RECORD, Volume 24, No. 3*

New York Annual Meeting
October 18-21, 1998

Session 139OF
Medicare Markets—The Latest Scoop

Track: Health
Key Words: Health Care Plans, Health Maintenance Organizations, Medicare/Medicaid

Moderator: DALE C. GRIFFIN
Panelists: EDWARD HINDIN†
JEAN LEMASOURIER‡
STEVEN J. SHERMAN
Recorder: DALE C. GRIFFIN

Summary: Although this panel covers a variety of current issues in the Medicare supplement marketplace, it mostly emphasizes the impact of the Balanced Budget Act of 1997. The potential for additional changes arising from the evolving 1999 federal budget is also considered. Issues affecting both managed care and traditional Medicare supplement are discussed.

Mr. Dale C. Griffin: This panel will address various aspects or at least various points of view on the Balanced Budget Act (BBA). Our first speaker is Jean Lemasurier, who is deputy director of the Center for Health Plans and Providers at the Health Care Financing Administration (HCFA). This is the group responsible for Medicare Plus Choice applications, contracting, monitoring, and enforcement. Previously Jean was deputy director of the Plan and Provider Purchasing Policy at HCFA, where she was responsible, among other things, for the development of the Medicare Plus Choice regulation. She has held leadership positions in HCFA, in policy legislation and research, primarily in the Medicare managed care program. Jean will give us her own point of view on this, specifically the new coverage options under the BBA, the consumer point of view, and what has happened recently.

†Mr. Hindin, not a member of the sponsoring organizations, is Vice President of the Tiber Group in Chicago, IL.

‡Ms. Lemasourier, not a member of the sponsoring organizations, is Deputy Director of the Health Plan Purchasing Administration for the Center for Health Plans & Providers of Health Care Financing Administration in Baltimore, MD.

Note: The charts referred to in the text can be found at the end of the manuscript.

Ms. Jean Lemasurier: There are three areas that I want to cover. The first is the goals and the key provisions of the legislation. It sounds like you know a lot of data and I won't dwell on it. The second thing that I want to address is the impact of the legislation to date. There clearly has been a lot of unintended impact. We've been reading a lot of articles. It seems like every day in *the New York Times*, *the Wall Street Journal*, and *the Washington Post* you can read about Medicare risk contracts dropping out of the market and their reduction of their service areas. What happens to the plans and to the beneficiaries is certainly an area that's of key concern to us. Then finally, the next step: Where do we go from here? I would like to say that we have had an incredible response in Washington and in HCFA to all of these changes in the Medicare marketplace. I was at a press conference last Thursday in the White House in the Roosevelt Room where President Clinton had a press conference to talk about his concern that Medicare beneficiaries will have to shop around and that the plans are leaving the marketplace. He emphasized that the administration does have a very strong roll-out strategy to try to provide information to consumers about what their choices are and to let them know they are not losing Medicare if their plans drop out. President Clinton directed my agency to come up with some legislative solutions to solve the problem. I thought, "oh, well, I wonder what they will be," but we have some ideas.

There's also been a congressional hearing. Plans were required to notify us by October 1 if they would be in the marketplace. That was only a couple of weeks ago. I can't believe all the stuff that's happened since then. We've had a congressional hearing already where a lot of the beneficiary groups and the plans and the providers got up and talked about what was wrong and what was right, what was working and what wasn't. As I mentioned, we've had the White House rollout, which was an incredible press strategy. We had sent a letter to the plans advising them that we would not be opening their Adjusted Community Rate Filings (ACRFs). These are their benefits and premiums for next year. They are required to send them in by May 1. A lot of the plans had not anticipated higher utilization trends. Perhaps they hadn't known about all the provisions in the Balanced Budget Act of 1977 (BBA), so they were reassessing their decision. But we did tell them it was too late. The other thing that we're doing is we're notifying all the MediGap companies and the state insurance commissioners of what the protections are for the beneficiaries on their MediGap supplemental insurance, writing letters to all the beneficiaries who are leaving the plans and what their choices are, and, of course, reaching out to all the consumer groups. In every community, our regional offices are reaching out to the American Association of Retired Persons (AARP), to seniors, to employers, to other purchasers, and to state regulators.

The BBA of 1997 was enacted in August 1997. It anticipated three major goals. The goal I'll be talking about first is the major structural reform of Medicare—

significant payment changes and consumer information. Congress really did intend that this program would have a fast-track effective date and be underway at the latest by January 1, 1999, if not before. There was a lot of pressure to get the program up and running.

The goals of the structural reform were similar to what was happening in the private marketplace: essentially to give consumers a choice, to have more flexible managed care options (not full locked in risk that only Medicare had), to expand managed care to rural areas, and to essentially give more accountability, not only to the consumers, but also to the purchasers, meaning us.

At the time that the BBA was enacted, there were about 6 million beneficiaries in managed care plans. That was about 17% of the market place We pay about $3 billion a month for the Medicare risk product. Our actuaries estimated in 3 years after this program was up and running that we would have 12 million beneficiaries enrolled in these new Medicare Plus Choice programs. That would be about one third of the entire population. Obviously, it would be a very fast growth rate not only because we would have current plans moving to new marketplaces, but also because we would have all these new types of plans and expand to areas where we had never had managed care before.

Briefly, what were these types of plans? Essentially, we would keep the Medicare risk product, the HMO product as we know it today, but we would broaden the definition of what it might be to include state licensure to HMOs. We would have for the first time something called the preferred provider organization (PPO), which would be similar to what was available primarily in the commercial marketplace—larger networks, a little bit less accountability, but similar to an HMO. Something called the provider-sponsored organization (PSO), which would be similar to what we have in the HMO, only it would be controlled by the providers who must actually be engaged in the delivery of the health care services, and other things that might fit into that definition of coordinated care.

Next we have the private fee-for-service plans where the providers will be paid fee for service. There would be no capitation, no utilization management review, and the beneficiaries could self-refer out. It's like an open-ended product for them, a self-referral option. Then we had the medical savings accounts (MSAs), plans, which you know about. They're the high-deductible plans. I'd be happy to answer any questions about these models. I don't think we need to go over the details unless you really want to know more about it.

The bottom line is that we have not had the response that we expected for all these products. I think at one point the consultants were out saying that we would have

100 PSOs, and then people were saying maybe 125 new ones the first year. To date we only have four PSO applications, one of which is a waiver and I'd be happy to discuss that if you want to know about that. The rest are coming through the state licensure route and seeking Medicare contracts through the normal channels. We have one PPO application. We still have 48 applications that are pending. These are the HMO-type models. Pretty much for the moment that seems like the program. We think there will be more applications coming in. In the short term, there are pending businesses and 25 service area expansions, but so far it's not the type of models that we thought they might be in.

I guess the other news really is the terminations, the nonrenewals of our Medicare risk business from the year before. As of today we have 42 risk plans that are terminating their Medicare contract. They are pulling out of the business altogether. We have 53 contracts that are reducing their service area. The terminations represent about 12% loss of the plans. In terms of the number of beneficiaries who are affected, there are over 400,000. So far, about 7% of the marketplace will be out of the Medicare risk options this year. Most of those are in markets where they have other managed care choices, but there will be about 1% of beneficiaries, almost 50,000, who will be in the market where there is no other Medicare managed care choice. Those are primarily rural areas, but it's very interesting to look at the trends. In the past, the Medicare risk program has certainly been on a growth trend and we were seeing more companies and more areas all the time. For example, in 1997, we only had 2 plans that nonrenewed, and they only affected about 6,000 beneficiaries. Most of those were plans that essentially had it in the contract and never really marketed it or had any enrollment. In 1998, which was the biggest year that we had, we had 5 plans that dropped out, affecting 25,000 beneficiaries. When you looked at the counties that were dropping, they were mostly small. This is a huge reversal in trend. It affects 30 states. It affects rural and urban areas. We've looked at the payment rates because a lot of people say, "Oh, it's what you pay, it's not enough." Looking at it from the Medicare payment side, that's not the case. What we've found is the average payment rate for all of the counties that are dropping out, whether termination or reduction, is higher than the average in the country. And when you consider that a substantial proportion of these are rural counties, what we're finding is that some of even the highest level countries are dropping out. For example, we have counties that are being paid $798 a month that are dropping out of the Medicare program. Clearly, the payment rate is not the only factor. There are a lot of other things going on.

What are the reasons? Essentially, it is a business decision of the company; it is something that is a voluntary decision to participate in the Medicare programs, so these are decisions that the companies are making on a market-by-market basis. In many cases these are plans with small enrollments. They might be on average

4,000, which is very small, but in some cases there are companies that have very large enrollments. Again, we are seeing almost a consistent pattern that started last year. The counties that are dropping out are the rural counties at the low payment levels with small markets, so the goal of the BBA to increase managed care in rural areas clearly in the short term has not been accomplished.

Some people are blaming the business cycle of causing trouble on the commercial side of the marketplace. Medicare is a higher risk business. Of course, some people are saying that the regulatory burden of the Part C regulation that has required a lot of new overhead in the short term and the long term certainly is a factor. Of course, the Medicare payment methodology could be affecting the decision making as well.

Anyhow, that's kind of a snapshot of where we are today. We will be asking the plans to sign contracts to do business with us starting next January. We have not, in fact, signed the contracts yet, and we expect a few more possibilities, such as companies not signing their contract.

The payment changes in the short term are not happening. We had the structural reform on the one side—new types of plans, new flexible models. The second thing is the payment changes. Actually, they have gone into effect from the BBA. They went into effect last year. They are also in effect this year and 1999 will be the third year. We don't use the word Average Adjusted Per Capita Cost (AAPCC) any more; essentially we're moving away from the AAPCC to a legislative formula. We're moving away from the fee-for-service base for the payment to the Medicare risk contracts.

We announce the rates every March. You can find them on the Internet. Essentially the formula is basing the rates on the 1997 standardized county rate, which varies between $221 and $767, depending on the county. We inflate it by a national average per capita growth factor, less a percent, and then we take out the graduate medical education (GME) cost over five years.

After we do that, we pay the plans the highest of three calculations. For this year, the rural floor of $380, a 2% increase guaranteed, or a blend of the local and national rates. We have something called budget neutrality because we were trying to bring up the rates in the rural area to be a floor. We have to in fact bring down the highest payment rates a little bit. Because of the formula and the budget neutrality adjustment, for last year, this year, and next year we will be essentially at the floor of $380 or at the 2% increase. There are no blend counties, possibly one or two next year, but we aren't sure exactly. We haven't announced those rates.

We've seen the effect of the floor. It hasn't helped. The 2% might be a factor for the dropout. The other significant payment change before was changing the formula. Two percent may not be enough given the trends. Risk adjustment is the other major thing we're doing. We're starting it next January. Initially, we're focusing on inpatient hospital risks. That's the easiest thing for us to get. We can get the hospitals to report inpatient diagnoses for Medicare managed care enrollees. We're collecting data from July 1997 as kind of a baseline, and we'll be implementing it in the year 2000. We don't really know the effects of what this might mean. We're running some calculations. We had a demonstration in Florida, the Orlando Hospital Association, which is a PSO-type model, where we are testing the methodology and the PSO. We're just running the numbers now, but we will have an increase in their payment rate as a result of the inpatient risk adjuster. That means that they had a sicker-than-average population.

Our goal, in fact, is to have a full risk adjustment system as soon as possible. It clearly won't be before the year 2001. I think the Y2K factor affects the collection of the data and processing it from our side. Of course, from the plan's side, they need to be able to collect the data, which is a problem. Many of the information systems can't handle it.

We've seen some calculations that the full risk adjustment system on average might reduce payments to plans by 7%, but clearly it will have a scattered effect. Some will be higher and some will be lower depending on the population characteristics. We support the risk adjustment system because we really believe that for a chronic, aged, and sick population in the end, it's going to be more equitable for plans and will essentially be the appropriate payment level.

Finally, the third goal is beneficiary information. Unlike many private purchasers, we are not putting the seal of approval on any of the Medicare risk contracts. We are more or less giving the information to consumers so they can figure that out. We make the cut when we approve the contract and when we renew it. What we are doing is we're creating an Internet web site where all the plans will be listed. Initially, we're having information on benefits and premiums and then we'll be adding data on performance. This will include information on enrollment and disenrollment rates, appeals levels, and increasingly some of our quality information. It's called Medicare Compare. It's on www.Medicare.gov.

We are also sending handbooks out to consumers and providing toll-free numbers. We want to get information. We've had to phase that in. I didn't mention that we did reduce the payment rate by a user fee in order to finance that. It's a small amount, but at one point it was a large dollar amount. We're phasing that in with

five states throughout the year. As I mentioned, the information will include benefits, cost sharing, premium for risk area, quality performance, and so forth.

From the Floor: Question on the five states.

Ms. Lemasurier: I'm sorry. We're doing it for five states. The open enrollment for all plans this year is in November. Needless to say, because we've been having a lot of plans dropping out, we want to be sure. We just got that information on October 1. We're having to update the database in the Internet and I think our goal would be to get it out around November 1 so the information would be available at that time. With regard to the handbook, it's already been printed for the five states. Fortunately, there aren't as many plans dropping out in the five states that will be getting the handbook, so it won't be as difficult or the information is at more of an aggregate level if not the county level. There is a list of all the plans and the counties that are dropping out on the HCFA web site.

We do have a lot of Internet sites out there where you can get information. The www.HCFA.gov site is primarily for documents. The beneficiary site and the HCFA Medicare site is where you can go to get the Medicare regulations, payment rates, and a lot of other information, including the counties of the plans that are dropping out.

I just want to mention a few more things. What are the next steps? Clearly one of the things that we did last year in order to keep the plans in the program was to allow plans to carve up their service area and to send different ACRFs based on their payment rates. As a matter of fact, we went from about 350 ACRFs to over 900. That was a huge explosion and we haven't really had a chance to understand all the implications of that, but clearly the plans were carving up their areas based on individual counties in some cases, so that's something we'll be looking at in the future.

We have announced some flexibility in our implementation of the program. We are allowing the quality program to be phased in over a period of time. We're allowing some flexibility in the renegotiation of our provider contracts over the next 12 months, and we're allowing some flexibility on the phase-in of the compliance plan. We're looking at the whole MediGap issue. We are sending a letter out to the states. We aren't exactly sure how that's happening, but that will be happening probably next week. We believe the BBA does include direct access without health screening for beneficiaries who are not only aged, but also for end stage renal disease and disabled for 63 days after their plans terminate without regard to health screening, previous condition, or underwriting. That is what we will be sending out to the states.

If you have any ideas about legislative reform, we'd certainly be interested in hearing what you have. First of all, we'd like to look at some changes in the payment methodology. We haven't really figured out what that might be. Clearly, the BBA means savings, not increases in cost. No one is interested at this point of adding on to the total cost, at least on the administration side, but we are looking at some flexibility. Should the government define what is the marketplace? Is it the MSA as opposed to the county? Should there be a statewide rate? Some are looking at the geographic areas, multiyear contracts, and how we handle the GME carve-out. These are some of the areas that we will be interested in looking at. We're also interested in looking at how we define the service area for next year and the time line for when all the proposals are due. Anyway, a lot is on our plate.

Mr. Harry L. Sutton, Jr.: Jean, are you going to run a health risk adjuster on the fee-for-service population to compare that with HMO enrollment?

Ms. Lemasurier: At this time, the methodology definitely includes adjusting on the fee-for-service side. We are collecting 100% encounter data on hospitals and eventually on all other services. I think it's the methodology that's based on some of the research that's been underway for the last 15 years.

Mr. Sutton: I assume the health risk adjuster would also apply if there were carriers selling MSAs with high deductibles? All of these other options under Medicare Plus Choices would have to have a risk adjuster even though their system is completely different from, say, the HMO system?

Ms. Lemasurier: Yes, all of these provisions apply across the board to all of the products. Not that we have any of the new products, the MSAs, or the private fee for service, but we did try to have a level playing field with all of our rules. That also affects the payment. Every model gets the exact same monthly payment, and it is on our full-risk basis. There is no partial risk.

Mr. Griffin: Our next panelist is Edward Hindin, vice president of the Tiber Group in Chicago. He has more than 25 years of experience managing and consulting with hospitals, academic medical centers, multi-hospital systems, alliances, physicians, managed care organizations, and integrated delivery systems. He received a bachelor's degree and a master's degree from Rutgers State University.

Mr. Edward Hindin: I should make a clear correction. We're going to talk about "some" of the latest scoop, not necessarily all of it and mine is going to be more of a provider perspective than perhaps I've heard before and certainly more of a market perspective than perhaps you've heard before.

I want to talk very briefly about the Medicare landscape and its changes. I want to also talk very briefly about the Medicare risk options because you already have a lot of information. We're going to blow right through the PSO discussions so that we can talk about some of the summary and key takeaways.

You've heard this before on several occasions: Medicare is big, it's growing; spending is big and it's growing. There's no news there. Medicare spending obviously is increasing at a rate that's not clearly sustainable going forward. Clearly, the BBA was an attempt to try to do something about that as was the conversion from the typical Medicare program into the risk program. Of course, we've already heard something about the unintended consequences of that.

I'm not going to read the forecasts to you in terms of expected percentages of expenditure for Medicare as a total percentage of gross national product or as a percentage of federal expenditures. Again, the point here is order of magnitude.

What's the driver for change? You've heard that essentially the government as the price maker has said they're not going to pay anymore and that's because the taxpayers have said they're not going to make anymore. I think more and more we need to recognize that for most providers in this larger community, government is the price maker, probably as much as 50% of any revenue stream, whether you're talking about hospitals or physicians or some of the new carve-out companies as Medicare-directed. If you add another 10–15% on some basis as it relates to Medicaid and other support, then clearly the provider is in a position to understand 80% of their prices as already given. Most of you know that the balance of the price structure is essentially being keyed off Medicare in one way or another, so clearly the federal government in response to pressures recognized that we are spending too much and that we don't have the appetite to spend more. The taxpayer said the same thing. The insurers have said the same thing in terms of being able to remain competitive. Clearly, the providers are in a position to try to understand how to recognize this change in reimbursement and how to be successful in that environment, recognizing as well that in most markets there is 50% more hospital capacity than is required and probably 50% more physician capacity than is required, so these are the ingredients of an interesting stew.

That's a great idea. What are we going to do about it? We're going to create the BBA in which we're going to create a number of options through which people can access Medicare choices and Medicare plans. It's interesting to note that the unintended consequences have been described in terms of the half a million or so people who will not be covered past January 1. You ask yourselves, "What does that mean to me as an insurance company person or as an HMO person?" We'll come to that in a moment. The bottom line is, most people don't understand that

the BBA has whacked the providers substantially, particularly in rural areas and particularly those providers that have done what we think they should have done historically in terms of diversifying the services they provide to get patients to the lowest level of care for the most cost effective use of that service. For example, I have a number of clients who have diversified into home care, into Skilled Nursing Facility units, and into transitional care. The BBA has literally taken their bottom line and reduced it by 50%. A million and a half to $2 million a year for these small providers with a budget of $30–40 million is pretty substantial, so at the end of the day you say to yourselves, "What does that have to do with the insurance industry?" The providers are going to be responsible for the care that needs to be provided. If we don't have a healthy provider community, that's not to say that we should have an overfed provider community, it's going to be difficult.

Unintended consequences, wholesale: in some markets, loss of alternatives and in some markets, substantial payment reductions for providers. We used Chart 1 up until a couple of months ago to suggest that risk enrollment was rising dramatically. Those numbers will go in the other direction as of October 1. How much and to what degree is probably debatable, but I think it is being recognized that most of the HMO providers that are leaving the market are leaving smaller markets. Despite something like $100 per member per month increases that were legislated probably a year or so ago when those numbers might have been as low as $250, they're now a minimum of $347 or something like that. So the question is, what's going to happen? We all like to look at Chart 2, which shows the extent to which Medicare risk is going to reduce length of stay and patient days per 1,000. We, I think, are clearly understanding that the rate of utilization, even with the declines that are being proposed is not going to be sufficient to be able to manage the kind of cost structures that we have to operate under. I guess the underlying theme here is that everybody thinks the Medicare business is easy and the fact of the matter is it's not.

I'm not going to go through the choices for the Medicare Choice Program. About a half million people, nearly 117 plans, have decided to leave the HMO risk market. It's also clear that those plans are leaving markets in more than one iteration. That is to say there aren't a lot of markets where some plans are leaving and some are staying, so I'm not sure what kind of alternative choices are going to be available.

Five hundred thousand or so members are going to be out of the business—7% of the Medicare enrollees. That is pretty dramatic information.

I think finally providers have understood that the Medicare risk business as a PSO is not any easier than the HMO business has been for them in the past, despite rates that might have been more attractive. Providers really don't know how to do this business any better than the HMOs do, and there's some question as to how well

the HMOs understand the Medicare risk business and medical management business as opposed to how well some HMOs have been able to shift risk to providers who have been willing to accept it without the capacity to manage it. Risk adjustments notwithstanding, I think it is a recognition that the providers are not in the insurance business and don't understand how to medically manage the business, so what does that mean for us as insurance company workers? I'm not sure that the insurance side of the business has been able to medically manage either, so at the end of the day we have a whole group of people trying to make money in this business without necessarily having the rudimentary tools at hand. That may be a harsh, critical statement, but it's intended to be provocative so that we can go further.

What's the big deal for those who are interested in Medicare supplemental coverage and carrying those kinds of plans? Again, if you don't have a provider that can withstand those kinds of plans and effectively utilize that insurance package, what's going to happen? You also have to ask the question that if many employers have looked at the Medicare program as an opportunity to lay off some of their pension expense or their long-term health care requirements, then what does that do in terms of your business and what does that do in terms of variability to be able to deal with some of your health care costs that have been commitments through contracts or through union negotiations or whatever?

That makes this conversation about PSOs relatively easy, but I'll leave that to you to look at as you see fit in your material. What we need to recognize is the critical success factors for developing Medicare risk programs: Whether you are a provider, an insurance company, or an HMO, the factors are probably a lot more complicated than most people understand. Right from the top, marketing and sales, as you know, are quite different propositions. It probably costs four or five times more per enrollee to get a Medicare person involved with the risk plan than to sell that same person on the commercial side. There are obvious reasons for that. Commercial, you go through group; Medicare risk or Medicare, you go through individuals. It is a one-on-one sale and you can't be assured that you can keep them. They can make changes relatively easily. Customer service is an entirely different focus from "How do I answer your questions about the claim in 15 seconds or less" to "I have a 20-minute conversation because I'm lonely." And that's the reality. That's the reality of the average times that people want to be on the phone when they respond to their calls.

Medical management is nonexistent for all intents and purposes. We have price management, we have managing price, and we have managing approval authority for utilization, but we're really not managing care to my way of thinking. Reimbursement levels next. Capital reserves are sufficient in terms of the ability to

actually mount and maintain that business over a business cycle. Providers thought that $2 million was a big deal for the PSO. Well, I suspect that you know better than I do how much reserves you really need to have to go through the business cycles.

Effective information technology and infrastructure. We just say next on that one. We really don't have people who have a lot of good information systems that can, in fact, on a real time basis, understand utilization patterns.

The fact that some of the plans are leaving the rural markets and the smaller markets has a lot to do with scale. We used to think that if you could enroll 5,000 enrollees in a plan, you had a reasonable base for economic and fiscal soundness. Given the problems of rural markets in accessibility and given the cost structure, my suspicion is that small numbers just won't cut it. That's another reason why there's been an exit for the marketplace, so good rates may not build a plan fast enough to be able to have the economic benefits.

Obviously, physicians have been an important and difficult part of this equation in terms of fee schedules. Obviously, the other point about the Medicare risk programs is the ability for the enrollees to understand that they are going to providers that they want to go to, they're going with plans that they want to be able to use, and they're dealing with a reliable plan that doesn't offer them all coverage for prescription and eyeglasses and the like and then claim it cannot afford it the next year. There are a whole series of critical success factors that I think, for the most part, we haven't really paid attention to. What does that have to do with me as an actuary when I'm sitting in this kind of environment and saying, "That's very interesting, maybe even entertaining?" What does it do? Well, the question is, how well are you thinking about what you're doing in terms of looking at your numbers, your forecasts, and your projections to understand how the business works as you go forward?

Here are some of the key take-aways from my perspective. Medicare is too big to ignore. It's not business as usual. We are finding ourselves in a situation where the price maker is saying we're not raising the prices. Costs are not decreasing, so the gap is increasing. The competitive situation is clear. There is more capacity that's chasing fewer dollars. Nobody has said to me in the last 20 years that I've been in this business that they'd like to give me more dollars for fewer services. It just doesn't work that way. The stakes are high and if you don't believe that, just ask Wall Street as they continue to punish stocks of companies that are not doing well on the Medicare side. It's not an isolated venture. We still think that there's the insurance side and the provider's side and some intermediaries, but unless the system is working well, we're all going to be the losers. Not everybody can

succeed. Just look at the exit several months ago of some of the managed care plans and provider organizations we talked about earlier. There will be winners and there will be losers.

From the Floor: You have some interesting comments. I'd like to hear you reconcile your view that there's no medical management in the Medicare risk program with your chart that shows 2,500 days per 1,000 fee for service and 1,500 in the HMOs.

Mr. Hindin: HMOs are doing better than non-HMOs. Are we doing well enough to be able to make this work? I can tell you that there are plans in our organizations that can take that utilization level well below where it is now, so it's all comparable. Yes, HMOs are doing better, but are we doing that consistently and are we really achieving the right kind of utilization? I think the answer to that is clearly no.

Mr. Griffin: Steven Sherman is a principal at the Milwaukee office of Milliman & Robertson. He joined the firm in 1989. His area of expertise is health care consulting. He has established premium rates for managed care plans, such as PPOs, HMOs, physician hospital organizations (PHOs), and self-funded arrangements. He has assisted clients in developing strategies to operate under small employer group rating and underwriting reforms. Steve has assisted health plans and providers in negotiating reimbursements for Medicaid and managed care programs. He has also assisted hospital and physician groups in establishing capitation levels and risk-sharing mechanisms. Steve also has assisted health plans by evaluating rating and reserving and providing required opinions in those cases. Steve has assisted clients in the U.S., U.K., France, and Ireland. Steve's topic will be, "An Actuarial Perspective on the Balanced Budget Act," and he'll share his point of view on what's happened with Medicare Choice and give a financial outlook from an actuary's point of view.

Mr. Steven J. Sherman: What I want to do is spend a little bit of time talking about the latest scoop because I think we have some great information. I was particularly pleased to have Jean here from the federal government to give us what I would call the official lowdown, which is always a good thing. Our biggest problem is lack of information. Of course, I have nothing to base that on. Therein lies how you bring the magic and the art into the science of actuarial analysis.

I took a quote from Bill Halvorson, who among other things, many, many years ago started the Milwaukee office of Milliman and Robertson where I work today. Bill used to say this a lot: "When uncertainty arises, the actuary has a role." That's something for us to remember as actuaries. For instance, it sounds really bad sometimes when we have people saying, "It's a tough situation, people are losing

money, and people are leaving the market for the MediGap here. Your market is going to change, but we don't know exactly how it's going to change. These are uncertainties. These are risks. We are actuaries. Our public, our employers, and our clients need us the most at a time like this, and it's up to us to do something for them.

What's forming the situations? Basically, a really quick overview. What everyone says is HMOs have been reporting losses. As an actuary, to me that's really important because other consulting actuaries here probably have had a similar experience over the last five to seven years. We do what we call a realistic appraisal on a Medicare risk contract for someone. You go into a provider group or an HMO and your appraisal is more or less a long-winded actuarial answer to a very simple question of how to pay providers. This is what we can get as revenue from the federal government. This is the premium we can charge people. These are the benefits we want to give people. What do we have to do to succeed? In many cases when we do this, if you have to boil down your report to one sentence, it is based on everything in your history. It isn't going to work. Many of these clients have gone and done it any way and it's interesting because some of them are people who are now giving the federal government and the Medicare beneficiaries migraines by leaving the program. I think any actuary over 35 or 40 has probably had this experience in some market, and we're seeing retrenching now as Jean talked about. The HMOs that are taking care of roughly a half million people are abandoning the business, which anybody who has parents is probably concerned about, to be honest with you.

HCFA or whoever does this under the Department of Health & Human Services has been making some pretty strong statements about fraud and abuse. For people contracting with Medicare, what this means is that you better be careful even if you think you're doing everything right. Your organization needs to make the efforts to make sure that everything you're doing is up to snuff because the people who regulate this program have promised to, as they would say on *Fox Sports*, bring it up to another level. They're going to make sure that when people are taking taxpayer and Part B premium money to help the federal government with the program, that they're really helping the government with the program and keeping all the promises and everything straight. That's the fairest and the most federal-government-friendly way I can think of describing it.

I don't think the issue with the 1997 BBA will change. Looking at the way legislation is done in the federal government now from a broad perspective, when we talk about Medicare and the laws and the regulations the federal government is putting together to ask us how we deal with this program, it comes into the budget part of the program. I think it's important to recognize that these people are looking

at it like a chief financial officer rather than a CEO. The federal government is extremely serious about controlling costs in this program. It's a new kind of trickle-down effect.

We have risk adjustment on the way. We heard from a credible source that on average the risk adjustment might cut HMO's payments by 7%. Another issue is patient's rights. I'm not particularly referring to this one patients rights law that failed to make its way through Congress, but I think that we are definitely in an environment where it is popular to enact and pass legislation and regulation relating to granting people in managed care plans entitlements. As actuaries, I think this is a case where in doing our work sometimes we need to look forward a little bit more than looking back. Over the last few years we've seen some rules like the two-day or four-day maternity rules. Be aware what might be on the forefront later on as you're doing your planning.

We've already talked about HMOs leaving the system. This year for 1999, enrollment was the first year that HMOs had to file with Medicare. They had to file on May 1 right before the May actuarial exams. Previously they had to file on November 1, right before our November actuarial exams. Maybe in the long run it keeps our labor costs cheaper, but it's really tough on our students. For anyone here who is still taking exams, I did lobby for a July 15 deadline. If we can get the federal government running on the actuarial exam schedule we can say that this profession has finally risen to its justified level of importance in this country.

At any rate there was a lot of talk. A lot of these HMOs who are now leaving and maybe some other health plans have talked with the federal government about rewriting the deal. They want to have a higher member premium or the permission not to offer prescription drugs. They want to change the deal because they didn't know as much as they know now on May 1. I got a pretty clear answer that that's not happening. It's one of those things that you need to check with, but apparently lawyers are still talking to lawyers about it. It has been an interesting situation.

What we're talking about here is the payment rate formerly known as AAPCC. That's good marketing; it's smart. Basically it got a 2% increase in most areas. I frankly haven't seen any information from health plans that show their costs increasing at 2%. There's sort of a bias for the larger. The second issue is the risk adjustment that's going to be phased in. I think Jean did a good job just outlining it. They're going to look at inpatient diagnosis or diagnosis-related inpatient care in 1999. The ultimate goal is to expand this so you do everything. You bring in ambulatory care. For a lot of plans, I think it's going to cost some money; it's going to cost a lot to comply with the reporting. I haven't actually looked at the reporting

rules, but I suspect that's going to be a challenge for some plans, particularly smaller plans that don't have a lot of infrastructure.

Again, we've been told that this will cut down HMO rates on average by 7%. I've heard some people say they are concerned because they are a pretty well managed HMO. That means in addition to having shorter average lengths of stays than everybody else, we also deal with a lot of diagnoses, a lot of people's problems, and a lot of people's conditions. We deal with them on an ambulatory basis, whereas these poorer managed HMOs would deal with this on an inpatient basis. There's been some concern that the HMOs, having gotten lower utilization by superior medical management, might end up getting a bigger reduction than the HMO who had the same patient. Only time will tell.

Now I want to get into the actuarial perspective. I think the key thing we need to remember in our actuarial perspective is, "Yes, Virginia, this is a risk contract." It is not an automatic profit contract; five years ago it seemed like nobody believed that. What I want to do is briefly go through an example and overview of a basic actuarial analysis of such a contract. Like anything else we do, it really involves three things—understanding the revenue behind this deal, understanding the structure and the level of the cost behind this deal, and then looking at the two together and reconciling both. If we're doing our job, that's what we're doing as actuaries.

We'll talk about the revenue side of this first, since that's a little easier to understand. The main source of revenue is the capitation or the rate payment you get from the government formerly known as the AAPCC. Something that hasn't been mentioned is what I would call a pseudorisk adjustment. There are demographic factors applied to your rates so you get paid less for a 66-year-old person than you would for an 82-year-old person. For the populations you normally see coming into HMOs, usually you're talking about getting an average adjustment for your whole population of something around 85%, so that means for that payment rate that used to be formally known as AAPCC, if that was $400 in your area, you can expect your average reimbursement from the government to be a little bit less than that. We have the risk adjustment coming soon. In general, when this payment was still known as the AAPCC, it was based on an estimate of 95% of Medicare's costs in a county, which was based on some experience data. I think it was between three and eight years ago or something like that. They had trend adjustments and all sorts of nice things. Last year it just increased 2% in most areas, unless you were in a low payment area. Then it was brought up a little more.

On the premium side of your revenue, you can collect the premium from the member in most markets. The premium is usually under $50 a month—plans

usually charge a pretty small premium. When the premiums have been high in most markets, the plans haven't gotten a lot of enrollment. That's basically where your revenue is coming from.

On the cost side, when I do a general talk about risk contracts, I like to build it up in a different way than we normally build up actuarial cost models. One way of looking at it is you're providing everything that Part A and Part B would provide for these people if they weren't in a risk contract. You're also filling in the Part A and the Part B deductibles, and the Part B coinsurance, which is worth a little chunk of change. It's worth some money since Part B coinsurance includes 20% of all your physician services-at-Medicare fee levels and outpatient-at-billed charges.

Plans generally throw in additional benefits. They throw in wellness benefits in order to attract people. Traditionally, we know that HMOs do these things in order to be attractive to healthy people although if the federal government's risk adjustment works perfectly that might not help you as much as it used to, but that seems fair to me.

You also have to administer this plan. I think Ed did a really good job talking about all the things health plans have to do to be effective at this. Yes, it costs money. We also have the HCFA marketing fee. It's really called the Medicare Plus Choice marketing fee, and it's a little bit less than 0.5%. It's either 0.43% or 0.47% or something like that.

Cost structures. You look at the Part A and the Part B benefits and what you realize is that what Medicare is paying you is more or less based on some analysis that started with the cost of those benefits and all these other things. That's what you have to add to be successful.

The 1998 payments are still known as the AAPCC. The payments vary widely with the HMO's demographics. There is a huge variation in the payment rates from area to area.

I'm going to provide you with an example just to prove that I am a real actuary. I have done some realistic appraisals over the years. We've done several for different clients in different areas of what it would look like to have a Medicare risk contract. I sort of collaborated among a bunch of them, put them together, and sanitized them. I used two hypothetical cities in the Midwest. Since we're in New York, I wanted to properly express the New Yorker's view of the Midwest, so the two counties we have are 76 Trombones County in the State of Iowa and the City of Rustbelt in the State of Despair. Rustbelt is pretty close to the middle of the range in the Medicare payments, and 76 Trombones is on the low end of the range. Most of

the stuff is not that interesting, but each client has their own assumptions and their own benefit plans as to how they want to do things. Let me do a realistic appraisal. We're really trying to answer the question, what do providers need to be paid. We know that managed care is going to pay you this way. You told us that you can't sell this plan with a premium. In both of these cases, they didn't need to offer prescription drugs, which is good. You end up with a big equation, speaking like an actuary. How well managed does your medical care system have to be? What kind of results do you have to get? In 76 Trombones, Iowa, the number 751 actually comes from a real case. In that case it came out as what to pay providers. They were looking at 100% Medicare reimbursement. They wanted to pay everybody the same fee-for-service fees that Medicare pays so they had to manage a utilization at that level at 750 days per 1,000 to make it all work out. Our conclusion to that plan was to say, "Please, please don't do this and if you do it, remember that we told you not to."

The City of Rustbelt in the State of Despair had a little bit higher payment and in that case the target came out to 1,400 days. To give you a perspective, you'd expect the unmanaged in the fee-for-service system to run at about 2,200 days per 1,000 members per year, so in both cases we're talking about a significant reduction in utilization. It's a real challenge for the providers or the health plan to get those kinds of reductions in utilization and take care of people.

Focusing more on the utilization targets, one thing I like to do is compare them with what the HMO industry looks like. Basically looking at a 25th and a 75th percentile, which is close to a standard deviation, we see that HMOs surveyed around the country roughly run between 1,300 and 1,800 days per 1,000 members per year for the Medicare risk contracts. What that tells us is that even in Rustbelt where things looked a little better, this health plan is going to have to do quite a bit better than the average health plan in order to make the contracts work out. These are not unusual results. They represent the range of results around the Midwest, if you leave out Chicago. I guess that suggests that if we're doing all our numbers right, there are a lot of health plans out there where the average performance really isn't good enough to break even and give the providers Medicare reimbursement, which is the lower bound of what they want and what they expect. It suggests that when there are withholds, there are a lot of withholds retained.

Basically, as actuaries we have revenues and we have costs. The question comes up, what do we do to reconcile these two? There are two general approaches. The methodology I recommend involves looking at what health plans have done to get over the gap. One approach is subcapitation or in more general corporate terms, outsourcing some of the services. Another area is in provider reimbursement. Try to negotiate better reimbursement deals. Utilization management becomes an

important area. We already talked about that a little bit. Plans are also looking at member premiums and member co-payments. You see a lot of risk contracts with a $10 office visit co-payment to try to lower the cost. I can remember two or three years ago only seldom would anyone want to charge a premium at all. The general knowledge was that the only way this would work was if we did it free with no member premium and we wanted a prescription drug benefit higher than anybody else's. But I think people are going to be a little more cautious going into the future, which gives us as actuaries the opportunity to work with people and help them get through some of these issues on a rational basis.

In terms of subcapitation and outsourcing, there are two general methods that we see. Ed briefly referred to one of them—if the health plan or the insurance company uses global capitation, which is more or less finding a provider organization that's willing to take all the risk, we certainly can get predictable profits and losses that way if we can take care of our administrative expenses. As well, we see both provider organizations and HMOs and insurance companies doing more specific capitation. We've seen them get what look like pretty low prices from the providers are in the radiology and laboratory areas. Those I can understand since they're really talking about a business, if you consider medicine a business. The radiology and laboratory facilities have a significant fixed cost, and I think these guys are doing a lot of variable cost pricing when they're looking at contracts because if they can cover variable, they're fine. They're better off than they are without the contract.

We also see capitation deals being cut for home health and Durable Medical Equipment (DME). Very often those are tied together along with the infusion therapy people. Primary care caps are common in Medicare, although I see a lot of cases where plans have had to negotiate pretty high. There are some markets where you have to pay a pretty high primary care capitation rate to get the primary care physicians (PCPs) that your senior citizens are going to sign up. If you don't get the PCPs, obviously, if you have any friends who own a drugstore, you know that it's just like employers. When you look at an HMO, if you're the decision maker or the purchaser, the first thing you're going to look at is if my doctor in the network. After that you look at the price and you buy it.

In some areas it's popular to have a capitation for all physician services. I see this a lot in Chicago where there's a broad physicians' services cap for an individual practice association. Interestingly enough, those caps also include emergency room costs as well and some other ambulatory facility costs.

What is a typical global capitation arrangement? The contracts tend to be longer, but basically the HMO would retain administration, out of area and prescription

drug services, although sometimes the HMO does not retain the risk for prescription drugs and the PHO or the capitated provider entity is really responsible for all other services. What I find interesting about this is really the bottom line. The HMOs tend to retain somewhere in the level of 15-25% of the revenue and none of the risk. The PHOs get the rest of the revenue and the risk. I've always thought that particularly if you're not providing the prescription drugs, some of these deals seem pretty good for the HMO.

No one understands the revenue—what it's been or what it's going to be. No one understands your cost structures and identifies the gap. Is there a gap? Is our revenue going to cover our cost structure? Where are the gaps? The natural stuff is to move on to identifying activity plans. If things aren't going to fit together, what can we do about it? What do we do to fit it together because in most government programs, Medicare is an example, and most markets in general, the traditional actuarial analysis might develop a 72% loss ratio, but we got an 80% loss ratio, so we need to raise the rates by 11%, that's not going to happen. I should check that with Jean to make sure, but if someone asked for an 11% rate increase, would they get it? The federal government will not look at your loss ratio and give you more money, at least not in my limited experience. Basically, when we see these gaps I think it's incumbent upon us as actuaries to move towards the process of answering the questions. What do we do about this gap? What can we do for action plans? How can we change our operation to make it work? Then, of course, we go forward, reevaluate after we have our plans for action, and go back to the top because it's already next year. That's really what I see as the actuarial process here.

Mr. Sutton: I have a couple of questions, but I think they're suitable for anybody. I realize that the federal payments to HMOs regardless of anything would go down over the next couple of years because of the removal of the medical education and other things, but there was an implication that because of the health risk adjustment they would drop 7%. My understanding was the health risk adjustment would be a zero sum gain. Some would get more, some would get less, but otherwise it should equal the federal budget. Is it true that the health risk adjustment will, by itself, lower the payment rate over what it would have been if you hadn't used it? Maybe it's more of Jean's, but several of you mentioned that 7%.

Ms. Lemasurier: I think you're probably right on both points. On average some plans will go down 7%, but some plans might go up 7%. I think net would be the same pool that would be reallocated among the plans that would be based on what their actual enrollment characteristics might be, so you're going to see winners and losers, but I think overall the estimated budget neutrality factor would be about the same.

Mr. Sutton: A zero sum gain.

Ms. Lemasurier: Depending on which plan.

Mr. Sutton: I mean averaging all plans together.

Mr. Hindin: I'm more of a cynic. I think the government has become the price maker and is going to look at Medicare payments based on budgetary constraints, so if the economy continues to bob along and there isn't protest over increases, then I think you'll get some increases on the Medicare side. I think that it is clearly a risk and to assume that it is either neutral or that somebody wants to pay more money going forward, absent clear evidence of that, is dangerous.

Mr. Griffin: I'd like to hear other people's information or thoughts on that too. I read the descriptions of the risk adjuster and what I understood and what people I've talked to have understood is that the risk adjustment factors will be based on the whole fee-for-service population and then just directly transferred to the HMO's members, in which case that would not be budget-neutral to the HMOs. That's what my understanding was.

Mr. Jon Harris-Shapiro: What I expect is—and probably not necessarily from a close analysis of the rules but more from experience with risk adjusters at the Medicaid level—that at the state level frequently what happens is the fee-for-service plan is put in there as a quasi-payer and between the fee-for-service plan and all the managed care plans put together, you wind up with a budget neutrality factor or a payment rate adjustment of one, which was a surprise at the state level because everyone was expecting the adjustments just to be done among the plans. They wound up shifting significant dollars from the managed care side to the fee-for-service side; however, I'm not saying that from a detailed understanding of the HCFA approach.

I have an unrelated question to risk adjusters. There was a benefit change as part of the BBA on the Part B side that affected the way in which the outpatient coinsurance is computed for the facility piece of it. As I understand it, for a long time it has been 20% of billed charges regardless of what the HCFA paid for their piece of the pie, so consequentially the member wound up paying about 50% of the freight for outpatient services. As we read through summaries of the BBA and some of the other things, we found that will be 20% of some national fee schedule with the intent over time of bringing the benefits portion back into 20% of the freight, so both are going to start coming together as they transition outpatient to fee for service and copay to fee for service. What wasn't clear was how this was going to affect perhaps individual states or individual benefits. It's fine to budget

neutrality. It will be a gradual phase-in and ultimately some kind of take-away for the hospitals nationally. However, we don't live nationally—we live in local markets and I can conceivably see a beneficiary copay or Medicare supplement cost jump if this national fee schedule is higher than the local charges that had been used for years. I was wondering if anybody on the panel or in the audience has seen anything on that.

Mr. Sherman: I've seen some fairly significant dramatic decreases, not increases, in payments as a result of that.

Mr. Harris-Shapiro: So the national fee schedule is less than anybody's.

Mr. Sherman: I don't think that anybody concocted this formula to pay more money. I think that clearly in lots of instances there may be adjustments up, but what I've seen so far are adjustments downward.

Mr. Sutton: Another short question. In early 1997, 72% of the enrollees in Medicare had zero premiums and a whole bunch of areas had nothing but zero premiums. It's clear that the BBA, and, of course, the government might not agree with this, is eventually going to cause the individuals enrolled to have premiums even though they seem to be blocking premium rate increases. My sense is a lot of HMOs are afraid to charge a premium. I think one of you mentioned that and I wondered if in your discussions with them as to why they dropped out, they're just afraid to do it even if it's $25, which is peanuts compared to MediGap. Of course, they have to set up a premium collection mechanism which is something that they don't have. In the old zero premium, you can have people enrolled who don't even know it. Look at Florida in the past. If they don't collect the premium, they don't find out they're in an HMO—they go to some other doctor and Medicare refuses to pay it. Then they have to disenroll. It is a lot of monkey business to collect small premiums, and I guess there's a feeling that people won't buy the HMO even if they have to pay $25. Is that part of the problem? Of course you don't know what the reenrollment will be. The HMOs that have stayed started charging smaller premiums. Iíd like to just get your comments on that.

Ms. Lemasurier: We haven't seen the data specifically for 1999, but that really seems to be the case that the HMOs are saying before we increase the premiums, we will be reducing benefits, so that's a long-term strategy. I don't know what the percentage of zero premiums is for next year. It will be interesting to see what that will be, but I think you also have the political factor. You can have a few case studies here, like Ohio for example, where plans did increase premiums. Congresspeople, governors, and numerous other politicians are coming out of the woodwork about that right before elections.

Mr. Roy Goldman: This is just my opinion and I don't see how you can prove it to be wrong, but it seems to me that when HMOs entered this marketplace, we did so with rose-colored glasses because you have individuals on Medicare paying over $100 a month—in some cases a lot more than $100 a month—for Medicare supplement insurance. We go out with plans that equal the richest Medicare supplement plans and maybe even better than even the richest Medicare supplement plans with no premium rate, and I think we set ourselves up for what exactly is happening. I just don't think you can continue without a reduction in benefits, particularly prescription drug benefits, without collecting some premiums from the insured.

Mr. Griffin: I'd like to get some reaction from the audience on Medicare supplements. As I said, I come from a company that has 300,000 Medicare supplement policies and we've seen our sales decrease. Terminations have not increased and the loss rates have not increased, but we've seen the sales drop off in the last year or two. We think it's because of the fairly popular Medicare risk in the Chicago area. Let me throw out a few questions to you. What do you plan to do about Medicare supplement? Whatever you expect from Medicare Choice, how do you see that affecting Medicare supplement? How do you plan to cope with the new environment on Medicare supplement?

Mr. Carl B. Wright: Actually we now have more people in our Medicare risk HMO than we do in our Medicare supplement, so we've seen a dramatic drop in that. What has been the problem is that first of all we're in the second oldest area in the country, behind Dade County, Florida, so we have an average age of 79 in our Medicare supplement contracts. We're seeing a tremendous increase in use of services, but what we have is a population that doesn't want to go into a Medicare HMO and they keep accusing us of doing that. We finally got the point across to some degree that the government was encouraging people to go into Medicare HMO. When we met and talked with the AARP people about it, they recognized that the healthier lives were going into the HMO until they needed some real medical services. We have continuous open enrollment back and forth as long as they're in a Blue Cross/Blue Shield plan in Pennsylvania. In fact, we'll let any Blue Cross/Blue Shield plan come back in. I'm concerned about the other programs. As they come in they will probably take, first of all, the people who can afford to pay more for medical care and, second of all, the more healthy people. We're going to have a death spiral on our Medicare supplement, but we are losing about 8–9% a year right now. It has settled down somewhat.

We have a Medicare risk HMO that has charged a premium. We're raising those premiums a bit, but still, we have three versions. One is a zero premium version,

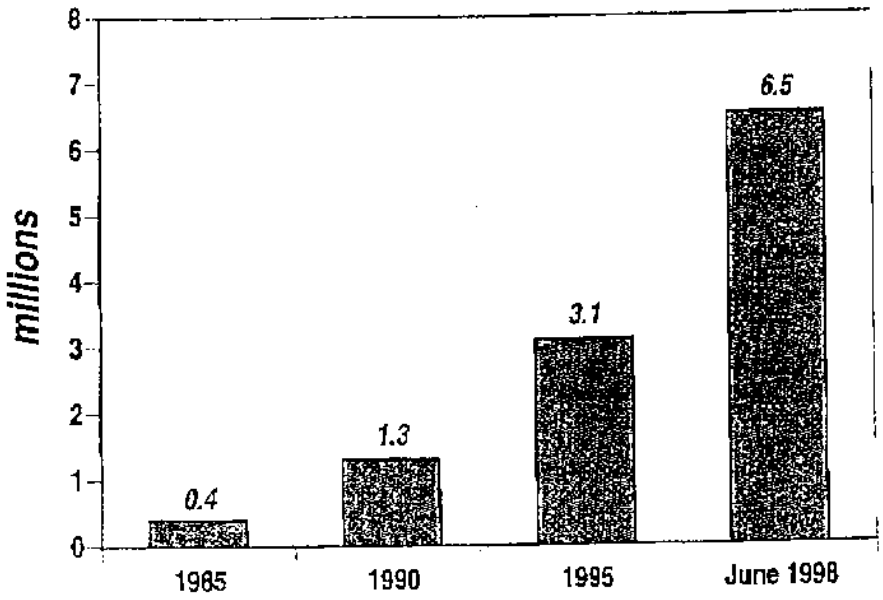
which has the basic benefits; the second is a premier version that should be $45 a month; and the third is an intermediate one that's $35. That has going up from $25. That's still for the people who find their PCP in the network. If you can't find your PCP in the network, you aren't looking because we have every doctor in western Pennsylvania in the network. But I'm very concerned personally as I do the pricing for this. I don't understand what's happening with Medicare supplements in terms of this new program. The impression I've gotten, and some other people expressed this to me, is that Medicare supplements have been cast out into the ocean to go adrift and whatever happens happens. The focus is on all the other options and choices. I guess if any of the panel has any comments on that particular issue, Iíd appreciate it.

Mr. Sherman: The story is pretty clear. We have rich premium packages that we aren't asking people to pay for and then we wonder why we can't afford them any longer. We assume that the Medicare population was not unique and not diverse and that everybody would opt in equally whether or not they were healthy or not, so we have two converging problems that are clear. We have the government who has finally figured it out. The government has said, "I'm the price maker. I'm tired of getting into the politics of all of these plans. I am going to bundle everything and let you guys figure it out." Now, get on the other side of the table. We're the we guys, so whether it comes out in a Medicare supplement plan that has to vie for dollars, which may or may not be available, or in a risk plan with or without premiums, that's the reality. There are a lot of people in this country in the senior categories who cannot afford supplemental insurance, copays, and deductibles. We know what's going to happen to them. They're going to go to the local doctor and to the local hospital and they're going to get cared for, and we're all going to wring our hands and say, "Gee, ain't it awful." Next case. I don't think there is an easy solution. I think the government has finally figured out that it can't figure out how to make all these things work. We're going to bundle our dollars, send it out to you in the form of a bid in one form or another, and let you guys worry about it. Be careful what you ask for—you may get it.

Mr. Jay P. Boekhoff: I have a response to the question that you asked earlier. I work with a couple of carriers who are in the Medicare supplement market and my experience has been consistent with what the prior speaker has said. Sales have been flat, although I think there's an expectation as the HMOs have departed that there will be an influx of members and probably a better mix of risk for those members coming in. What's needed is a review of the standardized plans. When the standardized plans were put into place, the expected premiums for those were relatively affordable, but the premiums have gone up over time, so we have kind of a discontinuity. More of the risk plans now are putting in office visit copays and

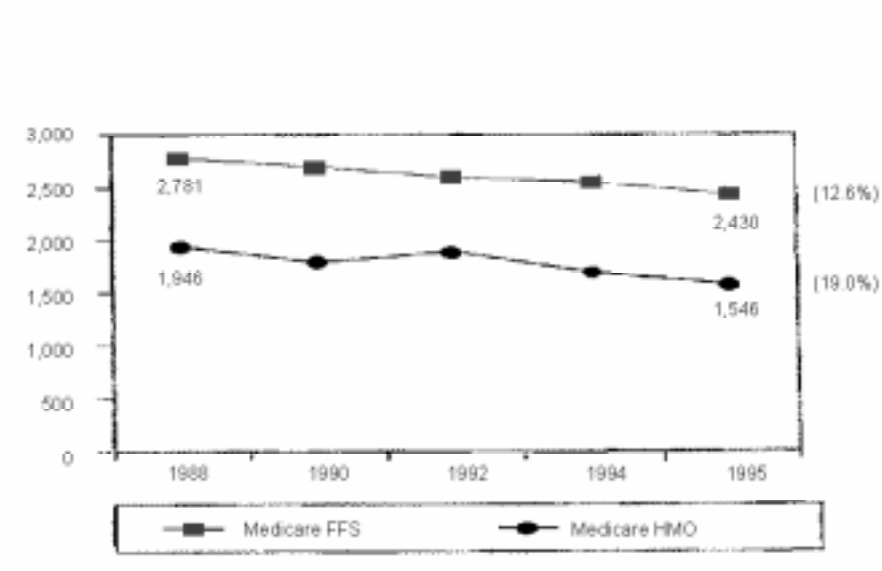
other copays, but Medicare supplement plans are providing essentially full pay coverage, which is probably not beneficial in a number of different respects. My experience has also been that the new MSAs, the high-deductible supplement plans, haven't been particularly popular either with the insurers or the insureds and that perhaps what's needed is another review of the standardized plan portfolio with some new plans with probably lower premiums, which will fit in a little bit better in the overall perspective.

CHART 1
MEDICARE RISK: A RAPIDLY GROWING PHENOMENON



The introduction of an extensive array of new options for Medicare beneficiaries will rapidly accelerate enrollment growth. By the year 2002, 10.5 million people or 26% of the total Medicare population are expected to be enrolled in Medicare managed care plans.

CHART 2
MEDICARE RISK PRODUCTS: THE SOURCE OF SAVINGS



Controlling the volume and intensity of services will yield greater savings over time than reducing reimbursement levels to fee-for-service providers.