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Moderator: WILLIAM E. FINCH
Panelists: MARTIN E. STAEHLIN
MARGARET WOOD WEAR
Recorder: WILLIAM E. FINCH

Summary: This session covers a variety of current issues in the senior healthcare marketplace. Among major topics is the expected change in Medicare managed care enrollment, the dearth of expanded private programs, and the miniscule growth of provider service organizations.

The continuing impact of the Balanced Budget Act of 1997 is discussed, including:
- *the health-risk adjuster mechanism*
- *the Medicare+Choice program*
- *Changes in the Medigap system arising from the redefined marketplace.*

Implementation of the health-risk adjuster mechanism, recently defined by the Health Care Financing Administration, is required by January 1, 2000. How will it affect HMOs and their interest in continuing enrollment in Medicare?

Mr. William E. Finch: I will talk about the Balanced Budget Act (BBA) of 1997 and the impact it has had on the Medicare program. Marty Staehlin will touch on that topic and talk about what the impact might be on providers, and how they might view it from the provider service organization (PSO) perspective. Margaret Wood Wear will talk about prescription drug benefits. Those of you who were here for the staged presidential candidate debate will recall that prescription drugs were a key part of their healthcare proposals for the Medicare population.

I'm going to interchangeably use the words Medicare Risk and Medicare+Choice, although they're really not the same thing. Prior to the BBA, plans contracting with Medicare on a risk basis were called Medicare Risk plans. After the BBA of 1997, the plans were all called Medicare+Choice plans and that applies to HMOs, PPOs, and medical savings accounts (MSAs).

Let me give a little bit of a historical perspective. Then we'll go into the BBA and the implications of that. The Medicare Risk program started back in the mid-1980s

with TEFRA. I think 1985 was the first year that HMOs were actually allowed to contract with Medicare on a risk basis. Initially, roughly about 100 health plans entered into the Medicare Risk market. A number of those health plans had significant losses and probably within two to three years half the health plans were already out of the marketplace. From the late 1980s to the early 1990s there were relatively few new players coming into the Medicare Risk market. Then, starting in the early 1990s until 1997-98, there was a significant increase in the number of plans in the Medicare Risk program.

There were roughly 2 million people in Medicare Risk programs in 1993. In 1998, there were 6 million. The total aged Medicare population right now is roughly 34 million, and it's projected to go to about 52 million by 2020. We're all aware of this as actuaries, but the Medicare population is growing much faster than the rest of the population.

One of the forces behind the growth from 1993-98 was the desire to enter new markets. If you think back to 1993-94 and some of the proposals in the Clinton administration, a lot of emphasis was put on market share and membership growth. Most health plans viewed the Medicare Risk market as an untapped market. It essentially was as far as the penetration, and that was part of the reason for the increased interest.

Another reason during this time period was that many providers, whether physician hospital organizations, hospitals, or physicians were interested in accepting financial risk. Providers accepted capitations or flat payment rates from the health plans to provide the services, and in the end they were financially responsible for those services. I think, to some extent, that helped some of the health plans feel a little bit safer about entering into Medicare Risk products. I would note that in some of these arrangements health plans have receivables from the providers which may not be collectable.

Another issue is the benefits and the member premiums. Starting in 1993-94 there was a significant increase in products with zero-dollar premiums with prescription drug benefits. From the member/beneficiary perspective, if you have a choice of a Medigap policy for about $100 per month, which includes no prescription drug, compared to a zero-dollar premium Medicare Risk product, which might have a $500 drug benefit, from a cost standpoint it's pretty attractive. The benefits and the member premiums became very aggressive.

Another issue is the federal government with its budget issues. The Medicare program currently costs roughly $200 billion a year for the federal government.

The BBA of 1997 had several different pieces in it that affected the Medicare senior market. The BBA changes also apply to disabled beneficiaries who are part of the Medicare program.

One objective was to provide beneficiaries with more choices. Congress felt that it wanted Medicare to be able to offer something more than just plain old fee-for-

service with a Medigap policy. They wanted to mirror more closely the commercial markets, so there were more types of products allowed under the BBA.

Another objective was to balance the budget though reductions in costs. There were some cost reductions in the regular Medicare fee-for-service market. In addition, there were changes in the Medicare+Choice reimbursement that was part of the BBA, and we'll get into that in more detail later.

Another change was in the Health Care Financing Administration (HCFA) adjusted community rate (ACR). That's something that is filed with HCFA that says what your premiums and benefits are going to be for the next year. Historically, that used to be filed in November. The BBA pushed that up to May, and what that did was make the lead time even longer on this business and brought additional risk. Many plans had just been getting their feet wet in 1996-97, and maybe 1998, and they could have used some additional time to evaluate their experience. Ultimately, HCFA for 2000 pushed the date back to July 1 for the HCFA ACR.

Product choices. The BBA specifically mentions some different products: HMOs, point-of-service plans, PPOs, private fee-for-service, and MSAs. I think that the PPO option may be one of the more viable ones of the new options. It is hard to see how the private fee-for-service plan would make sense financially when you analyze the details of the way it's set up. The MSAs may have some potential. It's interesting the MSAs can be offered under both a network or a non-network plan, so you could have a MSA-type plan under a network program where there's specified providers that you need to use.

Reductions in federal government costs. This was part of the BBA, and for those of you who follow the press on the provider side or at least know what's going on with the hospitals, there's been a significant amount of unhappiness with what the BBA is doing to them. There were reductions on both the inpatient and outpatient side. On the inpatient side the annual diagnostic-related group (DRG) payment updates were reduced. On the outpatient side, a prospective payment system is supposed to be implemented and there is also a technical correction that reduced the Medicare program expenditures.

The skilled nursing facilities are financially suffering. There's a lot of discussion about potentially reversing some of the BBA reductions in payments to providers.

There's an interim payment rule for home-health services. This may seem somewhat surprising how big home health has grown under the Medicare Risk program, but the home-health costs are roughly about $40 per person per month for home-health care. This has been a significant driver of the Part A cost increases.

Another reduction is the Medicare+Choice reimbursement for health plans.

Prior to the BBA, payments were determined for the Medicare program based on something called an adjusted average per capita cost (AAPCC). This is like a book

rate or a manual rate and it varied by county. A key point is that previous to the BBA, the cost for a county was based solely on that projected cost for members in that county. The BBA changed that dramatically for some areas.

There is a separate AAPCC for aged and disabled people, and there is a separate AAPCC for Part A and Part B. There are demographic factors that reflect gender and status. The status options include Medicaid, institutionalized, working aged, or none of the above. The plans are paid a different rate for each individual based on the demographic factor.

Prior to the BBA the AAPCC used to be 95% of the fee-for-service projected cost for that county for a demographic factor of 1.00. With the BBA whatever rate the fee-for-service trended at, the rate for managed-care payments was reduced relative to that. There was a 0.8% reduction in 1998, and then there is a 0.5% reduction for each of the years 1999 through 2002. In real rough terms, it went from about 95% of fee-for-service to about 92%.

Local and national blending. Prior to the BBA, a lot of geographic areas, particularly the rural areas, were dissatisfied with their payment rates. There was a wide disparity in payment rates among certain areas. Part of the solution to that in the BBA is a formula that changes the AAPCC from one based on only the cost for a specific county to one based on a combination of county costs and national average costs. It starts out with a 90% local 10% national weighting in 1998 and ultimately goes to 50%/50%.

Now, in some areas this may not have much of an impact, but, for example, if you look at Dade County, Florida, which is Miami, their national number is roughly 70-75% of their local number. Ultimately, what that means is when you weight those 50%/50%, it might be close to a 15% reduction in payment rates because of that provision, all other things being equal.

There are other areas where this national local blending will pull the AAPCCs up for that county. I think that you may see some of this actually reversed over time because there's a lot of uncertainty in this program and a lot of discussions at the congressional level of what to do.

One other point I wanted to mention about the national component is that it's not a national average cost per person. It's a national average cost, but adjusted to the Medicare price inputs for that geographic area. For example, on the Part A side, it reflects the hospital-wage index. It's really taking national utilization, but adjusting it to local Medicare prices.

The final point is medical education has been pulled out of the AAPCCs. Prior to the BBA, medical education was in the AAPCCs and that's being pulled out at 20% per-year phase-in.

Risk adjusters. These were included in the BBA for probably two main reasons. I think the primary consideration was at the congressional level. There was concern

that the health plans were being overpaid; that is, even after adjusting for demographics, the health plans were still enrolling healthier people, at least that was the HCFA assumption. The other consideration that was driving this is that at least some of the PSOs were expecting adverse selection because they were a provider-owned network and wanted some protection from that. The risk adjuster was a way to give them some protection, at least in the eyes of HCFA and Congress.

The phase-in of risk adjusters. The BBA specifies that there's a risk adjuster that needs to be used. It doesn't specify how it's to be phased in. HCFA decided to phase this in to alleviate or to dampen some of the concerns of the health plans. In 2000 only 10% of the impact of the risk adjustment will actually be reflected in the rates. On average, the 100% impact of the risk adjusters would reduce revenue by about 8% for the health plans.

Most of our clients saw reductions in the 5-10% range, at 100% impact. We saw some a little bit higher than 10% and a couple a little bit lower. HCFA published data that showed some plans did receive a positive increase.

From the Floor: Are they going to use anything besides inpatient adjusters in the future?

Mr. Finch: That's a good question. The current system is inpatient-only. When HCFA initially came out with their regulations on this, they said that by 2004 they would have an ambulatory-based system, so until that point they were going to use inpatient-only. It's pretty intuitive that if you're using an inpatient-only risk adjuster and you're effectively keeping people out of the hospital, that you're probably going to get underpaid. That being said, I'm not aware of anything the industry has done to show this.

On the risk adjuster, there are also some members of Congress who are trying to stretch out the implementation longer than this. Some are also trying to make it budget-neutral and not have it be a reduction on average. This is really in a state of flux at this point.

I want to touch briefly on the Medigap market and this will be a good point for a discussion, too, after the three of us are done presenting, on the impact of the Medicare+Choice or the Medicare Risk growth on the Medigap side. Recent cost trends I've seen in Medigap have been relatively moderate, which has resulted in relatively moderate rate increases. Some clients were concerned that their whole market was going to dry up because of Medicare+Choice. Marty is going to get into that a little bit later on and show you some of the enrollment projections by HCFA.

When you look at those projections and what the enrollment would be, you would think that's a reasonable assumption. At this point, though, it seems as if unless there are some significant changes in the legislation and the current payment rate structure, enrollment will decline rather than grow dramatically.

The current environment (and I'll emphasize the word *current* as in current existing law and current situation) for Medicare+Choice plans is relatively unfavorable. We've certainly seen some pullouts and some reductions in certain areas, particularly in the rural counties, but I think there may even be bigger ones to come in the future if there aren't changes in some of the major counties. In my opinion, the current environment is relatively bleak.

The pressure for change, though, is also there and I think it's not only coming from the health plans themselves, but also from the beneficiaries. The beneficiaries have had zero-dollar premium plans and $1,000 drug benefits and all of a sudden they're losing their drug benefits and going to a $40 monthly premium. I have a feeling the beneficiaries are going to start making some noise, which may also increase the pressure for change.

Mr. Martin E. Staehlin: I titled my part, "Provider Perspectives." I guess the point that I hope you would take away from what I say is that as a provider you ought to have a perspective. I'm not saying the providers are the most important or the health plans are the most important, but there's a fixed pot of dollars right now. We have a number of parties that are fighting for this fixed pot of dollars. I'm going to shed a little light on the provider perspective by starting out with the environment.

What does the environment look like? Connected to the BBA, most of these verbs are negatives: they're removing graduate medical education, they're reducing geographic variation by the blending, they're lowering the update factor that was the trending, and they're lowering fee-for-service growth. The only reason I used a positive verb, improved risk adjustment, is I worked on that task force. Maybe what they're doing is better than none. People might have ideas about including outpatient and other services, and at least right now there's movement in a direction.

You need a perspective. As a provider group there might be some benefit, as a rural provider integrated delivery network, to see if you ought to band together as a PSO or to partner with a health plan.

After your projection you might decide it's better not to do it. It might be better just to accept DRGs for a while, but at least you ought to think about doing the projection. However, as you saw earlier, in Southern California, Florida, and Texas, where a lot of the retirees live, they get 95% of the payment you get today.

Moving forward with the environment, what's going on with health plans? What have been the reactions? The payments, in general, are projected to decline. Some projections estimate it's at least down to 92%. Well, actually, it's 92% of 95%, maybe in the 87% of fee-for-service equivalent.

There have been changes in the budgeting cycle. HCFA had gone as early as May and now they have pushed that back to July. There's low enrollment and adverse selection. There's not very many effective medical management programs. A lot

of people just accept the payment and hope they can do better. That's a fairly negative perspective, at least with what you read currently from the health plan perspective.

If we look at the enrollment projections, 6 million out of 39 million are currently in a managed Medicare program. The early BBA projections estimated that 20 million people would be in managed programs in 2008. I don't how many of you believe that. Also, there was an increase to 50 million Medicare aged in 2020. This population is continuing to grow and there are a lot of pressures on the Medicare program, so something has to happen.

If you look at access, there are currently 9 million rural Medicare beneficiaries and 73% of rural beneficiaries do not have access to HMOs. Although there are 6 million people in HMOs, they're in metropolitan areas. Rural providers wouldn't have much competition if they could structure an integrated delivery network that made sense.

What's going on with reimbursement? Well, those are mostly negative trends. Spending will be reduced by $115 billion. Payments to hospitals are going to go down and outpatient hospital is projected to go down as it goes into a prospective payment.

One newspaper article said, "Rural hospitals were the big winners because they're going to get a 1% increase." But there are some positive numbers. Sole community and disproportionate share will also get an increase, but teaching hospitals will get a decrease.

Also, with the blending you would have to do that testing. Although the environment is negative, there are some potential opportunities. If we run through some of these considerations of what providers should get into and what they ought to know if they're thinking of assuming risk, these include understanding subcapitation and direct-contracting arrangements, since most of the providers cannot deliver the full range of services. However, to get a HCFA application approved, you have to be able to show that you can deliver all the types of care which are required to be in the filing.

You also have to consider your market reputation and the level of capital investment. Are you going to buy or build or are you going to partner as an integrated delivery system or with an HMO? Basically, if you just go at a fee-for-service level with less reimbursement, you can't make money, so you have to manage the care levels down appropriately to less hospitalization and less physician intensive care.

You also have to begin to understand how some of these dynamics might impact you. Provider systems might be able to do some fairly intensive evaluation of what risk adjustment would mean to payment rates. A cancer or heart center might be able to figure out your risk-adjusted score of the people who you would care for.

Providers need to understand risk assessment and what its impact on the payment rate will be. Providers need to understand medical management because there's an indication that the real high outliers will be underpaid. It might even be better to take DRGs, but you at least want to go through the modeling. Also, understanding health employer (effectiveness) data information set, customer satisfaction, and encounter data reporting are important.

I was trying to go through a lot of newspaper articles and I have cited some of them. This was a projection, I believe, by the Urban Institute or a combination of the American Hospital Association's annual survey and the Urban Institute. It's a total hospital revenue margin, not just Medicare hospital stays. In 1993-94 when this began, hospital margins were kind of average for the last 10 years. There were a couple of blips down, but they were around 5%. They've crept up in 1996-97 right before the BBA took effect.

One projection was that the impact of the BBA was that the margins would only return to the level that they had been in the 1985-94 period.

Looking at the trends in 1992-97 and projecting them forward with the impact of BBA, the margin would be down to 1.9%. Hence, this is why there is all this screaming by the providers. One of the interesting things is that providers may have a lag time to examine how this trend develops and figure out what their strategy will be.

If you come in later and learn to live at that level, the pressures going forward are not as negative. I stressed hospital margins because they were available and hospitals will usually be the drivers in the PSO organizations.

On the physician side in BBA, there's been a lot modeling about what these impacts are going to be and how they're reconfiguring a lot of payment schemes. The analysis that I had looked at said that actually PCPs were receiving some increases. Certain specialty physicians were receiving increases, radiology, oncology, and neurology, and there were a number of specialty physicians, mostly the surgeons who were receiving decreases. Again, your reaction depends on what your market basket of services are going to be. It's going to be very different in some of those rural environments than it is in what it's going to be for providers in urban cities that are competing for market share. There may be some opportunities to do some modeling and to figure out when's the appropriate time.

From the Floor: Did they change resource-based relative value schedule? Did they previously have three factors and compress it to two?

Mr. Staehlin: They now have one factor and I believe this was taken from the study about what the impact of these factors might be on a physician compensation.

There was a note that they need a new practice expense adjustment and there's a committee to figure out what that should be. That will also have an impact. There

was a footnote that if you're involved in labs, it's going to get even worse, so that's probably something that's going to change the trend of how those services are delivered.

When I started talking about options for provider organizations, I talked about buy, build, and partner. I'm going to talk a little bit about PSOs, especially if one of the potential areas to do that is in the rural market, because most of the plans probably don't want to go out to the rural marketplace. Even just getting an integrated network is difficult as you're dealing with individual hospitals in individual counties that maybe don't have any onus to sign a contract to deliver that care. Therefore, the opportunity might fall to PSOs.

There are reduced barriers to become a PSO. PSOs can get a federal waiver, and have reduced solvency standards. There are now minimum enrollment requirements, but they're not the same if you hold an HMO license. Because of the payment floor, the 2% increase, and the blending, some of those rural areas might have payment rates that go up for the next couple of years as opposed to the other areas. I think there have been some studies that say there are a number of urban hospitals that are going to suffer some serious payment decreases.

There had been a trend for employers doing direct-risk contracting. As a provider, you would compete with an HMO and maybe compete with direct contracting. However, there are a lot of problems around risk contracting from an employer perspective: figuring out what to do with prescription drugs, dependents, snowbirds, the antiselection issues, uniform benefits for active versus the retired, and collective bargaining. You see a lot of employers outsourcing a lot of these human resource and difficult functions. This probably isn't going to happen from the employer perspective. Of course, the jumbos are always sort of doing a little of this themselves.

When you finally figure out whether you should be a PSO, one of the things you probably want to convince yourself of is, do you actually have a competitive advantage over the HMO that would be competing in your area? If there is no competing HMO, then you start out with a competitive advantage. You ought at least go through that and prove to yourself that that's going to be a sustainable competitive advantage.

You also want to find out if there are a couple of HMOs in your area. They will not look kindly on your entry into this marketplace. Will they be more difficult in their negotiations? This might push you toward partnering initially to some level and then figuring out a way to joint venture or have a strategic partnership.

Can you afford to actually provide care at less cost than your competing HMOs if there are any in your area? Can you really push utilization down? If you just go in and take this payment and do the same thing, you're not going to be successful. You need to have some perspective and some plans for how you're going to manage this utilization. Hopefully, this is done in a cooperative fashion with the providers in your area. If you do need capital, how are you going to raise this

money? Are you going to go to the hospital boards, are you going to work through the doctors, or are you going to go through a joint venture partner?

Just a couple of last thoughts. You need a provider network to cover the people who you're going to sign up. In Medicare you sign up for a county, so if you are a really rural county are you going to be able to deliver care to all the people who might actually sign up with you? There are mapping algorithms of where these people live. Can you offer better care than the other plans and will your patients who you currently have follow you or is there a reason when you start doing this they'll get nervous about what you're trying to do and move?

If we return to summarizing the opportunities for entering a managed-care market, you can obtain an HMO license if that's what you decide. You can be a PSO or structure a strategic partnership.

This was a relatively recent article. Although there are plans withdrawing, there are 45 Medicare+Choice applications pending. There are also 29 applications for service area expansion and 4 PSO applications. Obviously, enough people did not think this was necessary at the time. However, they could have a wait-and-see attitude on the sideline.

From the Floor: Are you aware of any providers considering dropping out of the fee-for-service environment?

Mr. Staehlin: A lot of people are angry, but there are a lot of people who have 50% of their business in Medicare. It's really hard for them to make that decision to withdraw, so I don't see it right now; they're just struggling with it.

There is one case study that I want to discuss. Mt. Carmel Health System is not actually one of those four PSO applications. They are in Columbus, Ohio. They have three hospitals and ambulatory service centers, which have been a demonstration participant since 1996, and will undergo risk adjustment starting in 2000. At least they are one success story. There is at least one and I don't know if other people simply haven't gone through the numbers or they've just decided it's not the current time. However, we can talk about that at the end.

Ms. Margaret Wood Wear: I'm going to talk briefly about prescription drug issues as this has become a hot topic in light of potential Medicare reform. When we currently look at the prescription coverage for seniors, we find that approximately 65 % have some level of pharmaceutical coverage. When we look at approximately 34 million seniors, that means 12 million people have no coverage for drug benefits and are basically paying cash. An additional 1 million are basically only getting discounts.

I wanted to make one comment. My numbers are slightly different from some of the numbers that have been discussed and that's because some of the employer-sponsored enrollment is in a Medicare Risk plan. It depends on how you count them sometimes as to which bucket they're falling into.

Last summer there was a proposal out for modernizing Medicare benefits from the President that included some very specific drug recommendations. The proposal was for a voluntary benefit that included discounts with no deductible. The benefit level for the member would be 50% of the drug cost, and it had a phased-in benefit cap so that Medicare never paid more than $2,500 in drug benefits.

The premium would be charged to the beneficiary. In addition, there would be incentives to employers so that they would continue to provide the kinds of pharmaceutical coverage that they're already providing. It was a broad-based recommendation with a lot of things left open. It said formularies were allowed along with generic incentives. One of the big things about the proposal was that it would be administered by the private sector through geographic regions so that they would get bids from different types of companies including pharmacy benefit managers (PBMs). Potentially, pharmaceutical companies and drugstore chains could bid, so a lot of different things at this point are open. They had estimated that the premium in the first year would be $24 a month.

Some of the other proposals and recommendations focus more around the fact there are so many issues. Some people are pushing to provide coverage pretty quickly for low-income seniors and trying to immediately add that in with expanding in some states Medicaid programs or pharmacy assistance kinds of programs. Some people think that the President's proposal should be much stronger and should require formularies and other kinds of utilization management techniques. Some have suggested requiring minimum drug coverage on all Medicare supplement policies so that people will have the drug coverage when they make the purchases.

One reason that this is going to be a long time in coming is that there are so many issues that need to be worked out. These are only a few of them. One issue is voluntary versus mandatory coverage. When you make a drug benefit voluntary, there's a significant adverse selection potential. This is a benefit which people will really have an idea of how much they're going to spend so that they can decide if the premium is worth it. However, all the potential subsidies in the President's proposal would eliminate some of it, but it's a significant issue that needs to be considered when deciding what the benefit's going to be.

Another issue is integration with current coverage. We certainly don’t want the coverage that is currently being provided through Medicare Risk and employer-sponsored plans to go away. If we shifted the entire burden of all the drug costs of all the seniors back to the government, that would be a problem and they need to be very careful about how they continue to incent employers to provide this coverage.

Another question is, do they provide first dollar coverage or should they have a deductible? The President's current proposal is for first-dollar coverage. Some people think that having a deductible will help control utilization on the front end, so that's just another point of contention.

What drugs should really be covered, medical necessity versus lifestyle kinds of drugs? I'm not sure if everyone knows what we mean when we talk about lifestyle kinds of drugs, which could include cosmetic types of drugs, even things like Viagra or certain products that might be for toenail fungus. Some people, instead of taking good care of their feet, use this product, and it's a very expensive therapy.

Generics versus brands. Can the beneficiary be mandated to use generics or required to pay the difference in the event that they select the brand when a generic is available? Another major issue is that part of the President's proposal is that this benefit is administered through the private sector. How does that really work? PBMs and HMOs manage the prescription drug coverage and all the issues around that and the types of things that those plans do to actually control utilization.

There are some other considerations in that the plan design, we believe, should probably leave some flexibility for geographic regions. When looking at how you might set copayment levels, coinsurance levels, deductibles, who's covered, what gets covered, and how the formularies are set, those things work regionally at some level. Copayments in the Northeast look very different from copayments in California.

When we look at low-income beneficiaries, one of the issues here is how would the premium subsidies work? What kinds of coverage are they going to get? What kinds of benefit maximums are they going to get? If the plan would normally stop paying for benefits once they reached a certain level, where would the additional money come from to pick up those drugs? Additionally, one of the issues with low-income beneficiaries is that some of these people currently are receiving benefits through Medicaid. How would that be coordinated? Again, deductibles, copayments, and coinsurance are sometimes used as cost-control measures, as are separate levels of copayments for generics versus brands.

Different Medicare Risk plans that currently cover drug benefits do different things when they're looking at their benefit maximums. This is something that needs to be spelled out specifically. For drug utilization management techniques, what's appropriate to be included, and will it be flexible and open so that different areas might actually use different techniques or should it be spelled out?

With pharmacy networks, a more restricted network might give a deeper discount, but is that appropriate for this population? Should it be a broader-based network or a more restricted network? One of the issues with current employer coverage is if the employer coverage is much less than what might be provided under the new Medicare Plan. How then do you coordinate those kinds of coverages? What's considered to be an actual coverage?

One of the last things I wanted to touch on is this issue of cost and determining the cost. With cash customers no one really knows exactly what they're paying right now, so it's difficult to estimate what the real cost of this plan is going to be. There

are a lot of concerns about the long-term affordability of including drug benefits under the Medicare plan. I think that there will be a lot of discussion and a lot of debate.

From the Floor: You don't think it's very likely that this legislation will go through in the next few years on the Medicare drug coverage?

Ms. Wear: As a sweeping overall change, no, I don't. Potentially, some changes could be made for people who actually don't have drug-benefit coverage. There's more focus on those people at this point than even the overall, and that makes it kind of sticky, too, because what you want to do for them, you're still going to have to integrate it in later.

From the Floor: On MSAs, my impression is that there have been none that are being proposed by insurers for Medicare. I can certainly understand why not, but has anybody heard of any?

Mr. Finch: On the MSA, I also don't know of one, but I'm curious if anyone in the audience knows of one or is working on one.

From the Floor: You talked about the pressure on hospital margins. Any thoughts on strategies about what hospitals are going to do?

Mr. Staehlin: You know, I think that hospitals are going to have to go through modeling and I think they're doing that. They're going to have to decide which areas to concentrate in. You might be able to figure out that you can deliver the care for a better price. I'm not saying make it up on margin, but actually have a presence, at least in a rural hospital. I have no idea where the downtown hospitals are going to go with the pressures that they face, but that's a more difficult issue.

From the Floor: This is a question for the panel as well as the participants. In Florida, we sell Medigap, Medicare Risk HMO, and Medicare+Choice HMO. There are quite a few plans around the country that are going out of business. Four hundred thousand members dropped last year somewhere. That same number this year dropped out of the Medicare+Choice HMOs. I have heard great concern voiced by some insurance companies that their Medicare supplement business is going rapidly down the tubes because of the guaranteed issue requirements that are built-in. They have to take these people back into their Medicare supplemental product.

My own thinking is this is a question that is likely to turn out to be a nonevent. Our market research says that the people who have purchased the Medicare Risk HMOs, typically, are the less affluent people, the older people, the ones who purchased an HMO because they've had zero or a nominal premium for quite rich benefits compared with their Medicare supplement. If their plan goes away and there's no other HMO available, how are they going to come up with the Medicare supplement premium, especially if as in Florida all the products are issue-age-rated and they have to buy back in at an age-85 rate? I'd appreciate any comments as

well as the audience's comments on what they see really happening with the Medicare supplement market as a result of the Medicare+Choice.

Mr. Staehlin: Margaret, If there's going to be antiselection by the people who are being pushed back into Medigap from Medicare+Choice, I think a lot of people who have taken Medicare+Choice took it for the drug benefit. And one question would be, are they actually receiving a benefit from that drug benefit and are they going to be able to buy really expensive drugs now? Are they going to need alternative therapies which may, in fact, make them sicker, even though your assertion is they may not be sicker? They might not be sicker if they had taken the drugs that they were able to get before. They may be able to scrape enough money together to buy that first premium, so they're at least on your plan.

From the Floor: But my question is whether they could buy not only the first premium, but the second and third. They had been getting zero-dollar premiums. Now, they're going to have to pay $150 a month.

Mr. Staehlin: I don't have any answers for that size of where they're going to come up with the money.

Mr. Finch: That's part of that whole thing, though, where I think there will be some pressure on Congress to do something. Again, I don't have an answer either. I'm assuming they probably were not able to buy Medigap coverage before and that this will be an issue.

As an aside, there is one other thing, too, that I think potentially helps some of these people. It's different from what we've been talking about here. Qualified Medicare beneficiaries are covered, I think, up to 200% of the federal poverty level. These are dual eligibles; in other words, dually eligible for Medicare and Medicaid. My understanding is there is a number of people who are eligible for that and whether through ignorance or personal philosophical reasons don't sign up. That's one alternative potentially.

Mr. Staehlin: I do not know the offhand percentage, but I've been told that we have a significant percentage of our Medicare+Choice members who are dual-eligible, Medicaid and Medicare, and that gives them an option out into the Medicaid.

From the Floor: Today's *New York Times* had an article about the President's proposal to create a national PPO and Medicare program. That a lot of providers are discounting their Medicare rates to be on a list is intriguing, but are you aware of how that would interact if we did that?

Mr. Finch: I would be very surprised if they could pull it off, so I'm suggesting that I don't really think that's going to happen. Just as soon as you start excluding certain hospitals or certain physicians, someone influential in Congress is likely to get involved—the same way you see all the stuff going on with the teaching hospitals in New York and exceptions like that.

From the Floor: You mentioned that for the Medicare+Choice organization in the future we're going to have reduction in the premium because of the risk adjuster, and potentially we have problems with the provider because they're looking for a larger percent of the global percentage of premiums. They're looking for a fee-for-service arrangement here. Even under the current environment we see a lot of the plans jumping out. Looking at the future for five years or so, how would you be in this if you have a managed-care organization? How are you able to prevent yourself from getting into a deficit position? How are you going to carry on? Why would I continue to be in the Medicare Risk business?

Mr. Finch: One possibility is potentially more sustainable premiums and benefits. Let me back up a little bit and explain what I mean. In the rush to get into this, a lot of health plans went in a lot more aggressively than they should have with the premiums and the benefits. And even without BBA, those people are in trouble. I think that's consistent with what you just said.

I think one potential way to manage this is to establish realistic premiums and benefits that the health plan can sustain it. For example, that may mean that you offer a $45 premium plan with no drug benefits. This is obviously a lot harder to market than a zero-dollar plan with a $500 or $1,000 drug benefit. On the other hand, the $50 premium is still relatively attractive to what some have to pay for a Medigap policy. You have to balance the enrollment and the financial, but the program needs to be financially sustainable.

From the Floor: How about from a provider point of view? It sounds to me that it is by a partnership between the plans and the provider in order to make these things work. It can be similar to a mental care point of view, we have reduced the fee schedule while from a provider point of view, they were saying that I want a higher fee schedule to cover our losses here. Rather than a percentage of premium, maybe a risk-sharing kind of contract would work better.

Mr. Staehlin: I'm going to answer that by way of the Mt. Carmel example. Somebody else mentioned that Mt. Carmel example. I'll tell you more if you're interested. There was an article on page 39 of the June 1999 issue of *Health Care Financial Management* called “Creating a competitive PSO: A Case Study” by Joseph T. Calvaruso. Some things they did included analyzing the market. They found that people in central Ohio, for whatever reason, liked providers more than they liked health plans.

They did some market research. When you look at developing both a business and marketing plan, these are key tasks that you have to figure out, whether you're a provider, PSO, or an HMO. They figured out that they needed 13,000 lives to break even by year 3. The staff that they hired was 24 people. Their plan was to have 2,000 lives by the first year.

They ended up with 6,000 lives in the first year and 12,000 lives in the second year. By the second year, they had met their target. They had 24 people doing

administrative things and 6 marketing people. I don't know if those ratios are the same with health-plan people, but that's how they were successful.

They obtained infrastructure. They spent a lot of money on systems. They did the marketing. As a result there was a lot of advertising saying we are your doctors and hospitals that care for you, not an HMO. Whatever their strategy was, for them it worked in central Ohio from a focused-marketing approach, which was geared to a feasibility study that looked at the market. There were some clear guidelines about needing about 13,000 lives. When they got up to 12 and 13, they were happy. They didn't shoot for 30 and 40, which sometimes happens when you succeed in your marketing plan.

There are two other things I want to mention, although I apologize I couldn't find the premium. This was called a rich plan, a MediGold Plan, but there was a lot of out-of-pocket costs. There was a $15 copayment for your personal doctor, a $25 copayment for specialists, no copayment for inpatient hospital, a $5 generic copayment, a $20 name-brand copayment, a $15 copayment for any outpatient hospital service, a $25 copayment for any mental and nervous session, a $50 emergency room copayment, and a $25 copayment for an urgent services facility out-of-area or not.

They had a lot of copayments, so there was some initial payment to get into the system. The article mentions that they targeted in their area 2,200 days per 1,000. They achieved 950. It doesn't say how they achieved 950. But they had some very structured managed care targets and physician and hospital buy-in to achieve those targets. That's the only way you're going to get that radical a reduction.

They were asked for another fee reduction. That's the response of why would you be in a PPO with another reduction. Obviously, they had less units, but they achieved 30% more payment per day than they achieved under the contract that their 2 main HMOs asked them to sign. They said they couldn't pay that rate. That was 50% less days although 30% more dollars per day, but I don't know how the whole equation played itself out. The article says 2.5 million at the outset, which was probably for solvency and such, and a potential 5 million over those next two years. It didn't say how much of that may be offset in the rate base. That was beyond the scope of what I read.

From the Floor: My question deals with *Financial Accounting Standard (FAS) 106*. It deals with the Medicare Risk programs, zero-dollar premiums, and the drug benefits. I'm assuming that there was some reduction of *FAS 106* liability. I'm curious what people were doing with *FAS 106* and projections at that point and what people are trying to do now. Does anyone have anything they're willing to share?

From the Floor: I do a lot of *FAS 106* work. A few years ago a few clients had the Medicare+Choice Program for Medicare Risk. We did not reduce their liability

for that. We felt that the zero premium wasn't sustainable. We don't have the problem of bringing it back up now because we never let them go down there. However, I'm sure there are others who will have to address that problem.