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Traditional Medicare Supplement Insurance: Future Opportunities and Challenges

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Moderator: JOHN K. HEINS
Panelists: GAIL M. LAWERENCE
EDWARD P. MOHORIC
Recorder: JOHN K. HEINS

The Balanced Budget Act of 1997 provides the insurance industry with a few new "things to think about," including the addition of a $1,500 deductible option on plans F and J, medical savings account options, private fee-for-service plans, etc. These changes, in addition to reductions in future payment levels to many Medicare risk contracts (possibly leading to reduced benefits being provided by the HMOs), could provide greater opportunities for insurance companies to retain healthier risks.

Mr. John K. Heins: We have a lot of expertise here to share with you. Ed Mohoric is an FSA and a consulting actuary with Milliman & Robertson since 1982. His expertise is pretty broad. He covers a lot of lines of business but has spent a great deal of time in health and, in specific, on senior issues. Ed has served on the AAA Committee on Life Insurance and is a member of the Section Council for Nontraditional Marketing for the SOA. He has spoken frequently at SOA and other meetings. Gail Lawrence is with American Republic. She's an FSA and a member of the AAA. She's been with American Republic since 1991. She manages the Medicare Supplement block at American Republic, and under her management that block has grown 700% in just 7 years. It now comprises $180 million in annualized in-force premium. According to recent statistics it's the 10th largest writer of Medicare Supplement. Gail is currently co-authoring an article for the Health Section Newsletter regarding the impact of the Balanced Budget Act (BBA) on traditional Medicare supplement markets, specifically what she's speaking about today, so that would certainly lend some credence that she's an expert at it. She's a former member of the Senior Issues Committee of the Council for Affordable Health Insurance and was invited to a working meeting sponsored by the Robert Wood

Johnson Foundation on implementation and policy issues for Medicare and medical savings accounts (MSAs). She has spoken previously at SOA and other meetings. With that, I'll introduce Ed.

Mr. Edward P. Mohoric: We're going to split our talk into the recent past and the future. My section is going to be the recent past. In fact, I'm going to call my part "Omnibus Budget Reconciliation Act (OBRA) 90: The Sequel." It has been 8 years since OBRA 90, and I'm going to review several of the items that were implemented with this federal regulation with an eye to their intent and some discussion as to whether this intent or whether some unintended things were achieved. I will then review the ever-popular state implementation of OBRA 90 and the model regulation. Then I will focus on standardization of benefits, loss-ratio issues, refunds, and replacements. This product line has been interesting in the last few years. There's frequent debate on the merits of state versus federal regulation, and I personally don't have a fully formed opinion on it.

I've heard arguments on both sides, and sometimes I agree with the idea of more federal, and sometimes I agree with the idea of more state, but Medicare supplement has managed to combine the worst of both elements. Clearly, this is not the way to go. OBRA 90, of course, was passed by Congress. The Health Care Financing Administration (HCFA) was charged with the interpretation and dictated to the states pretty much what had to be done with Medicare supplement. In a sense that was good because that made it a largely uniform law, but some states have interpreted and enforced things very differently and have added some points to the law. The result, both from the federal level and the state level, has presented some actuarially unsound results in several respects.

We normally think in terms of how the insurance companies can't keep up with and abide by the changes in the law, but I found one real interesting thing when we tried to do a little research two years ago. One of the things that the states are charged with as part of OBRA 90 is to prepare an annual guide for Medicare supplement. The intent of this, which is pretty good, is to give to consumers a guide that will aid them in rate comparisons in the state so they can have a better understanding of what is available and what they should buy. Two years ago, as part of a client project, we contacted all 50 states to try to get a copy of these guides because we were trying to do some rate comparisons for the client and figured this would be the best way to really find out who's issuing what and where. We called all 50 states and got something from 38 of them. For the other 12, we really just couldn't get through to the right person to get a guide. This was in May 1996, so we expected that we'd get the 1996 guides with either the 1996 or possibly the 1995 premiums, and we could use that as a basis of comparison.

Of the 38 states that we got something from, we got 18 consumer guides for 1996. We got eight guides for 1995, which was a little bit backdated. We received two guides from 1994. Four states just sent us a list of companies with their phone numbers. Two states sent us these generic NAIC guides that define the standard benefit packages. Two states actually told us they didn't publish the guides and didn't intend to. One state sent us a long-term care guide. And one state sent us a guide on auto insurance. So, needless to say, the client project was of somewhat limited use with what we did get.

Let's spend a little bit of time on standardization of benefits. I'm sure everyone here has seen Table 1. It's pretty standard in anything with Medicare supplement now that identifies the 10-pack and what benefits are offered with each one. Plan A is required, of course, and Plans B through J are optional. We did an informal survey. Dawn Helwig helped compile a survey of about 20 companies to find out which plans are being offered, even though all 10 may be offered. Of course, every single company has to offer Plan A. There's no choice there. Often the companies will pick three or four plans to sell. Some will pick all 10. What we found from this survey is that there's a real preponderance of Plans B (65%), C (81%), and F (92%), mostly F, with a smattering of some of the other ones.

TABLE 1

MEDICARE SUPPLEMENT

STANDARDIZED PLANS

Benefit	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
1. Basic	X	X	X	X	X	X	X	X	X	X
2. Part A Deductible		X	X	X	X	X	X	X	X	X
3. Part B Deductible			X			X				X
4. SNF Coinsurance			X	X	X	X	X	X	X	X
5. Part B Excess						X	X[1]		X	X
6.. Foreign Travel			X	X	X	X	X	X	X	X
7. At-Home Recovery				X			X		X	X
8. Preventive Care					X		X			X
9. Prescription Drugs								X[2]	X[2]	X[3]

[1] Only 80% of excess covered
[2] Basic Coverage
[3] Extended coverage

Even though these plans are the ones being offered, these are not necessarily the ones being bought. Of the percent of sales by plan, the popular plans are F (47%), C (23%), and B (9%), and even though everyone offers A, basically nobody is buying A (only 4%). And of those offerings, some have developed certain niches. For instance, if you look at J, basically it's only 3% of the plan, but some niches develop, particularly with Plan J. While very few offer it; it's a fairly large seller for

those who do sell it. So, we found out some interesting information as to what is being sold among the 10-pack of standard plans.

What was the intent of standardization and was it accomplished? The intent was to take away some confusion. A lot of the plans had small, minor variations in benefits. It was perceived that the seniors couldn't interpret what it did and didn't cover. Plans would have very small changes covering nursing home for an extended length or ambulance benefits—very small distinctions in plans. What this did is it took a near-commodity and made it even more so. The sales are done today mostly on price, a little bit on service but I think very little, and companies have done all they can to thin their prices down. There's been a movement to attained age because of this. Companies have tried to lower their prices as much as possible and to get more actuarially correct loss ratios, which I'll cover in a little while.

There's some exception to the movement to attained-age plans. Florida, in particular, Georgia, and probably a couple other states require entry age only. There's been some movement to split into nonsmoker/smoker categories in order to slice up a piece of the potential insurers and thin down the price as much as possible. Now, you can't do this at age 65 because of the open enrollment, non-underwriting issues, and you can't, in most states at least, make smoker/nonsmoker a distinction. There's been some movement toward sex-distinct rates. Females, of course, are a little bit cheaper and you can segment your product that way. And there's been a much stronger move toward what I'll call more intense area rating. I think eight or nine years ago most companies would have two or three area rates, maybe pick a couple of the higher states, and segment those out. Now many companies have four to six segments within a state.

Plan standardization has had some unintended effects. In my mind, the 10-pack has really become a 9-pack. Plan F is starting to converge into Plan C. The only difference in benefits between the two plans has to do with excess doctor coverage. At the time, in 1991, when this was developed there were a lot of doctors still not accepting assignment, and we had estimated at that time that there was about a 20–21% variation between Plan C's expected claim cost and Plan F's. Currently we're expecting about a 2% difference. They're really not very different plans anymore, so the 10-pack has become pretty much a 9-pack. Another effect has been the purchase of undesired benefits. Because insureds only have 10 choices, they have to make decisions and buy some benefits that they may not be interested in. The foreign coverage benefit, for instance, is one that many seniors feel they will never need, but it's still built-in. That's a relatively minor coverage.

Another issue has been the purchase of undesired combinations. If you want a drug benefit, you have to have the Plan A deductible. There are no choices anymore. The Part A deductible certainly drives the cost of the product a good bit, and you really don't have that many choices. I think Gail may get into that a little bit in her talk with the proposed high-deductible plans, but there really has been a limited ability to make choices that are useful to you. Also the coverages have, of course, have been limited, drug coverage in particular. For the few plans that offer drugs, you have to choose either $1,250 of basic drug coverage or $3,000 total. The real insurance needs, the people who have serious prescription drug costs, run beyond that, and there's no coverage for them. If you have some serious problems that require a lot of pill taking, at $10 a pop with Viagra you can run through $3,000 quickly. This limitation of coverage I also believe, although we're talking about traditional Medicare supplement today, has hurt the traditional coverage in trying to compete with Medicare risk coverages, which can pretty much offer what they want to offer with drugs, vision, and anything else. There's purportedly an out to the 10 standardized by coming up with what's called innovative benefits. Each company is allowed to have one innovative benefit if they desire and can implement this one time, but the reality, I found, is that it's very difficult, in the few cases that we've tried, to get an innovative benefit approved, and very few companies have used this.

The one other thing I'll cover while I'm on the subject of standardization is a movement I've seen lately between a couple plans. I'm not sure if it's a trend yet or not, but there might be some shortsighted reasons here. Traditionally, as I showed you before, companies have focused on Plans C and F competitively and have sold a lot of them. In some companies, the loss experience may be starting to merge somewhat poorly, and there's been some need to take some rate increases. One restriction of the model law now is that you can't have more than one Plan F or Plan C, or some variation on that for group or individual, but you can't just close off a block and start a new block. If you've been selling a lot of Plan C and have to raise the rates because of loss-ratios, it can easily make you uncompetitive for a new sale and can force you into a closed-block situation. Although I'm not going to say it's a trend, I've noticed a few companies coming out with some very competitive rates for Plan D as a solution, I believe, to get away from Plans C and F and sell Plan D competitively . If the reason that you have to do this is because your C and F rates need to be increased greatly, it's like concluding that, "We did it wrong once, let's see if we can do it wrong again." We at least want to be consistent. But I have seen a couple situations where the premium for Plan D was as much as 25% lower than Plan C.

Let's move on to loss-ratio mandates. When OBRA 90 was passed there was perceived and sometimes real, abuse with respect to loss ratios. Companies weren't

necessarily complying with the peg of 60% loss ratios, and one of the big focuses on OBRA 90 was to get tough on compliance. This was done in a couple of ways. First, they moved what was originally a 60% lifetime loss ratio up to 65%. This was pure ratcheting. The rationale was that premiums had increased, so the loss ratio should increase too. That was truly the rationale that was given by some of the consumer advocates who sat in on some of the meetings after OBRA 90 was passed and some of the development meetings for the model regulation. The industry at the time made arguments that expenses had increased, as well as taxes and target surplus requirements, but that didn't hold much water.

Second, OBRA forced the idea of not only a 65% lifetime loss ratio but because of the refund requirements, a 65% loss ratio by the third policy year. If you have an entry-age product with reasonable underwriting and reasonable lapses, you simply don't get to 65% by year 3. It's actuarially not correct. When I spoke at the time with one of the regulators charged with working out the model regulation, who frankly had a lot of pressure from all sides—the industry, the consumers, and the federal government—I tried to convince him that it just doesn't hit 65% by year 3. He said, "Yes, but the consumers wanted it by year 2." That was the best actuarial justification that could be given at the time.

The use of the refund calculations are forcing certain requirements at certain points in time. Table 2 summarizes quickly what the benchmark loss ratios need to be. Of course, the 65% by year 3 is a big one. But as companies start needing to comply with these loss ratios, and in creating the benchmarks, it's not just the loss ratio, but several other actuarial side points that need to be built in. Whenever you're working within such a well-defined structure, any variations from that structure, positive or negative, can change your results.

TABLE 2
BENCHMARK LOSS RATIOS

Year	Loss Ratio	Year	Loss Ratio
1	40%	6	71%
2	55	7	73
3	65	8	75
4	67	9-11	76
5	69	12+	77

Table 3 displays the typical refund calculation slide and shows what the loss ratios, the persistency, and the rates have to be to get to 65%. I'll run quickly through the details underlying the refund calculations. Lifetime is not defined as lifetime. It's defined as over 15 years. Policies are assumed to be issued uniformly throughout

the calendar year. It assumes a 10% trend in both premiums and claims in the calculation. It assumes a certain structure of loss ratios, which I already showed you, and a certain set of lapse rates. I'm talking here exclusively about individual forms, which add up to 65%. Group is similar but adds up to 75%. If any of these change, you could be running amok high or low on the anticipated loss ratios.

TABLE 3
MEDICARE SUPPLEMENT RATE
REFUND CALCULATIONS

ASSUMPTION UNDERLYING THE DEVELOPMENT OF BENCHMARK LOSS RATIO

Year	LR	Persistency	Rate Level	Premium	Claims	Cumulative Loss Ratio
1	40%	0.70	1.00	1.00	0.40	40.0%
2	55	0.75	1.10	0.77	0.42	46.5
3	65	0.80	1.21	0.63	0.41	51.4
4	67	0.80	1.33	0.56	0.37	54.3
5	69	0.80	1.46	0.49	0.34	56.4
6	71	0.83	1.61	0.43	0.30	58.1
7	73	0.83	1.77	0.39	0.29	59.4
8	75	0.83	1.95	0.36	0.27	60.6
9	76	0.83	2.14	0.33	0.25	61.7
10	76	0.83	2.36	0.30	0.23	62.5
11	76	0.83	2.59	0.27	0.21	63.1
12	77	0.83	2.85	0.25	0.19	63.7
13	77	0.83	3.14	0.23	0.18	64.2
14	77	0.83	3.45	0.21	0.16	64.7
15	77	0.83	3.80	0.19	0.15	65.0
Total				6.43 Loss Ratio	4.18 65%	

Table 4 shows the historical changes in the Part A deductible. The average was 14.6%, but it dropped to 4.8%. In recent years it's been actually very low, but at the time OBRA 90 and the model regulation were written, we had had several years of 10–15% increases. As shown in Table 5, Part B increases have not trended down as quickly, and even though the medical services combined premium increase (CPI) is down lately in the 3–4% range, Part B has ranged from 7% to 9% in recent years, a lot of that being due to outpatient hospitalization issues. But what can tend to happen, just to pick an example of how real experience deviates from what the refund calculation says, is that you can find yourself further and further off. The refund calculation says you have to assume a 10% trend. In aggregate, trends are a little bit below 10%, and it is not unlikely that in the future they could stay in the 5–7% range if inflation does stay low. What would this mean? If, instead of a 10%, you issued a block of policies over an extended period, and you only had and needed a 5% trend increase, over the 15 years, with everything else remaining the

same, you wouldn't hit a 65% loss ratio. You'd only hit 61.5%. This would force refunds if, in fact, you did this.

TABLE 4
MEDICARE PART A
HISTORY OF DEDUCTIBLES

Year	Deductible	Percentage Increase
1984-1988 Average		14.6%
1988-1991 Average		4.8
1992	$652	3.8
1993	676	3.7
1994	696	3.0
1995	716	2.9
1996	736	2.8
1997	760	3.3
1998	764	.5

The reality is, as you see it coming, to avoid refunds. What you'd start to do is not take the 5% increase but take a lower increase. In fact, what you need to do in order for the loss ratio to hit 65% is to take a 3.4% rate increase, which is 1.6% below the trend. Ultimately, if you do that, you'll end up in a forced-subsidy position as your new business becomes under-priced in order to insure that your older business is not hitting the loss ratio purely because the trend is lower than 10%. There's no other deviation. You'll end up having subsidies of new business versus old. The same type of thing can happen anytime you have a structure that says actuarially you have to hit this loss ratio at these lapse rates with this trend at this time. With any sort of a structure that you build, real deviations from those structures are going to set up anomalies. If, for instance, lapses are lower, you're going to end up with a loss ratio that's higher than the 65%, and it's going to be the opposite of what I just showed you. You're going to have to react with higher rate increases and less competitive premiums to make up for the fact that your persistency is higher.

TABLE 5
MEDICARE PART B EXPENSES
HISTORY OF TRENDS IN PART B
COSTS PER ENROLLEE

Year	HCFA Total Reimbursement/ Enrollee Part B Trend	CPI-U Professional Medical Services U.S. City Average Annual Charge	Ratio Part B/ CPI-U
1984-1987	12.9%	6.6%	1.95
1988-1991	9.8	6.4	1.53
1992	3.9	5.7	.68
1993	5.6	4.5	1.24
1994	8.4	4.6	1.83
1995	7.6	4.0	1.90
1996	6.0	3.6	1.66
1997	7.9*	3.1	2.55
1998	9.5*	4.0**	2.38

*HCFA Estimates
**Estimated by Milliman & Robertson, Inc.

One thing I thought as I was talking with one client who was intending to do some upgrades, since the calculations have to be done on a by-policy basis, by-plan basis, what happens if you upgrade from one group, say a Plan B to a Plan F or G? A company's normal incentive for upgrade is, of course, higher premium and better persistency with your upgraded people. But the plan that you're moving from will, of course, have worse lapses, not because the people are leaving your company but because they're moving to a different product. What I did in this example is assume everything remains the same, except in year 3 I changed the expected persistency of 80% to 60%, assuming the other 20% would move up to the next product. That in itself forces a result that's 1.5% lower, and that lower result means, of course, that you're going to have to take a lower rate increase in order to meet the 65% loss ratio. Over time, if you continue to upgrade like this, the product you're upgrading to is going to have the opposite impact, and you're going to need higher-than-trend loss ratios to achieve the 65%. You'll end up in the situation of serious divergence, where the low plan has to continually take less than trend, and the high plan has to take more than trend, all because you can't aggregate.

I'll just hit one quick point on the refunds, which is that the refund calculation is done by plan and by state and on a cumulative basis. Three years ago, in 1995, we took a survey of 30 companies to see if anyone had done any refunding yet. The answer was no. There may have been an exception, but we hadn't found anyone who had had to do that. I asked a few clients in preparation for this whether they've had to take refunds yet, and the answer was, "Not much because it hasn't

been important," which tells me that people still aren't thinking about it. Bit by bit it's becoming a reality, though, and I want to throw some alarm into you because I don't think management has realized the seriousness of this yet. The fact that it's cumulative means it's going to happen. Depending on how many policies each year you sell in a state, you will get to where you have to worry about the refund issue, and it's going to be a reality. The management is going to be seriously concerned when expected 65% loss ratios end up really not being there because of payments given out and the fact that it has to be done on a state by state basis. The reality is going to be that, if you have one state slightly running over and another state running under, you'll end up at more than 65% because there's very little tolerance, 0.5% with full credibility, on the low end of the state.

I try with clients to price in terms of a 67% or 68% expected loss ratio where I can to try to build in for the fact that we're not good enough to hit 65% exactly. Competitiveness, sales costs, and margins being what they are, we often are forced to shoot for 65%. You can run into some problems with that. If there's more time later, I can get into some details on replacements and refunds, but I will turn this over to Gail at this point.

Ms. Gail M. Lawrence: My job is to visit with you about the BBA of 1997, and its impact on traditional Medicare supplement coverage. I'm also going to be talking about two new potential opportunities, which are basically private fee-for-service and Medicare MSAs. I'm sure most of you are familiar with the managed care risk options that are available today. The government has given managed care a new name. It's called "coordinated care," and coordinated care plans will be offered by HMOs, the provider-sponsored organizations, and the PPOs. Seniors are also going to have options with respect to private fee-for-service and Medicare MSAs.

I will try to give you a broad overview of the law provisions mostly from a product development and implementation point of view, as well as from a marketing viability point of view. What's coming down the pike is the mega-regulation, which is going to be published in the June 26 issue of the *Federal Register*. You heard it first from me. It's 833 pages long, and this is the regulation for Medicare Part C or the Medicare Plus Choice.

With respect to the BBA impact on traditional Medigap coverage we have some new open enrollment provisions. We have to give guaranteed issue in the case of a loss of coverage of an employee welfare benefit plan. To date, 34% of seniors have employer-sponsored supplemental coverage. If that plan gets discontinued or, say, a spouse loses coverage because of the death of the other spouse, we'll have to give them guaranteed issue. I think we'll also be picking up some open enrollment because of discontinuation of Medicare Risk or Choice plans. It also provides for a

one-time opportunity to opt out of Medicare Choice plans and back into a Medicare supplement plan.

There's also a limitation on the preexisting condition exclusions that you can apply. Today we can impose a preexisting condition exclusion mostly on open enrollees. In the future you will not be able to impose a preexisting condition exclusion on open enrollees who satisfy continuation of coverage requirements as defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The federal effective date of those provisions is July 1, 1998. The NAIC has taken the position that compliance is required as of that date. I will say it's always fuzzy, and states may have a different opinion as to that effective date because they are going to have to change their regulations. The NAIC adopted a new model effective April 29, 1998, and states have one year to change their laws.

From a product management point of view, carriers are going to have to review their applications. I know at American Republic we found that we're going to have to file a new application to properly identify the new open enrollees. You're going to need to retrain your policy issue personnel as well as your agents. You might want to review your sales material and your claims administration procedures. We also found that we needed to endorse our preexisting condition exclusion policy language, and, of course, as actuaries you should review the rate adequacy. One thing that was significant that was not passed in the BBA is a provision calling for open enrollment of those under age 65. The industry didn't feel that we would have a level playing field because that was not required with the other Medicare Choice options. I would note that the NAIC does continue to encourage states to adopt such an open enrollment for the underage market.

With the BBA we also have two new standardized plans. These are going to be high-deductible plans where there's 100% coverage after satisfaction of a $1,500 annual deductible, with either Plan F benefits or Plan J benefits. After 1999 the deductible will be updated annually in $10 increments based on the CPI change for urban consumers. The effective date was actually with the passage of the BBA, but here again states have not adopted regulations such that you could probably get approval for these proposed policies. I think Ed illustrated very well that there's very little consumer interest in low-benefit plans, and I think it's safe to say, even if you offer them, you aren't going to have many sales.

I did spend a little bit of time doing some rough pricing on a Plan F high-deductible plan. Based on the claim cost of American Republic, about 15% of the insurers would probably receive a benefit or, in other words, satisfy the deductible. And I think average premiums would be between the $30 and $35 range, which would be applicable more in the Midwest. In terms of special pricing considerations, with

this lower benefit plan you are going to have smaller margins available. So, you may want to review what compensation you want to pay, and I would certainly expect more volatility in the loss ratio, which is an important consideration in light of refunding requirements.

There have been some other changes to the Medicare program that will have an impact on traditional Medicare supplement. There are changes in the provider payment methods, and if you've gone to the Medicare track, you've already heard those twice, so I'm not going to review them again, but hopefully we'll have some lower trend. There's also improved Medicare coverage for preventive care, so you may get some reduced claim costs for that reason on say, Plans E and J. For the Wisconsin basic plans most carriers offer a preventive benefit in their basic coverage. I think the real question on my mind is, what is the impact of Medicare Plus Choice going to be on Medigap market shares? Medigap market shares are decreasing. In 1995 there was a 10% decrease in the number of lives, and in 1996 there was a 4% decrease. I expect that trend to continue.

As our lives have dropped, Medicare managed care lives have increased. Regarding Medicare penetration by state, as with the West Coast, you have tremendous penetration, with rates of nearly 40% and 25% in Florida. In the high plains states, we have very little managed care, so where American Republic operates, we've been somewhat insulated from managed care penetration, which is why the minimum floors were increased. Iowa Senator Charles Grassley and Iowa Representative Greg Ganske felt that it was not fair that there was no managed care in Iowa, so seniors did not get free eyeglasses and prescription drugs. It was very much a political issue in terms of the changes in the payment rates. If any of you experts out there would like to comment, I'd certainly like to know whether we are going to continue to see increasing penetration in the West Coast. Also, I'd like to know whether the minimum payments are sufficient to attract managed care into the high plains states. We definitely will be receiving some huge windfalls.

I'd like to move on to private fee-for-service. Enrollees must have an unrestricted selection of providers. The provider must not be at risk. And the provider fee payment levels must be uncorrelated with utilization. If you elect to offer a private fee-for-service plan, there are some restrictions as to what your benefit design options will be. It is required that your basic plan provide coverage for current Medicare services and items, except for hospice. You can have cost sharing in your plan. However, it can be no greater than the equivalent value of Medicare's cost sharing. Just like risk contracts today, you may have additional required benefits if the average of the capitation payments is greater than the value of the required benefits, in which case you need to return that excess value to the enrollee in terms

of additional required benefits. You will be allowed to have supplemental, non-optional benefits subject to approval by HCFA, as well as optional benefits.

With respect to provider reimbursement rules, contracted providers are paid per plan fee schedules. There's unlimited access. Do I have to contract with the whole world? The law's going to help you here. In fact, I'm going to read it because it is amazing: "A provider is treated as having a contract in effect if the provider furnishes covered services basically to a private fee-for-service enrollee, and before providing such services, the provider has been informed of the individual's enrollment under the plan and either has been informed of the terms and conditions of payment or is given a reasonable opportunity to obtain information concerning such terms and conditions in a manner reasonably designed to effect informed agreement by the provider." So, the law's kind of helping you out. The monkey's on their back to find out what your fee schedules are.

Now, here's a big one. Contracted providers are allowed to balance bill beneficiaries an additional 15%. This is not the 15% balanced billing that's part of Medicare. They get to balance bill your fee schedules an additional 15%. If you want, you can offer supplemental coverage for that liability. Because this is a huge liability, and it's very important to realize that this applies to all providers. The balanced billing limits today apply only to physicians. This includes hospitals and labs. Everybody gets to balance bill. And because of this huge additional liability there are some disclosure requirements.

I guess what you want to know is what are you going to get paid to offer these plans? Well, you're going to get the monthly capitation payment from HCFA, the same as coordinated care providers or managed care providers, and that capitation payment is going to be based on the county level subject to blending, minimums, floors, ceilings, and risk adjusters. The risk adjustment mechanism will be applied to payments beginning no later than January 1, 2000. Besides the HCFA payment that you're going to get, you're also allowed to collect a premium from the enrollee, and the good news is that premium is not subject to approval by HCFA, and you'll probably get to change that once a year.

We have a number of other provisions that are rather lengthy, and I'm not going to go over them in detail. The enrollment of coverage by enrollees is going to be the same as under coordinated care, and coverage can begin effective January 1999. You're going to have numerous requirements involving disclosure, quality assurance provisions, grievance and appeals procedures, and confidentiality requirements. You're going to have to go through the standard HCFA contracting provisions. You will have minimum enrollment requirements. You will have to be

licensed. You're going to have to adhere to their marketing rules. And HCFA gets 45 days to review your marketing materials.

Is this going to be a viable marketplace option? Well, clearly what you have in this option is a situation where you are allowed to pay providers more than the Medicare allowable amount. I think the political motivation for this option came from the providers because they would like to get more than the Medicare allowables, and this allows them to do it without having to opt out of Medicare, so I think the providers will love it. Are the consumers going to love it? I'm certainly concerned whether or not the private fee-for-service premiums are going to be competitive against, say, traditional Medicare Plus and Medigap policies, particularly if you have providers who are willing to accept Medicare-allowable charges. I think in today's environment the premiums probably won't be competitive, but there's always tomorrow, and things can change very, very quickly. There may be potential opportunity in the rural markets where the payment rates are going up so much and there are potential windfalls. You might want your centers of excellence to put together a private fee-for-service plan.

Medicare MSA enrollment begins effective January 1, 1999, and new enrollment ends the earlier of 390,000 enrollees or January 1, 2003. HCFA has to do an evaluation of the project, and the report to Congress is due March 1, 2002. The HCFA assessment will be focusing on, among other things, utilization by beneficiaries and the impact on their health, a risk profile of enrollees, and potential gains or losses to the trust fund. HCFA people very much consider themselves in the role of guardians of the trust fund and protectors of the beneficiaries.

We are going to have some special enrollment rules that are unique to Medicare MSAs. You can enroll only during the initial eligibility for Medicare, the annual coordinated election period, and November 1998. Disenrollments are allowed only during those same enrollment periods or if a plan is discontinued or someone moves out of the service area. Basically what they're trying to do with these enrollment rules is tighten them up and lock enrollees in for at least one year. There are going to be a few low-income and disabled groups who are ineligible to participate.

How do Medicare MSAs work? Just in terms of a general concept, there's a bag of money at HCFA for a person. Part of that bag of money can be used to buy a high-deductible Medicare plan, and the remainder of the money gets deposited into an MSA. With that MSA you're allowed to withdraw funds on a tax-free basis for qualified medical expenses.

Let's look at what kind of plan designs you have to offer. Your plan must cover at least all Medicare services and items. You can offer any number of deductibles, but the law does specify a maximum deductible of $6,000. That deductible will be updated annually in $50 increments. In terms of satisfaction of the deductible, countable expenses are the amounts payable under Medicare, and that would be at the Medicare fee schedule amounts, including any cost sharing, which would be Medicare's coinsurance and deductible. After the deductible has been satisfied, the plan pays the lesser of actual charges or the Medicare allowable amount. You will be able to offer optional supplemental benefits, provided that supplemental benefit does not cover the MSA deductible. And I do think you're going to be allowed some flexibility in plan design. You can either have your supplemental benefits included in the annual deductible, or, if you want, you can keep them separate and have separate deductibles and coinsurances on those supplemental benefits.

Next I'd like to talk a little bit about the MSA accounts. Account trustees or custodians must satisfy IRS requirements. Generally they are banks, financial institutions, fund managers, or insurance companies. I do want to warn you if you want to be a Medicare MSA administrator, as an insurance company, you do tend to have more claims because you end up processing claims that would have been left in a shoebox, so that has been a downside if you want to take on that transactions role.

Contributions from HCFA are the only ones that are allowed, and the contributions and account income are tax-free. You can withdraw money from your account for qualified medical and dental expenses on a tax-free basis. The definition of a qualified medical expense is found in IRS *Publication 502,* which would be just your standard medical deduction expenses. If you want to withdraw money for nonmedical purposes, you're allowed to do that, but you are subject to routine income tax, and if the account balance falls below 60% of the deductible, you'll have to pay a 50% penalty. The accounts are going to be self-administered or self-policing. Basically, nobody's going to authorize withdrawals. Employees are going to be required to itemize qualified medical expenses for IRS purposes on Form 8853. They'll have a little homework.

What am I going to get paid if I offer a plan? Well, it's kind of interesting. First what I'd like to do is go over how the MSA contribution level is determined. Basically, it's going to be the plan that determines the MSA contribution level, and for their given service area they're going to have to calculate at HCFA's average payment, and then subtract the average premium that they want to collect. That becomes the MSA contribution level, and they get to market that information.

In terms of what the plan is actually going to get paid for each enrollee that the plan gets, HCFA is going to provide a demographically adjusted capitation payment, the same as in a coordinated care plan or a private fee-for-service plan, minus that community MSA contribution. What is this going to mean from the enrollee's point of view? Well, we have a community contribution. Community means subsidies. High-cost people will be subsidizing low-cost people. That's interesting. From the carrier perspective, you're going to have to manage your demographic mix. In terms of the flow of funds, the annual lump sum is going to be deposited by HCFA into the MSA account, and plans will receive monthly payments from HCFA.

What do I have to pay providers? You are allowed to have network plans. If you have a network plan, you've negotiated fee schedules, and you pay according to your contract with the providers. If you choose the non-network basis, what you really need to understand, and this is very important, is that enrollees will be liable for any amounts not covered by the plan. So, basically the non-network providers are going to have unlimited balanced billing rights, which is going to be a huge liability. Although, if you want, you can offer supplemental benefits. That's HCFA's solution. I am very concerned about the unlimited balanced billing, and I think it's going to have a big impact on the viability of this option. I'm hoping for a legislative solution to that problem. If you read the law, the law was actually silent on the matter, and HCFA said we have no regulatory authority to impose a balanced billing limit, so that's what we have.

There are some other, significant things that you need to consider when looking at this option. Plans must be able to process claims at Medicare-allowable amounts. Plans will be required to submit encounter data, mostly diagnosis information, to HCFA. In terms of contracting requirements, 45 days are required for a review of marketing materials by HCFA. If you want to start up a plan on January 1, 1999, it's recommended that the application be submitted by mid-August for non-network or established network plans, and even earlier for new networks. A little bit of a rub is that the application is unavailable yet, but hopefully it'll be out on the HCFA site soon. Plans must satisfy standard Medicare Plus Choice contracting provisions. Much like the laundry list of other requirements that I went over with private fee-for-service, you have the same thing with Medicare MSAs: disclosure, confidentiality, etc.

What are other sources of information? If you want to look at the law and find it, it's H.R. 2015. The HCFA Internet address is www.hcfa.gov, and there's a hotlink to the *Federal Register* if you want to get a copy of all 833 pages of the mega-regulation. At HCFA, Marty Abelm is the private fee-for-service contact person and Cynthia Mason is the Medicare MSA contact person. If you want to know what the BBA does from a layman's point of view, try to find the "Congressional Research

Service Report for Congress, Medicare Provisions" in the BBA of 1997. My congressman actually sent me that, and it does a very good job of describing the current law and what the BBA does.

In closing, I would note that the regulations coming out are interim regulations. HCFA is asking for comments by September 24, and hopefully final regulations will be published next year. I would encourage you to comment on those regulations, although I will say, at 833 pages, it's going to be hard to follow my own advice. I do think I've mentioned a couple of concerns about the new options, although this is just a first stab at some new private market options for seniors. I hope as a profession we will be willing to work with Congress and HCFA to come up with some viable options. Has anybody been approached about offering a private fee-for-service or seen any interest in your company, or have consultants been approached by clients? One. Well, HCFA's ready to go. That's all I have.

Mr. Harry L. Sutton, Jr.: I'd like to compliment the speakers. You've done a tremendous job with a very confusing subject. I have a short comment and then a question. You showed in the great Midwest where I come from that there's very low penetration of Medicare risk contracts. It doesn't create any private market. The American Association of Retired Persons has no business there either. In Minnesota, they get about $350 a month. They all have cost contracts or health care prepayment plans, which are all being phased out, so the different Medicare contracts have high penetration in Minnesota. That just shows that the risk contracts are not representative of what the market for Medicare Supplements would be. That was just a clarification of your table. I'm interested in the MSA part. In fact, I'm going to ask you a leading question.

Do you intend to go into the individual Medicare market or the MSA market? You don't have to commit yourself. The way I read the original law, and I realize there were all kinds of meetings with HCFA, it appeared that the premiums paid to the insurance carriers had to be community rated. In fact, that's what it says in plain English. But then there were discussions because the carriers didn't feel they could issue it that way because of the high deductible creating huge differences in prices, so they community rated it. Instead of community rating the premiums to be paid, they community rated the amount to go into the MSA. If your age slope and so on conformed with that, your insurance premiums might come out OK, but if they didn't, then you didn't have much chance of making any money with that kind of a product. How much interest do you feel is in the MSA product itself, which is not doing too well in the private community?

Ms. Lawrence: There are some reasons why it's not doing well in the under-age-65 market, in part because of the limited number of groups that can participate. Are

we going to go into Medicare MSAs? When we were making our strategic planning decisions, HCFA had made the decision at that time that the premium had to be community rated, and the Medicare MSA amount was going to be basically a demographically adjusted amount. You would have institutionalized people getting a $12,000 MSA contribution, and they could go out and buy a $2,000 premium or a $2,000 high-deductible policy. It was sort of a no-brainer, and I think it was maybe a stupid test for companies, but I think when HCFA decided nobody's going to come to the party and offer these, and it's always under a lot of political fire, it reassessed how it was going to rate these things.

My main concern is the balanced billing. You can manage that by doing a network plan, and then you have the managed care infrastructure on top of a plan that's supposed to save money because of individual responsibility. I don't like that. I'd like to see the balanced billing problem fixed. I think there's some good opportunity potentially in 1999 because, with the MSA contribution being community rated, it's going to attract healthier people, but risk adjustment's coming January 1, 2000, and to the extent that you have a window of opportunity, it's going to be very short. Another thing is that the law was just the egg. It's getting fertilized with all these regulations, so we really don't have the whole story yet. What's extremely controversial, and HCFA wouldn't tell you this, is the service-area definitions. Are you going to be able to have enough enrollees in a given plan area to make it work economically? I do think you're going to have limited interest by seniors. Like you said, I think private fee-for-service was an option to give providers more money. I'm not sure there's a market today, but hopefully there'll be a market in the future.

Mr. Heins: Can I ask one very general question on this because it's very interesting to me? This BBA and all the changes sound interesting. Companies ought to be able to make a go of it in some way. Is HCFA preempting state regulation on this? If yours or any other insurance company decides to go with this, does it even need to tell the states? Do the states have any say in the matter?

Ms. Lawrence: Beyond maybe licensing requirements that may require you to be licensed with the state as a health care entity, I'm not sure the states are necessarily going to have a role.

Mr. Heins: So, this is defined as non-Medicare supplement?

Ms. Lawrence: Right.

Mr. Heins: And therefore, you don't have to comply with the laws as written.

Ms. Lawrence: I don't want to say you don't have to comply with the laws.

Mr. Heins: Well, you won't be able to.

Ms. Lawrence: You're not going to have state law.

Mr. David C. Sky: I might take a little exception to that comment. We just wrote a bulletin saying that our HMO—for example, with the Medicare managed care or any licensed entity that has a contract with HCFA, a contract that you're issuing, with certificates being issued to the New Hampshire citizens—is still subject to this department's oversight.

Ms. Lawrence: Thank you for that clarification. I'm sure, in terms of the regulations, we may see some additional information. In my reading of the law, it didn't really address that issue.

Mr. Brian K. Leonhardt: I had a couple questions. The first one is for Ed. When you put up your chart on the relative cost among Plans C, D, and E, I was kind of surprised to see how close you had those costs. You then made the comment that you thought some companies were underpricing D. From our experience, D just doesn't cover the Part B deductible as home recovery, so, actually, there is a larger difference, I think, than what you showed. And, in our own experience, offering both C and D exaggerates it even. D experience is a lot better than what you would expect on a theoretical basis, so I think there is some reason why those premiums look lower than that. I don't know if you have any comments about that.

Mr. Mohoric: Actual experience can, of course, vary for a number of reasons, such as who's interested in buying it and how much they use the preventive care, so it certainly is possible. Just from a pure claim cost perspective, you'd think they'd be pretty close.

Mr. Leonhardt: I think part of it, too, is with the Part B deductible having to be covered. People who use the service and don't want to have to deal with even the Part B deductible will tend to buy C over D. That is what we suspect.

Mr. Mohoric: So, basically you're saying that you have a better class of people buying D.

Mr. Leonhardt: Right. Gail, you made some comment about changing your application related to the guaranteed issue requirements. It is our belief that the burden of proof is on the prospects to prove that they are eligible for open enrollment under these guaranteed issue requirements. I don't think we're planning

on making any changes to our application. We're going to be relying on the fact that they have to show us a piece of paper that the terminating company has to offer. I'm not sure exactly what you're getting at in terms of what kind of information you need beyond that piece of paper to help you decide whether it's a guaranteed issue requirement.

Ms. Lawrence: You need to know what kind of previous coverage that person had. For example, say we're in an employer group plan and my dad has employer coverage as a retiree of the phone company. If the phone company would terminate its plan, he has a guaranteed issue right for a Medicare supplement policy. Or if my father predeceases my mother, my mother is going to lose that coverage, and she has a guaranteed issue right then. Today, that right doesn't exist. I guess you need to know what kind of coverage people have to properly identify whether or not they're an open enrollee.

Mr. Leonhardt: Well, again, the piece of paper they're supposed to get is to show what their rights are or what open enrollment opportunities are available to them, so I'm not exactly sure what kinds of questions you mean.

Ms. Lawrence: What was interesting in the development of the model is that previously legislators helped us determine what kind of questions to ask because they put that in the model. When we saw it, we were kind of shocked. I guess they thought it was complicated, too. So, you may be on safe ground because the model has not changed.

Mr. Leonhardt: I listened in on the working group's deliberations on the model regulation, and I think that was exactly the discussion that took place, that the burden of proof was on the other one. What was interesting is they actually have language in there that says these companies have to provide that, but they have no authority over ERISA plans or other types of plans to enforce that disclosure requirement.

Ms. Lawrence: Thank you. You've given me some insight.

Ms. Valerie Ann Lendt: Maybe this would be a good spot for a form similar to the one we're using on the underage when somebody is coming off of COBRA. Now we have to guarantee issue them through HIPAA. Maybe a verification of eligibility form should be kept on hand to submit. You don't really change your application; you just have that form. If somebody claims they're eligible, you can just hand that form out.

Ms. Lawrence: Good comment. I don't think that's a requirement today.