network benefits, you may need to scale down your precertification a little bit. Third, HCFA will also review any POS plans with a very high benefit, say, $100,000 and above, and very high premiums. Finally and most importantly, if it's viewed that the POS benefit is being used to fill an inadequate PCP network, that's grounds for pretty quick disapproval. In some of the disapprovals that we've seen it's generally because of not being able to meet some of the administrative requirements.

Before I talk about pricing the POS plan, I want to talk about benefit design. As I mentioned earlier, you are free to design your benefits however you wish on a POS plan. You really need to stop and think about the benefits you do want to offer. Since you're trying to attract a senior who probably doesn't want to join your plan because they have to change doctors, it makes sense that you'd want to cover preventative benefits and second surgical opinions as well as some office visits. It would seem logical that you would not want to cover certain high usage benefits such as prescription drugs or chiropractic, and you also probably would not want to cover benefits where your in-network providers are perceived as not being top quality, and when you're setting your benefits it seems that you should remember a couple goals of the point-of-service plan. One is to be able to add new members and to keep membership. The other is to keep them in-network. Your goal is not to get people in your plan and have them go out-of-network.

With that in mind, I want to talk about pricing the POS. As I said, there's no data available, so it's a very interesting process. The first thing you need is a PMPM medical expense by benefit, and that'll be for all your benefits because you're probably going to need to apply some sort of adverse selection factor to not only your out-of-network benefits but your in-network benefits as well. You could probably use your ACR as a starting point. Maybe you have some commercial experience that would also be applicable.

One of the big factors in pricing the POS benefit is the selection factor. This is the adverse selection that is due to the out-of-network benefits. The adverse selection will vary by your benefit design and your POS benefit type. Remember, I talked

about the mandatory benefit versus the optional supplemental benefit and your service area, which I will address shortly. You also need to determine your in- and out-of-network split. That's your percentage of services you expect by benefit to be gotten in-network versus out-of-network. Obviously, the variables there are your benefit design, and you want to build incentives into your benefit to keep people in-network. You do that by penalizing them for going out-of-network. Whatever the provider incentives are, they need to be accounted for. If you have risk sharing with your in-network providers, you probably want to put that same risk-sharing on the out-of-network benefit with the in-network providers because you don't want any sort of awkward situations going on where the providers are pushing people out of network. That's not a good situation.

Your service area, the coverage area, and the quality of your providers are also variables that need to be looked at in determining your in- and out-of-network split. Another consideration would be your utilization factors, or actually, your increase in utilization factors starting from your ACR or some sort of experience base that reflects in-network utilization. You need to put some sort of factor in there to reflect an out-of-network utilization, and the typical thing you need to look at when you're setting that factor is what kind of precertification you have. The cost factors reflect again, since your initial starting point is your in-network. You're saying these people go out-of-network. If I don't have contractual arrangements out-of-network, I need to load up my out-of-network benefits. The impact of the Balanced Budget Act of 1997 is great because that says that you only have to reimburse your out-of-network providers at Medicare levels, so DRGs for hospitals and RBRVSs for physicians really dampen some of your out-of-network cost risk.

Finally, your benefit design factors. Hopefully you've put some sort of cost-sharing in there on your out-of-network benefits penalizing the beneficiaries for going out-of-network. The out-of-network definition is another factor you need to consider. There are three options here. First, you can say your out-of-network would be only in your service area. Say you're a metropolitan area. You'll cover only out-of-network benefits within that metropolitan area. Second, you could define your out-of-network as being outside your service area within your state. Third, you can define your service area as being outside your state. I guess you could go beyond that and say it's everywhere. But if you stop and think about it, again you're trying to draw the seniors who are reluctant to change their doctors, so you probably want to cover your in-service-area type out-of-network benefits. If you're like me, from Minnesota, we tend to have a lot of people around January and February who head out of town for two or three months to go to a warmer climate. This is a great product to take with them. You need to consider what your out-of-network definition is going to be. And, finally, that'll be your medical expensing to add some sort of administration for this product. That concludes my comments on the

Balanced Budget Act and POS plans, and, with that, we'll let Cliff talk about the HCFA payments.

Mr. Clifton I. Maze: Thirteen years ago I calculated the first AAPCC for HCFA under prospective Risk contracting, and now, after 13 years of success, I'm here to tell you that everything is going to change. The original AAPCC methodology was developed by actuaries, but the new Medicare Plus Choice payment methodology was developed by bureaucrats in Washington who defined in the law how the payment rates should be set. When I first calculated the rates 13 years ago I spent the next 3 or 4 years trying to explain to everybody how the rate calculation was performed. I decided to get all of that out of the way. I thought that we'd go through a rate calculation, and maybe for the next couple of years I won't have very much to do.

I thought we would go over the rate calculation for Los Angeles County. Those calculations are pretty complex. The Medicare Plus Choice payment rate requires that rates are calculated separately by county. Three rates are calculated for each county: a minimum rate, a 2% minimum increase rate, and a blended rate. The higher of those three rates are paid. The minimum dollar amount is a flat dollar amount. It's simple to calculate because the law mandates that it be $367 per month. I'm calling that the floor. You might hear that term in the future. Every county will be paid at least $367 per month for Medicare beneficiaries who are enrolled into the risk plans, and that $367 covers Part A and Part B benefits.

The second rate that has to be calculated is the 2% minimum increase rate. The 2% minimum increase is an increase over the prior year's rates. In 1997 Risk plans were paid 95% of the AAPCC. The 2% increase is based upon the prior year's rate. Every county is promised a 2% increase in their prior year rate. For 1997, in Los Angeles County, the AAPCCs can be found in Section 2 of your worksheet. You can see that the AAPCC for Part A was roughly $417, and for Part B, roughly $238, for a total of $655. Multiplying that amount by 1.02 and also by 95%, which is mandated by the law, will give you a minimum rate of $635.01. That is the rate that Los Angeles County ended up getting for 1998. They received a 2% minimum increase.

The third rate that has to be calculated is the blended rate, which is a mixture of two other rates. One is called the area-specific rate, which is based also on the 1997 AAPCC, and the second part of the blended rate is the input price-adjusted rate. The input price-adjusted rate is a national rate that has been adjusted to reflect prices at the county level. For the next few years the mix between the area-specific rate and the input price-adjusted rate changes. It starts off at 90/10 for 1998 and eventually becomes 50/50 in year 2003. Again, blended rate formula says that the

blended rate is based upon two components: the area-specific rate and the input price-adjusted rate. The input price-adjusted rate, which is sometimes referred to as the national rate, gradually becomes 50% of the payment rate, and the local rate or the area-specific rate gradually decreases from 90% to 50% of the payment rate in year 2003 and greater. The formula for the blended rate, *x* is the percent that's applied to the area-specific rate. For 1998, *x* was 90%. Of course, 100 minus *x* will be 10%.

Let's look at the area-specific rate portion of the blended rate. Two primary factors determine the area specific portion. One of the factors is a Medicare growth percentage which is simply an inflation factor that projects how quickly Medicare expenditures are growing. The other factor is what I call a modified 1997 AAPCC. The 1990 AAPCCs have to be modified to exclude expenses that hospitals incur for training doctors. The idea behind that HMOs were accused of not using these teaching hospitals. They were going to the cheaper hospitals. In fee-for-service there's a cost that HCFA allows teaching hospitals for training doctors called graduate medical education expenses and indirect medical education expenses. The bureaucrats decided to take that part out of the AAPCC because of the thinking that HMOs were sending people to nonteaching hospitals.

The Medicare growth percentage is defined using a formula. The formula is the ratio of two U.S. Per Capita Costs (USPCCs) minus a cost-saving reduction, and the cost-saving reduction is gradually phased out. The ratio of the two USPCCs will be the inflation rate because a USPCC is simply the average cost that Medicare spends on a beneficiary. When we project the average cost for the year under consideration and divide by the prior year, we have a projection factor or an inflation factor. However, we want to achieve some additional cost savings, so we cheat a little bit and subtract out; for example, 0.8% in 1998.

For USPCCs the cost-savings reduction for 1998 will be 0.008. Using those numbers you're able to calculate the Medicare growth percentage for 1998 of 2.64%. Again, the area-specific rates will gradually exclude expenses for medical education and indirect medical education expenses—100% of the teaching of the medical education expenses were included in the 1997 AAPCCs. Gradually we have to carve those amounts out. We're going to carve out 20% a year up through the year 2000. We're going to increase the amount of the carve-out by 20% a year up through the year 2002. In 2002 we will carve out all of the medical education expenses in the 1997 AAPCC, so we're softening the blow to the HMO.

The modified AAPCC, less medical education expenses, will be the AAPCC for 1997 minus the same AAPCC times the P of I, which will be the percentage that we will carve out—20% in 1998, 40% in 1999, 100% in 2000—times the medical

portion. To determine the medical portion we went to the hospitals in each county and used their financial data to obtain what part of the 1997 AAPCC was attributable to medical education expenses. For Los Angeles County we determined that 2.8% of their 1997 AAPCC was for medical education expenses. So, if we want to carve out 20% of that amount, we would end up with a modified 1997 AAPCC of $651.65, which is only about $3 or $4 less than the regular AAPCC. So, we're taking out just a little bit the first year. If we're taking out $3 or $4 in the first year, by the fifth year we'll take out five times that amount. Somewhere between $15 and $20 will be taken out of the original $655.32, so eventually the modified AAPCC for Los Angeles County will be, roughly, $635, and that'll stay fixed for the life of this methodology. I don't think it's going to survive 13 years like the AAPCC did, but we'll see.

Again, the area-specific rate is based upon two main factors: the modified AAPCC and the growth rate. Now that we've gone through the calculation for the modified AAPCC and the growth rate, we can simply perform the multiplications and find out that the area-specific rate is $635.41 for Los Angeles County—90% of the area-specific rate in year 1998; 10% of the national rate or the input price-adjusted rate. Let's turn to the input price-adjusted rate. Again, the blended rate is formed from an area-specific rate and an input price-adjusted rate. The input price-adjusted rate for a county again is calculated by taking a national rate and adjusting it to reflect price levels in the county. The national rate is called the standardized national rate which is a weighted average of all the area-specific rates.

Let's return to the area-specific rate calculation we just went through for Los Angeles County. We'd have to go through that same calculation for every county in the country and take a weighted average of those rates, and what we'd come up with is called a standardized national rate. If you don't like this, remember an actuary did not do this. This was done by bureaucrats. The standardized national rate for 1998 is $471.56. That's a weighted average of all the area-specific rates. You can see that for Los Angeles County. Since this area-specific rate was $635.41, it's much higher than the standardized national rate. We're going to take the standardized national rate next and apply some factors to it to make it a Los Angeles County rate.

The input price-adjusted rate is obtained by splitting the standardized national rate into component parts. For each county each component part, once you do the split, is multiplied by an index. The index reflects the price levels in the county relative to the national average price levels. After the components parts are multiplied by the price indexes, they're summed together to give you an input price-adjusted rate. The first thing we do to split the standardized national rate is to split it into Part A and Part B services. Sixty-five percent of the standardized national rate is attributable to Part A services, and 35% is attributable to Part B services.

We have to further subdivide the Part A services. Part A covers facility-based benefits, inpatient hospital costs, skilled nursing facilities, home health, and things of that nature. It was decided that the cost of services for Part A should be split up into two types of cost: labor-related and nonlabor-related cost. Labor-related costs are 70% of all Part A cost on a national level basis. The nonlabor-related costs are 30%. The Part A services are, therefore, broken up into those two parts, and you need some indexes that reflect the price levels in the local county. The indexes that we applied to the labor-related portion of Part A is the prospective payment system (PPS) wage index. It's conveniently there for us. The (PPS) and those wage indexes are already calculated in order to pay under the DRG system. It reflects wage levels in the local area relative to the national average. The wage index for Los Angeles County is 1.227. That's saying that wages are higher in Los Angeles County, about 23% higher than the national average. We don't have an index for the nonlabor portion of Part A, so, everybody gives a factor of one, which basically puts them at the national level.

If we look at Part B, a similar thing is done. We split the Part B cost up. As I said at first, 35% of the national rate is Part B. We have to split that 35% up further. On Part B we split it up into professional services. That's 66%. Facility services is the other 34%. The facility services are subdivided into labor and nonlabor with 40% of the 34% going to labor and 60% of the 34% going to nonlabor facility cost. For the labor cost we use the same index as we do for Part A, the PPS wage index. For the professional services we use the physician geographic practice code indexes, which are indexes that come out of the way HCFA pays physicians under physician payment reform. They're conveniently there too, and I want to ask who knows about those because I don't know very much about those myself, but I can tell you that they reflect the cost of providing physician services in a local area as compared to the cost in providing those services at a national level. There are no indexes conveniently available for the facility nonlabor portion of Part B, so we use a factor of one.

Using those breakdowns of types of services and those indexes, we can actually figure out the input price-adjusted rate by summing the products that are shown in the formula. Once you do all the cross-multiplication, the input price-adjusted rate for Los Angeles County comes out to be $536.90. You can see that the $536.90 is lower than the area-specific rate of $635.41. Taking this national rate and adjusting it down to the county level doesn't necessarily give you a representation of what the costs truly are in that county. That because these indexes don't take into account the differences in utilization in a county. They're only taking the difference in cost levels. People in Los Angeles probably use a lot more services than people on a national average. But that's how the law requires us to do the calculation.

Finally, when you take the formula for the blended rate, you take 90% of the area-specific rate and 10% of the input price-adjusted rate. You'll come up with a figure of $625.56. That number is lower than the 2% minimum increase of $635, but it's higher than the floor of $367 so Los Angeles County ends up getting the 2% minimum increase.

From the Floor: The difference between where the cost is incurred versus where the member lives pays the geographic rate based on the residence of the member, but that member does not necessarily get care in his or her county. I was wondering if there was an attempt to fix that or if there was any payment methodology.

Mr. Maze: Yes. In the past with the AAPCC we did approve expenses by the residence of the beneficiary, so if the person went outside of the county and received services, those services would follow the individual home. On the medical education portion I'm not sure. I think there could still be ways that we could make the expenses follow the individual, and I can't honestly say that we're not doing that. That's a good question. I'm going to check into it and see if we're doing that and, if not, see if that would be the appropriate thing to do. The thing about this methodology is that Congress passed a law in August, and we were under a lot of pressure to print out the rates three or four weeks later. I wasn't actively involved. I'll make sure I check into that.

From the Floor: PSOs will typically not have any commercial membership. Is there any discussion as to how they're going to prepare an ACR filing?

Panelist: I'm not really sure what the answer to that has been.

From the Floor: What is going to be the starting point in the formula? Would it be the area-specific rate?

Mr. Maze: The starting point is still the 1997 AAPCCs.

From the Floor: Is that going to be in your example? Is that going to be the 2% rate which is going to be the 625 or is it going to start with the medical-adjusted number of 651?

Mr. Maze: Well, it's going to start with the area-specific rate based upon the 1997 AAPCC modified.

From the Floor: So, in 1999 in order to get the 2% minimum in 1999 are you going to apply the 2% to the 651 or are you going to apply it to the 625?

Mr. Maze: No, we're going to apply it to 635 because that's what they were paid, and the 2% minimum is based on what you were paid. That's the easy thing. So, they were paid 635. You just multiply that by 2%.

From the Floor: Six hundred and thirty-five, yes?

Mr. Maze: Yes.

From the Floor: Carve-outs: how are the hospitals reimbursed now?

Mr. Maze: The hospitals have to submit for payment to HCFA.

From the Floor: I work in a health organization. It's not fully carved-out. You're still getting reimbursed for it. Whatever they can't recover from you they might try to recover payment from us.