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Designing Employer Medicare Products

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Summary: Most HMOs today offer group products to employers alongside their individual Medicare product. What are today's employees demanding in these contracts and how are health plans responding?

Panelists talk about what they are seeing in today's market and invite audience participation for comments about employers' demands and health plans' responses.

Mr. James S. Matthisen: We do have an employer with us. MaryAnne Lindeblad is the assistant administrator for the Public Employees' Benefits Board for the State of Washington. She manages a big and complex benefit offering, including about 300,000 actives and retirees. We also recruited Dale Yamamoto as a last minute stand-in to provide some words of wisdom.

I hope that the audience can help supplement what we're going to say from an employer perspective. I think that we'll end up talking about this in "real people" terms as opposed to complex actuarial factors.

From the Floor: There are concerns about the pharmacy benefit. Looking at Medicare+Choice plans, there's a concern there that employers offer unlimited pharmacy benefits to their retirees.

Mr. Matthisen: We'll address limits on pharmacy benefits.

Mr. Todd W. Whitney: I'd like to get some ideas on selection patterns for retirees at Medicare Choice plans and their other alternatives.

Ms. MaryAnne Lindeblad: I just thought I would talk a little bit about what's happening in the State of Washington with our purchasing for our Medicare product

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and some of the challenges that we're facing more from the employer who's trying to manage this product. We purchase for about 300,000 total members, and that's on both actives and retirees. About 40,000 of them are Medicare-eligible retirees, and we offer them three essentially different product designs. They can purchase a Medicare Risk product. Our health plans have risk products and we want to offer them that option.

They can purchase a Medicare supplement product, and we only offer Plans E and J. They also can purchase through the managed care plans which provide essentially a Medicare wraparound product. If the person enrolls in one of our plans that does not have a risk product, then they would just get their benefit supplemented up to the same level of benefit that the active employees get. As for the Medicare Risk products, we expect that our plans provide a product design that is at least equal or better than what they would get if they were in the wraparound product. They're not offering a lesser benefit, so most of them have to enhance the benefit that they would currently offer the individual market.

We also ask that the plans experience rate these groups. That's a challenge because of the 16 health plans that we contract with, all of them except one is a managed care plan. We have one PPO plan. Some of the managed care plans offer a point-of-service product, but some of those have some pretty small Medicare populations with 300–400 people. Some of the plans also offer a risk product in some counties, and they'll offer a wraparound product in others. We ask them to blend that rate. The retired employee pays the majority of the premium, so it's essentially self-pay. There's a small subsidy, about $34 a month, and next year that subsidy is going up to about $60.

We try to get information out that explains the product to our members. They get communications from us. We go through an annual open enrollment. Most of the interaction with us as a retiree is done through the mail, which is a challenge in and of itself. We have a small customer service staff that provides support in terms of answering questions. Throughout our open enrollment period, we do some benefit fairs across the state, and we do some separate seminars for retirees so they can come in and ask specific questions.

Let's discuss some characteristics of our plan. Members have one opportunity to enroll. At the point of retirement they have 60 days to exercise their option, and if they don't exercise it, they can't get into the program. They can't leave and come back. They have one chance, unless they come back as an active state employee. That's their only chance.

There are a lot of challenges. Those of you who might be close to some employer groups that purchase, know that there really are a number of challenges as we try to have a product that is acceptable, easy to understand, and provides the sort of services that these enrollees want. It just really is a big challenge. One of the biggest pertains to communication with members, things such as marketing to them, and the administrative complexities of a program, such as ours and how to help someone choose what is the best plan design for them when they have a number of choices. They might be cognitively impaired. There are a variety of just

operational challenges with this population, quite different from an active employee.

Designing affordable packages. Right now we essentially provide the same product in the sense that it's the same benefit design for an active employee or a Medicare-eligible employee. When you link those designs, is that really the best design? That's certainly a question that we're sort of wrestling with right now. Another challenge with this group is it's much more difficult to measure member satisfaction and find out what some of the problems are. Again, it's part of that communication with them. A Medicare beneficiary gets lots of information. There was a situation involving a retired state employee. It happened in October 1998 when Medicare went out with their Medicare+Choice products and notified people about Medicare+Choice. A retired Washington state employee got information from Medicare. This all happened in October. There was information from Medicare about Medicare+Choice. Then they get information from us just about what their plan design options are for the next plan year.

They also get information from the Statewide Health Insurance Benefits Advisors Helpline (SHIBA), which is an organization that our insurance commissioner has that helps seniors with choices around Medicare products. They received mailings from AARP, and other organizations, and they were bombarded with a lot of other information in newspapers that encouraged them to join a certain Medicare Risk plan. There's so much stuff out there for a group that sometimes has a really difficult time comprehending all of this. We found that trying to get them information that they find usable was probably one of our greatest challenges. They get overwhelmed with so much information that, oftentimes, they're not reading it. They don't understand it. They get some significant rate changes in a new plan year. They don't exercise an option to look at what some of their other opportunities might be, so they find out that their premium has doubled, but not until February when they get their first pension check that has the increase taken out. They suddenly have this big obligation, and don't know what to do."

Having a lot of the choice can be very helpful for the member. A Medicare+Choice product is a more tightly managed product. It's generally less expensive for them, but there are also the issues of making them or helping them understand what it means when you enroll in a risk product. There are the administrative issues around a risk product. The Health Care Financing Administration (HCFA) came out with some new rulings around the kinds of enrollment forms that people have to sign up. In addition to all the information we send out, the Medicare Risk individual gets another packet that's probably a half-inch thick and has a four-page form that they have to read and sign, which confirms that they understand that they're in a risk arrangement situation. It is quite confusing for the members.

One of the problems with our Medicare Risk product has been that there has been a lot of really aggressive marketing of those products. A couple of the plans in our state were aggressively marketed to a number of counties. A year later they found that they couldn't stay in those counties, couldn't maintain their networks, and were not affordable. We're losing too much money. Then they go in and pull that back. So one year the seniors have a very affordable plan, and the next year that

affordable plan isn't offered to them. They end up going into something that's much more costly to them. There have been a lot of problems with just maintaining a stable network for this population. I think it is really important to the senior population. Trying to find a physician that'll take Medicare is enough of a challenge for them if they lose their doctor. Having a stable network is a really critical issue for us.

One of the things that we also are trying to do is elicit some information from our Medicare enrollees about the program and the plan. We have just recently undertaken an effort with our Medicare population. We've done it in the past with our active population, and we're also doing it with our actives right now. It's called the Consumer Assessment Health Plan Survey (CAHPS) . It is a national survey tool that has been developed. It has also been adopted by the National Committee for Quality Assurance, (the HMO-accrediting body) as its survey instrument. Sending out surveys to this group has been a really interesting challenge. We're just starting to evaluate some of those issues. There's not a lot of information about how to survey and engage an elderly population into this sort of a thing and get survey results from them. When we started the survey, we sent a letter to alert people that the survey would be coming. If they didn't want to participate they should let us know. We received an amazing number of calls from relatives of the seniors who said, "My relative got this. They're not either physically or mentally capable of responding. They're in a nursing home." One member said, "This is just so totally overwhelming to me. It's really not something that I can take on." We need to think about other ways of getting information from this population. It will be really interesting to see what we end up with. We are getting a fair number of responses, but there are a fair number of folks who have just decided they're not able to complete that instrument.

We're always working on ways to evaluate it, to make sure that we can improve on this product design, and we are continuing to look at our purchasing strategy. We'll be moving forward in the next year to look at some other ways. Do we continue to link the product with the active benefit design? Do we try to create a benefit design that is separate just for our membership or for a Medicare membership? Do we create, for example, a pharmacy-only design? For instance, someone might want a pharmacy-only benefit. The federal government is looking at the possibility of including pharmacy in the Medicare benefit, and that may take us a different direction. We're currently in a state of revising our member materials, trying to make them less confusing and less conflicting. We are also working with HCFA in terms of some ways that we can redesign forms that make it simpler for people so they can fill out one form instead of three. We are also looking for information from the CAHPS survey. We will evaluate that and see how meaningful that is and whether there are some other ways of outreaching and working with this population.

Mr. Matthisen: You offer essentially the same plan benefit design to actives and retirees.

Ms. Lindeblad: Yes.

Mr. Matthisen: And you actually offer the same plans?

Ms. Lindeblad: Yes. Although Plan E and J for Medicare are not offered to actives. Everything else is exactly the same.

Mr. Matthisen: Another dynamic in the state program is the range of rates. The Medicare risk, Medicare supplement and the wraparound, are incredible. It's about a four-fold price differential, $50 versus $200. Retirees who are getting more or less the same benefits have this huge range of prices. I sometimes wonder if they question your credibility a little because of those rates.

Ms. Lindeblad: I think it's interesting that the majority of our Medicare eligibles stay with the PPO plan, which is probably up towards one of the more expensive plans. Because of issues like snowbirds, they have a lot more flexibility, and from that perspective, I think they see something in that plan that they don't see necessarily with the risk products or the wraparound products. This population seems to have a lot more plan loyalty, and they seem to stick with plans and not change as often. As you can see, with the active employees, if the cost share changes a little bit, they might switch to a different plan if they get their same provider.

We don't get that question a lot because this population tends to be looking more for their doctor than a plan. Approximately a year ago, we did some focus groups with some retirees. There's still some real negative feelings about managed care, and I think some of the press about managed care affects them also. I remember this one member saying dramatically and emphatically, "There's no HMO for me." "This is not the way I want to go. I need the freedom and flexibility."

Mr. Dale A. Rayman: Your retirees enroll once a year. They can change the plan design each year?

Ms. Lindeblad: Yes.

Mr. Rayman: Is there any way they can change mid-year? In other words, could they actually elect Plan J, use their drugs, and actually switch at some point mid-year?

Ms. Lindeblad: We are not allowing that if they moved. But then with E and J they have to stay with that. If they're in one of the other plan designs and they move to another location or something like that, they can change, but basically they're in for a year.

Mr. Matthisen: MaryAnne, did you want to make any comments about the different prescription drug benefits offered through the three different designs? Do you have any idea in terms of selection patterns for those in risk supplement or wraparound?

Ms. Lindeblad: I actually brought some information, so I was going to look that up. I haven't had a chance to. The pharmacy benefit design is essentially the

same. The plans have some ability, of course, to institute formularies, but the co-payment structure for the HMOs are the same. It's different for our PPO product, but it is essentially the same product design as for actives. Whether they're in a risk product or not, it is the same thing, and I can double check the numbers. As I said earlier, most of our enrollees do go with a PPO. Plan E and J get maybe 20% of the membership, and then the rest is spread out throughout the managed care plans. With the exception of one managed care plan there's not great Medicare penetration.

Mr. Daniel C. Hemingway: Is there anything that you've done to make the HMOs attractive to snowbirds?

Ms. Lindeblad: We'd like to. It's more the problem of the HMOs not wanting to cover people when they're out of area. We would like them to offer reciprocal coverage where they might have a reciprocal arrangement, but that has not been something that has been easy to do. Part of the problem is we ask the plans to maintain the benefit design that we are offering. They often don't have a benefit design that they can match up with ours. If somebody is in Arizona for six months, the offering would be different. So far, that hasn't been something that we've allowed because the individual's purchasing X product, and we don't want to provide them with Y if Y is substantially different.

Mr. Anthony J. Wittmann: The drug benefit is the same on all three choices. How about the underlying hospital and medical?

Ms. Lindeblad: It is not for E and J. The drug benefit follows Medicare's E and J.

Mr. Wittmann: But it's standardized?

Ms. Lindeblad: It's a standard E and J product, but for the HMOs and the PPO, it's the same.

Mr. Wittmann: The PPO plan and the Medicare+Choice would typically be a co-payment plan with 100% hospital coverage. What do Medicare-eligible people get under the PPO side?

Ms. Lindeblad: With PPO it's essentially the same identical benefit as our active employees.

Mr. Wittmann: Is it coordinated so they get the deductible and coinsurance paid?

Ms. Lindeblad: That's correct.

Mr. Wittmann: Essentially, it's 100%.

Ms. Lindeblad: Right. There's a non-duplication in our PPO. If Medicare is paid up to what the PPO would have paid, then they don't get anything additional. They may be paying something towards individual claims.

Mr. Wittmann: There is the premium range for the PPO plans versus the Medicare+Choice. Do you have a range of what those premiums are?

Mr. Matthisen: I think our lowest premiums are Medicare+Choice in the $50 range.

Ms. Lindeblad: The Medicare+Choice are in the high 40s or low 50s, right now. We're just looking at rates. That is after the subsidy.

Mr. Matthisen: That's after a $34 or $40 subsidy.

Mr. Wittmann: That's after the subsidy?

Ms. Lindeblad: That's after the subsidy. We have the PPO Uniform Medical Plan at $172. There are a couple of wraparound Medicare plans that are even more than that. They are close to $200.

Mr. Robert G. Lynch: I just wanted a clarification about the PPO. Is that a Medicare Select or is it a wraparound?

Ms. Lindeblad: It's a wraparound. It is our PPO that we provide to our active employees.

Mr. Dale Yamamoto: My comments are really going to be more from my perspective with our employer clients directed to health plans, insurers, and anyone who's out there focusing on plan designs and provisions, both administrative, communication, and just overall design. Must I attract employers to my product? Many of our clients are frustrated to a certain extent by some of the limitations and administrative types of things that some of the health plans have come back to them with.

I think I'd like to echo Dale's comment that prescription drugs and pharmacy benefits are probably the biggest thing on the employer's wish list. There's not a single employer out there who wants to have their retirees go into a plan with limited pharmacy benefits. For every employer client that I have, one of the demands is that the prescription drug benefits not be limited in any fashion. Their ultimate desire is that the pharmacy benefits look exactly like they do for the active employee plans or their pre-65 retiree programs. They want the standard $10-15 copayment. They might accept some formulary types of copayments in the program, but they do want it to look as much like the active plan as possible. If they see something like a $500,000 annual maximum on the drug benefit, they're going to back away from that. That's going to be the first thing that they'll negotiate with you. We want that pharmacy benefit to be unlimited. Get ready to sharpen your pencils on those types of things.

The other issue is overall plan design. During negotiations with other plans, they're saying that they have some restrictions on what kind of plan designs can be offered to the employer clients. Is it because of the way the program is filed? Is it trying to get a mass market individual product into the employer's hands or is it because of

the way the group plan happened to be filed with the HCFA. Most of them are going to say they want that plan to look like and smell like that active employee plan because that's what the employees are coming from. That's what they're familiar with. Someone turning age 65 hates change, and a change in plan is going to create a lot more calls to your service centers and your client service centers that we'd like to avoid. If it can be designed to match employer plans as much as possible, that's what our clients are looking for.

Something else that I think a lot of our clients are looking for is a way to coordinate individual marketing materials with the group side. I think we're looking forward a lot to November 1999 when you guys are planning market blitzes to the Medicare market in total. I think most of our clients are concerned that their retirees are going to be getting information from the individual marketing material that's going to be going out in October and November (regarding the regular open enrollment for the Medicare+Choice plans) that will be different from what the health plans send out.

If it's an employer product that you're sending marketing materials out to, it may get thrown away just because they may have gotten something very similar the day before through the individual marketing materials. Perhaps there is some way that you can coordinate the mailing list or maybe even send the individual marketing list out two weeks later when employer materials are going out. Then there can be some distinguishing mark that our clients can go out to their retirees and say, "If you get something in the next week or two from XYZ health plans and ABC health plans, it is a plan that we are sponsoring. Take a close look at this material." Then they at least can distinguish between what their plan is and what their overall program is subsidizing versus what is coming through on just the individual market lines.

Many of our clients are having trouble getting managed care products into the more rural areas. I know everyone was hoping that the provider-sponsored organizations (PSOs) were going to be the silver bullet to solve that problem. HCFA has approved only one PSO since it has been open to the markets. You consulting actuaries out there working with PSOs get that product out in the market if you can as soon as possible. I think there's a demand for it, but the supply is not there yet. I personally have a lot of clients that are in more rural areas that could probably benefit from the more managed care type of program for their retirees.

Mr. Matthisen: Dale, do some employers have retirees who, after getting their individual marketing materials, drop their retiree coverage from their employer, sign up for a zero premium plan, and get a bad surprise down the road?

Mr. Yamamoto: I have one client who said since Medicare+Choice legislation came into effect, this is great. We're going to give everyone a $1,500 subsidy that they can use to either pay for the Medicare Part B premium or pay for any health plan that they want to enroll in. It's not really a voucher, but something like a flexible spending account that they have available to them, so that the only thing the retiree has to do is submit the premium statement on a quarterly basis. Either that or just let them know that they're paying for their Medicare Part B premium

through the social security checks. They'll get reimbursement from the health plan. I haven't really found out what kind of feedback they're getting from the retirees on this program. They have enough money right now. Most of them can buy something comparable to what they had previously. In fact, some of them are even getting coverage that's essentially free now, whereas they used to have to pay somewhere between $25 and $50 a month for the program. For now, I think they're happy with what they have. I can see at some future point in time, because that $1,500 is fixed, that retirees may be coming back to them and saying, what's the deal?

While I was talking something else came to mind. For all of our HMO renewals that we're sending out this year for active employees, we included a question in the request for proposal (RFP). Do you offer a Medicare+Choice product? This happens in situations where you're the incumbent for the client or they're actually going out and marketing new HMOs for a given market area. We have several clients who included in their criteria list an ultimatum: if a Medicare+Choice product is not offered, it is not on the final list. For those of you that don't have Medicare+Choice products or they are not in the same service areas as the commercial products, there are large employers out there that are looking prospectively. They're not going to offer the Medicare+Choice product this year, but they're asking for it in the RFP process because they know two to five years from now they will. A lot of our clients are cutting out some of the health plans in given market areas, but it's a conscious effort and decision on their part to not only encourage managed care for their employees, but to encourage managed care for their retirees.

Mr. Dale A. Rayman: I went to Harry Sutton's session (54PD, Medicare Commission Recommendations), and they were talking about the issue the government has right now. I guess part of the reason that the Bipartisan Committee couldn't come up with a solution or a recommendation was because of the whole issue of how to fund the pharmacy benefit. The government's concerned that if they offer this benefit now, employers will pull back and stop offering the benefit. Therefore, the 70% of the post-65 population who has coverage either through Medicare+Choice, MediGap, or employer coverage will no longer offer that. Maybe you can just help me with this idea. I can see that the retirees feel that their biggest health care gap is the pharmacy benefit. If the government gives them that benefit in traditional Medicare, the government's concern is paying for that. Offer them the benefit. Make the retirees pay the full cost. Let's say that's $60 a month. MaryAnne, would the employer continue to help pay for that benefit? My assumption is if the employer's paying for that right now, there's no additional *Financial Accounting Standard 106* cost to them if they decide to pay that $60 for the retiree because they are paying for it right now to fill in that gap.

Ms. Lindeblad: Coming from state government as the employer, that is part of the whole retirement compensation package so to speak, that they have the insurance available to them. I guess I don't see us pulling back, but it would certainly become a rate issue, and we would expect that the cost would go down.

Mr. Rayman: With the government's negotiating leverage, the cost of that probably would go down. At least it would give retirees who are, let's say, $2,000-

3,000 or higher in drug spending a more affordable benefit. They would pay a premium and spread the cost.

Ms. Lindeblad: Right.

Mr. Rayman: I guess the retirees who are purchasing Plans H, I, and J on the MediGap side would see a savings because they no longer have to buy drug benefits on top of that.

Ms. Lindeblad: Yes.

Mr. Rayman: The savings they get there would be used towards their contributions to the drug benefit.

Ms. Lindeblad: I think that would be a pretty logical conclusion.

Mr. Rayman: I guess the retiree's concern then is affordability for those who think they can't afford $60 per month. How much communication are you doing right now to allow your retirees to prepare, and for your active population to prepare for retirement?

Ms. Lindeblad: Retirement?

Mr. Rayman: If you're going to have this drug benefit gap or the government will provide it, and you have to pay for it as part of Part B, you need to start preparing for that.

Ms. Lindeblad: Yes, we actually do pre-retirement seminars for state employees. A big focus of those seminars is creating an understanding of what the health care benefits are going to look like so they can start some of that pre-planning. That's probably one of the major ways we communicate. Then, of course, there are pamphlets that people get as they start thinking about retirement or 90 days before they retire. They just get people thinking about it. I think that's an area where there's a lot of room to grow and to do some things differently. I think one of the biggest surprises for our folks getting ready for retirement is how much they're going to have to pay for their health care.

Mr. Rayman: I guess 90 days before retirement doesn't help. It's kind of late to start.

Ms. Lindeblad: Some people actually go to the pre-retirement seminars years in advance. We are trying to meet their own needs in terms of retirement planning, and they're actually encouraged to go five to 10 years before they plan to retire.

Mr. Harry L. Sutton, Jr.: I have a couple of questions. Dale, you mentioned some big employers having a requirement that their HMOs offer a Medicare+Choice option. As an example, I'm working in Kansas City. CIGNA has a health plan, and it is a big national player. It is dropping out of six areas. In Kansas City it only has 468 Medicare members. It doesn't feel it could afford to spend $2 million to have a

Medicare contract for 468 members. Is the employer going to accept that it only has three retirees in an area? Every HMO is not going to set up for its three retirees? I can understand what it's saying. It wants to encourage it. On the other hand, what it's saying doesn't make any sense.

Mr. Yamamoto: What our clients are doing is definitely one decision point in whether or not to select an HMO. Whether there's a Medicare contract available is just one of those points. You're going to get no points if there aren't any contracts there. It may detract from the availability of that program. In the extreme case, I mentioned we do have some clients who say if a Medicare contract is not available, they're not in consideration for active employees because there will be some other HMOs in the Kansas City market that have Medicare+Choice contracts along with the commercial contracts. That will be the selection point. There aren't very many. It's a definite minority, and it's a very small minority right now, but there are a few.

Mr. Sutton: I think part of the problem with some of the HMOs dropping out of certain counties is the rules have changed a little bit. They have to submit a separate bid for each county, and it's too much work for 100 people. Even though it's on the fringe of a metropolitan area, they just can't justify the expense of doing it. The other thing is on the competitive bidding, at least in Phoenix and Kansas City, the employers are left out of the situation. I am speaking for myself and not HCFA. The HMO can negotiate any benefit plan they want with any employer.

Now, what I don't know is whether they can get the total bid premium or the adjusted average per capita cost (AAPCC), which would give them benefits that are lower than Medicare because the government currently has a one-payment rate. In competitive bidding they will have an average payment rate, and if your costs are more than that, you can have any benefit you want, but you have to justify the additional benefits and charge a premium. I'm not sure, but based on history, it seems that most of the Medicare HMOs can negotiate almost any deal they want with an employer. They're not subject to the restrictions. Many of them had health care prepayment plans (HCPPs) because, within that environment, they could do clearly anything they wanted. I'm not sure how the Medicare reimbursement to the HMO is affected by a plan with coinsurance and deductibles. If they were going to keep the coinsurance and deductibles in rather than provide full coverage, even though they added prescription drugs which raised the cost way up, it's not a Medicare benefit so I'm not sure if they could still get the total premium or not. I think, in bidding, it's clear that the HMO can negotiate any benefit it wants with any employer, but I'm not too sure.

Mr. Yamamoto: When you mentioned Phoenix and Kansas City, were you referring to the demonstration projects?

Mr. Sutton: Yes.

Mr. Yamamoto: We're actually going to talk about that in a session. I'm not sure which time slot it was in, but one of the people on the panel was going to talk briefly about the demonstration projects.

Mr. Lynch: I'm personally interested very much in helping insurance companies to develop Medicare+Choice PPOs and private fee for service. I was just wondering if you could give some impact on how that would be perceived by large employers, and what might be some objections or misgivings that employers would have for such plans. Maybe a plan would want to keep that in mind when developing that or marketing it.

Mr. Yamamoto: I think probably the key issue for my clients is creating too many networks out there. Even though the plan provisions may look the same moving from one PPO network to another and moving from 64 to 65, the availability of having that PPO is attractive to a lot of our clients. But it will depend on how many networks they already have under their PPO network, because we have some clients who insist that they're going to go with one national carrier and that's it. We've got others that will have five or six different PPO carriers spread around the country with the same plan design but different networks just because they're looking for "the best in market," if you will. I think different PPOs from a national basis will be more financially efficient in some markets and not others. I think one potential in the Medicare market is if the PPOs that are available can mimic the pre-65 or the active benefits core provision. That would be very important.

Mr. Lynch: It would be helpful if it were an existing PPO that developed a Medicare+Choice plan, in addition to being there already.

Mr. Yamamoto: I don't think it necessarily has to be, but it's going to have to be someone that's flexible enough to be able to allow and administer the employer's plan design, which for a lot of large ones, may be strange. On the private fee-for-service side I guess I can come up with a lot of different phrases. However, I really don't think employers will offer that, mostly because the plan designs aren't going to be as flexible as they have to be to meet the employer's needs. If they are, I certainly think it's something they might look at. But I guess I see the viability for the private fee-for-service plans to probably still be marketed in select areas. I think it is just because of the reimbursement scheme. I don't think it's going to work on a national basis.

Mr. Lynch: No. I'm looking at it for certain areas of the country.

Mr. Yamamoto: I think one insurance company has actually filed for a private fee-for-service plan. It hasn't been approved yet, but I think there's one insurance company that filed.

Mr. Lynch: I was one that filed for a PPO, which has since been dropped.

Mr. Wittmann: We see very high costs on our employer-sponsored plans on the drug side compared to benefit-adjusted drug costs on our individual product. I was wondering if anybody on the panel or in the audience had any ideas behind that. Is it selection? Or is it just the fact that when employers sponsor a retiree plan, they tend to have high drug utilization just because they've had a rich, active plan along the way?

Mr. Yamamoto: What's high? High relative to what?

Mr. Wittmann: We have some areas where we have some pretty rich drug benefits on the underlying individual plan. We're pretty comfortable with our plan factor adjustments for different maximum levels to an unlimited plan. You can take the drug utilization on the underlying plan and adjust for the benefit differential to the unlimited plan. There's a step function of maybe $15 in cost to get from the individual plan to the retiree plan to the aggregate experience.

Mr. Yamamoto: What's the individual plan?

Mr. Wittmann: We take the individual plan experience and adjust it for a plan factor up to an unlimited plan.

Mr. Yamamoto: Taking an individual.

Mr. Wittmann: Say the underlying plan is a $2,500 plan. We adjust it for the benefit differential to an unlimited plan, which typically might be 10% or something like that to get up to an unlimited plan. That doesn't get you near to where the actual retiree's drug cost comes in.

Mr. Matthisen: Are you typically alongside other options?

Mr. Wittmann: Obviously they do have other options, and that's really what I'm trying to understand. Somehow we're getting more high-risk people.

Mr. Yamamoto: Is it the kind of commercial market that's under pre-Medicare versus the Medicare population?

Mr. Wittmann: It's individual Medicare versus the employer plan.

Mr. Yamamoto: It is difficult to measure what the individual prescription drug cost is.

Mr. Wittmann: We have individual Medicare+Choice plans with drug benefits.

Mr. Yamamoto: You're looking at your own data.

Mr. Wittmann: Yes. Between individual and group.

Mr. Yamamoto: I guess I'm not sure. Does anyone in the group have any comments?

Mr. Wittmann: Along with that what kind of incentives are there in employer plans for members to join Medicare+Choice plans?

Mr. Matthisen: Premium.

Ms. Lindeblad: Premium, yes.

Mr. Wittmann: It's just the premium?

Ms. Lindeblad: Right.

Mr. Yamamoto: The premium's probably the big thing. I think in the last two years, since the disparity between the employer's cost and its self-funded plan or whatever they were sponsoring before, the HMOs versus the HMO price is large enough that they can offer some sweeteners to encourage people to move into the HMOs. We have clients who would give bonuses. If someone moved to an HMO, they'd give them $750. If they stayed in the HMO for two years, they would get $1,000. They'll pay for the Medicare Part B premium if they go into the HMO, because they're going from paying the full cost of $1,500-2,000 a year to paying $500 a year. They can afford to pay the $46 Medicare Part B premium now and still save money. You have some of those kinds of subsidies going on.

Mr. Wittmann: If they're not paying the full cost of the coverage, then the premium itself takes care of the difference?

Mr. Yamamoto: Right.

Mr. Wittmann: If they are paying the full cost, then they're offering incentives to join the Medicare+Choice plan?

Mr. Yamamoto: They'll put limits on what those incentives are to make sure they still save money. That's the general goal. It is supposed to lower their overall health care costs, and if that's not happening, they won't do it.

Mr. Sutton: I happen to deal with a large employer who had segregated out its prescription drug plan for both its active employees and retirees. It has a card plan with mail order, but it's a separately managed plan, and it's exactly the same for active and retired employees. I just wondered, in that kind of a situation, would the employer go looking for a zero premium HMO without any prescription drugs? It might be easier to find it in the future (without the drugs in it) and to keep their other plan. Now, I do not know how their drug costs for their retirees would compare with how much it would cost the HMO to provide the same benefits, but it would get rid of the selection aspect. Do many big employers look at it that way? Many of them have segregated the prescription drug into a card plan.

Mr. Yamamoto: When they looked at this two or three years ago, most employers were deciding whether or not to subsidize any HMOs. It was thought about but not done. In one-half of the HMOs that they're offering, there's still some subsidy in there or there's still some pharmacy benefit. Even in that zero-premium plan, it was tough to kind of say, "We have this prescription drug plan for everyone with retiree coverage and also pay the HMO premiums that may duplicate coverage."

Harry, I think you're right. As the HCFA reimbursements come down relative to the benefits that are being delivered and there aren't any more zero-premium

programs, I think zero-premium without prescription drugs is a design that will happen in the future.

Mr. Sutton: I've seen a couple of employers that are just saying, "We'll do a stand-alone drug plan," and that's it.

Mr. Lynch: I haven't dealt too much with large employers and their Medicare benefits, but I'm a little bit surprised about the employer-sponsored plans or the employers paying essentially a cash benefit or subsidy to their retirees to take Medicare+Choice. I know the plans themselves are expressly forbidden from doing such things as that under the BBA. Has there been a ruling on that or could you point me toward that ruling so I could get some parameters on it?

Mr. Yamamoto: I don't think there's any ruling on something like that. It's being paid as a cash payment. It's a taxable benefit for the most part. I think you have to be careful about that type of thing. It's the employer providing the cash benefit, too. It's almost like an extra retirement benefit, if you will, that's being given to them in a lump sum. They're trying to divorce it from the decision or influencing you to go to a specific plan. On the Medicare Part B side, a lot of employers provide Medicare Part B reimbursement.

Mr. Lynch: But as soon as you say Medicare or tax-deductible. . .

Mr. Yamamoto: It is not tax deductible. It's a taxable benefit.

Mr. Lynch: The IRS probably would be less likely to get upset over it.

Mr. Yamamoto: It gets its share.

From the Floor: MaryAnne, is there a minimum size for select and supplements for retirees that you do?

Ms. Lindeblad: Do they have to come in with a minimum total number?

From the Floor: Yes.

Ms. Lindeblad: No, all the plans that participate with active have to participate with retiree. If they have a very small number of retiree enrollments, they would still have to provide it even in a risk product.

From the Floor: Is there any certain size above which they tend to self-insure?

Ms. Lindeblad: I don't know what the answer to that would be. James?

Mr. Matthisen: Ask again, because you started out on supplements.

From the Floor: Is there a size above which they tend to self-insure rather than have a fully insured retiree plan?

Mr. Matthisen: MaryAnne might not have mentioned there's just a single Med Sup E and Med Sup J. That's essentially an experience-rated product offered statewide. There is also only one PPO. The competition is in the Med Risk and the wraparound where there are multiple plans.

From the Floor: Right. You're not even talking about the self-insured market at all.

Ms. Lindeblad: No.

Mr. Matthisen: Right. Another interesting twist is that their Med Sup products are also available to all residents of the state.

Ms. Lindeblad: And it's rated that way.

From the Floor: You were talking about actives and retirees together. Do you get a retiree group that does not have the actives associated with it? Do you write that type of business?

Ms. Lindeblad: Actually we do. We have the K-12 employees. When they come off active status, they go into our retirement program. They do not necessarily have to participate in our program as an active. The school district may offer its own health plan. We have a few school districts that purchase through us for the active, and then they rollover into retirees, but for the most part, the school districts purchase their own. If the school districts don't offer a retiree benefit, it comes through us. We do get those school district employees coming off a different sort of plan as an active into our pubic employees benefits board (PEBB) plans, which, in some cases, is a fairly significant, different-looking benefit.

From the Floor: Is that medically underwritten or is this just when they're initially eligible?

Ms. Lindeblad: Right, they have to elect it immediately.

Mr. Matthisen: I had one question about Washington that maybe some of the health-plan actuaries would want to weigh in on. MaryAnne mentioned that with the state employees there are people all over. We have pockets of Medicare Risk plans. One of the requirements is that the plans offer a blended rate that covers the expected population in and out of the Medicare Risk service area. I think that has been somewhat of a complexity and a reason for plans to sort of throw up their hands and say, we can't offer you our risk products. Does anybody have some experience or is there any insight in trying to be geographically diverse when you only have a risk product in part of a state or a region?

From the Floor: We have an entity called Missouri Consolidated Health Care Plans. It works the same way. Their set-up is either eight or nine regions. Each region gets bids and has its own rate. Some of the HMOs in some of the regions had more trouble lately in terms of things like providers bouncing out sometimes. There'll be one hospital in the area, and that one will totally drop out. It's another

issue. They set up regions. Local governmental agencies can opt into this plan as well.

I might relate it to the competitive bidding project areas. We've asked the HMOs there. They're covering a metropolitan area. In Kansas City, for example, there are two counties that are not in the service area of any of the HMOs, but they all have a few hundred people enrolled in the HMOs. In the new rules, as I understand them, if HCFA finds out you're not in the service area of the HMO, they will cancel you out and put you back in fee for service. However, the people that are already in there are grandfathered in. They're not supposed to kick them out if they've already been in legitimately under the old rules. We have offered a number of different ways of bidding. We'll let them bid in all 11 metropolitan counties, if they want to bid that way. They will have to weigh their membership in each county and the payment rate to come up with an average bid if they wanted to do that. Plans wouldn't agree to do that. They're going to bid on the central county, and then they're going to ratio the rate for each of the other counties based on the payment rate for each county. Then the multipliers and the risk adjusters will apply to each county separately. The government was toying with trying to include some outlying counties with very little population into the bid, but I don't think anybody wanted to do that. In fact, they were pulling out of a couple of the counties because there's only a few hundred Medicare members in some of them.

Ms. Lindeblad: It's not worth it.

Mr. Yamamoto: I'd like to still get some answers from folks from the health plans and insurance companies. You have a lot of products out there with $500,000 annual maximums on pharmacy benefits, and I guess I've got a lot of feedback from a few that you don't want to have unlimited benefits. What's the prospects of having unlimited benefits the way our clients would like to see them? How many of you have products with unlimited pharmacy benefits? I think two-thirds of the room were from insurance companies. So what's the percent? Maybe 10%?

Mr. Matthisen: Does that mean that no employers have that option with your plans?

Mr. Yamamoto: Maybe I should ask how many offer group plans instead of just individual Medicare plans? I think it's the same number of people who raised their hands on unlimited benefits.

From the Floor: What about knowing what their limits are?

From the Floor: Some have $5,000 limits. Some have $10,000 limits.

Mr. Yamamoto: For the individual plans, how many have limits above $1,000, $1,500, or $2,000? How many have it above $2,000 for an individual product? Anything over $2,000? We have a couple. I think individual plans are probably the next frontier to explore: increasing those limits to make it more attractive for employers even to offer individual products. I have a meeting with a client who's seriously considering having some kind of subsidy to get their retirees to join

individual HMO products. We're trying to figure out exactly how to define what that subsidy level is. One of the things that they're going to be giving to their retirees is a benefit comparison of how plans that they have available compare to the benefits being offered by the potential plan. They will pull off as much as they can from the Medicare Compare database, which will give a side-by-side comparison. Then they can have the individual contract versus the employer plan, along with a dollar subsidy. I think we're going to see more and more of this as more plans become available. This is the first client who's actually going to be doing that for the next year.

From the Floor: MaryAnne, have you yet dealt with the issue of continuation areas for plans in negotiating size of continuation areas for your own group plan or negotiating the options available to the plans for the covered beneficiaries?

Ms. Lindeblad: We haven't had to at this point.

Mr. Matthisen: We didn't talk much about selection issues. That might mean that we don't have people with much recent experience or anything they want to share on that.

Mr. Sutton: I might talk about Minneapolis, which is a low AAPCC state. It's getting an 8% increase, like Washington. In our state, all the HMOs offer a $65 Medicare-Risk-type contract with premiums of $60-70. It does not include drugs. I'm in a plan that's now legally a Medicare supplement. It replaces the HCPP that I was in before. And I have an unlimited prescription drug plan, but it's only offered to employers like the HCPP was. The premium that my former employer pays is about $200 a month, but the premiums are $250-270 if you are in an open enrollment plan. In talking to the executives of one of the HMOs, I found out that his HMO was one of the last ones to build prescription drugs into every plan. That was until they were losing all their people who didn't use prescription drugs who were joining another HMO that had choices. They looked at their experience under these plans, and the cost of providing total care was around $1,100 a month, which is almost three times the AAPCC that they were getting from the government. Only part of that amount included the drugs. Approximately $100-150 a month was the drugs, but the rest was the fact that they were highly impaired.

I don't know if the risk adjuster will take care of that to some degree. The drugs aren't measured by the risk adjuster at the present time. It could keep people out of the hospital for some things or minimize the hospitalization length of stay. They may get burned. The state wanted to use community rating. It said, "You can charge only $150 for the drugs, but you have to community rate the base plan." They called on HCFA like they did in Massachusetts to get the state out of their hair in terms of how to set the rates. Based on my knowledge and my own rate, I would say that the employer plans had lower prescription drug costs than at least the open enrollees. They had to pay a high premium. Of course, you would expect a high level of selection, whether they have to pay an extra $100 a month or more for drug coverage.

From the Floor: I'd just like to add something in terms of drug selection. Being from Wisconsin, I have a rather unique situation. I mentioned that anybody on Medicare supplement in Wisconsin could not buy prescription drug coverage because nobody will sell it. It's an issue. It's because Wisconsin, along with Minnesota and Massachusetts, is one of three states that have a waiver for MediGap. In Wisconsin, the law states that you have to sell the prescription drug for Medicare supplement as a stand-alone rider so people can buy it by itself.

My previous employer was one of the last companies to actually be selling such a product. While we could price the prescription drug rider to cover the prescription drug benefits, the experience at our company and several other companies was that if you looked at the costs for everything else, the medical costs ran about 50% higher than those that didn't have the prescription drugs. This is why no companies in Wisconsin will sell prescription drugs to Medicare supplement anymore.

Mr. Matthisen: This population is older than average. Most of the people are not working. Someone also commented that they don't like surprises. Stability is a pretty key concept. I guess I'd keep that in my mind if I were trying to design products. I'd try not to have a new design every other month. I'd try to pull something together that could feel like the same thing year after year. Simplicity was discussed quite a bit. Flexibility was another issue that gives employers the option to provide what they want to provide, not what you happen to have. I guess affordability is a concern above all.

Mr. Yamamoto: They do not want surprises late in the year, such as dropping service areas in November.