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Medicare+Choice Capitated Plans Update

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Summary: The Balanced Budget Act of 1997 dramatically changes the competitive landscape for Medicare products by establishing the Medicare+Choice program. This session recaps the Balanced Budget Act's impact on payment rates for capitated plans and the effects that the changes have made on benefit design and enrollment trends in certain geographical areas. The panel also provides an outlook for what to expect in future years.

Ms. Lynette L. Trygstad: We have three speakers today. Suzanne Daly is vice president of network management for PacifiCare Northwest. She's been there for 10 years. Our second speaker is Dr. Marvin Segal. He has been with Reden & Anders for five years. He's the director of the clinical consulting division at Reden & Anders. I'm a principal at Redden & Anders in Minneapolis and I do a lot of Medicare work. Marv is also in our Minneapolis office.

I'm going to talk about some background information on regulatory update information, and in order to give us the right framework to start from I wanted to go back a little bit over what started Medicare+Choice. The authorizing regulation for Medicare+Choice is the Balanced Budget Act of 1997 (BBA), which instituted Medicare Part C or the Medicare+Choice program.

From a practical viewpoint, it really is a regulatory reform on the old risk contracts that were always in place, but the biggest thing it did was change the payment methodology, and we no longer have what was called adjusted-average-per- capital (AAPCs) payments. We froze the rate-book payment at the 1997 levels and now

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

apply trend rates to those numbers. The trend rates are determined by HCFA, with some adjustments for what I'm going to refer to as the BBA adjustment, which is strictly to get budgetary concerns for Congress to reduce their outlying payment outline.

We also attempted through the BBA to get a narrowing of the range of the payment rates. They varied immensely from some rural county in Wyoming or South Dakota to payment areas like New York City, Miami, and Los Angeles with very high payment rates. Obviously, if the payment rate gets too small nobody would even consider going into it, and the whole point of Medicare+Choice was the emphasis on the choice part, to get more involvement in the managed Medicare market. It's debatable whether this has occurred or not, but that was the intent. They put in a floor rate that would be paid and presumably, out of a payment level could actually result in a contract in those areas.

We also had a strong desire to not have total disruption in the marketplace in terms of the payment rates, so there was also a minimum 2% increase that people were guaranteed to receive. The rest of the people who didn't fall into the 2% increase or the floor rate were to receive a blended payment between the local payment rate and a national average rate. And that was going to be phased in over several years. We'll see that the blending hasn't always occurred as much as it had been assumed.

Another aspect of the payment rate was to pull out the medical education payments that had been buried in the AAPCs, and pay those directly to the institutions that were entitled to them. And last, but certainly not least in terms of the interest level, is the government and different studies had shown that despite the fact that you always had your payment rates adjusted for demographic factors that there wasn't enough of an adjustment. You were having people enroll into your plans who were a better risk selection, so they wanted to implement a new payment methodology using risk-adjustment methodology, which is called the principal in-patient (PIP) method.

We expanded the different types of plan designs that were available. Again, emphasizing the word "choice," typically everything has been an HMO product. That's probably still true today, but we have several other designs that are available that are very much like the HMOs, just a different kind of legal structure behind them: preferred provider organizations, point-of-service plans, and provider services organizations. And one called private fee for service that is designed to not have all the contracting with the providers, and pay at some set fee schedule with only a minimal kind of managed care behind it. Then the medical savings accounts were brought into this market as well.

There were many compliance requirements in enrollment and marketing kinds of things that were instituted in the BBA. Another impact on the actuarial profession significantly is that one-third of the managed-care organizations were to be audited every year. Then, it changed the filing date on the ACR from November 15 to May 1.

Chart 1 "Medicare Risk Enrollment" shows the 'Congressional Budget Office's (CBO) estimates of historical enrollment in Medicare Risk, and what they projected for 2000. You can see that there was significant growth rate during 1996-98. I can tell you as a consultant that we had no lack of people approaching us either from the standpoint of saying, "I want to file an application with HCFA to enter this new market," which is probably more like a second- and third-level tiers in terms of the level of payment rate, or from the provider communities saying, "I'm being asked to sign this contract, what can you tell me about it? Is it reasonable or not?"

I think when actual results are in for 2000, we may find that the CBO's projection for 2000 was a little ambitious, and probably membership will stay flat. It could even be a net decrease by the end of the year, but pretty much a flat rate, I think.

Chart 2, "Medicare Risk Eligibles Enrolled," gives another background look at the proportion of Medicare beneficiaries who enrolled in risk contracts. You can see that same growth rate, and the leveling off so that about 16 percent of Medicare beneficiaries are now in this product line.

In Table 1, "M+C Rate Book Payment Rates," I thought I'd give you some idea of what's happened in terms of the payment rates. The BBA implemented three different ways you can get paid, at a minimum 2% rate, a floor rate, or a blended rate between local and national. In 1999, all the counties fell in the two end points, the floor, or the 2% increase, and none were blended. In 2000, there was some blending. It wasn't very large, and it was reduced by the impact of budget neutrality. Moreover, in 2001 we're back to minimum 2% and floors. It will be some period of time, I think, before we really see this narrowing of the range from high to low payment rates. The floor has helped it, but it hasn't moved as far as had been envisioned.

The first line in Table 1 indicates the growth rate, and this is, on the very surface, the level at which you would expect your payment rate to increase from year to year. However, always you have to look at the fine print, and if you look at the footnote "after BBA adjustments does not reflect prior year restatements," you can see that this does not reflect the prior-year adjustments.

TABLE 1
M+C RATEBOOK PAYMENT RATES

	1999	2000	2001
Growth Rate [1]	3.50%	5.26%	5.54%
# of Countries at:			
Min 2%	1,958	318	2,183
Floor	1,291	944	1,066
Blend	0	1,987	0

[1] After BBA Adjustment: does not reflect prior year adjustments.

Another thing that the BBA said was: "I'm going to calculate the growth rate, but if I miscalculated it in the prior years, I'm going to fix it as I go along." Our rate-book increase was so low for 2001 because of all this restatement and fixing up of prior-year estimates,

The real change is the Balanced Budget Refinement Act of 1999 (BBRA), which went into play in late 1999, and it changed some of the things that were envisioned in the BBA. There's been a lot of outcry that the risk-adjustment methodology is being implemented too fast, too soon. It's not accurate. The methodology only takes inpatient encounters into consideration, and HCFA plans to take all sides of care into consideration, but we're not there yet. In the interim, the managed-care industry feels it's being adversely influenced by that.

As an example, there's a move (and HCFA has indicated a willingness to look at this further and potentially implement it) for certain diagnoses, such as congestive heart failure that the managed-care industry might treat in a way that doesn't end up in an inpatient stay or doesn't end up in an inpatient stay that qualifies for an extra risk-adjustment payment. They wanted to look at secondary diagnosis, or some kind of outpatient kind of classifications of diagnosis in order to get that extra payment that would occur if you practiced medicine like the fee-for-service market.

Because there's such an outcry on this, HCFA has agreed to limit the blending of the risk adjustment method to another year at 10%, which should have gone up to 30% in 2001. Then in 2002, it'll only go to 20%. It's not being phased in as rapidly, and then after that it was left up in the air what's going to happen. They're waiting for a report from Med PAC to see what recommendations they have, but they still hope by 2004 to be on this comprehensive risk-adjustment method.

Another thing it did was reduce the impact of the thing that I referred to as a balanced-budget adjustment. It was a reduction of 0.5% after the first year until 2002, and the BBRA reduced the 0.5% to a 0.3%. It's small, but it's something.

Again, the point of the BBRA is to increase choice for Medicare beneficiaries. It hasn't happened as well as envisioned, and one thing that HCFA threw into the BBRA was to increase your payment rates if you enter what's called an unserved or underserved area, meaning that there are no risk contracts to the Medicare beneficiaries who live in an unserved area. If you're the first organization to enter such an area, you will get an extra payment of one-half percent in the first two years that you're there.

There were many things that went on in terms of changes in fee-for-service payments. Some of which are reductions, some of which are increases, and over time those would influence your payment rate as well since they would be factored into the calculation of the growth rate. Then there were all these fee-for-service changes. I don't want to go into them at this point of time.

Another one that was a nice one (dollar-wise it's not a huge impact), but the BBA had an assessment called a user fee to pay for some of the marketing campaigns that were taking place on a national basis to all Medicare beneficiaries. That cost was being born entirely by the managed-care industry, which doesn't seem equitable. The BBRA fixed this, and said that they will share it pro-rata between the trust funds and managed-care industry. That probably has an impact of a $1-1.50 per month per member, but again, it's kind of the equity issue.

The May 1 deadline for adjusted community rate system (ACR) has turned out to not be very workable in terms of the timeframe from when the rate book is released, but more importantly, it's too early relative to the start of the contract year to know what's going to happen. They've agreed to change this filing date to July 1, and that helps some, but it's still six months lead time, well, seven months if you lead in actually trying to work with the data, and get something filed, but it is still a short timeframe.

They also delayed the competitive bid demonstrations to at least 2002. They were originally planned to be in, I think, Phoenix and Kansas City. Everybody at HCFA loves the idea of a competitive bid. I think it's a good thing to try, but nobody wants it in their own backyard. There's a lot of dispute about when, where, and how this should happen.

They continued the cost contracts and the social HMOs. There's been such an exodus of people from Medicare Risk. Over the last two years there have been about 700,000-750,000 members who were affected by contractors leaving their service area or dropping their contract altogether, and they used to have to wait five years in order to re-enter the market. And now, under the BBRA, that's been reduced to two years.

As far as the ACR, there have been changes in that as well. There used to be a methodology that essentially started with the commercial marketplace, or technically the non-Medicare marketplace, and applied some factors that were called volume complexity factors. There was actually, a lot of variation in the industry in terms of how those factors were calculated, but they weren't intended to necessarily be the ratio of the payment rates between the two lines of business. HCFA decided that it was time to change the ACR spreadsheets, actually, for the year 2000.

There was a lot of change in the way the thing looked and worked. It still started with commercial and applied some factor if the factor was clearly the relationship between the Medicare and the non-Medicare line of business on your actual paid basis. But the really good thing was where you used to be locked in to whatever the ACR developed under the old methodology, you can now use something that's referred to as expected variations, but more commonly could be thought of as a fudge factor. in order to get the ACR worksheet to end up in the numbers that you think are the right projection for your Medicare product line.

For the year 2001, if you look at the spreadsheets, they've actually changed, but mathematically they end up in the same place as last year. The "2001 ACR Proposal Revisions" indicates what you do when you're projecting your Medicare+Choice experience for 2001. You start with your 1999 experience and then apply a two-year trend rate. Again, based on non-Medicare data, you apply those trend rates to the different components of this equation. The total, which is your revenue side, has its own trend rate. Claims has its trend rate; administration has its trend rate. Then you calculate the additional revenue, which is the terminology for profit line, and balance that equation out. Again, you can use

expected variations if you think the result of this formula approach doesn't give you what you think your costs are going to be.

- Mathematically essentially the same
- Projected M+C used a 2-year non-Medicare trend

1999 M+C:	Total =	Claims +	Admin + Add'l Revenue
	x t_1	x t_2	x t_3
2000 M+C:	Total =	Claims +	Admin + Add'l Revenue

Last year we had to file Part B only plans for those grandfathered members along with our Parts A and B Plan which resulted in a multiple of Part B only filings, and HCFA wasn't contemplating that. It's an administrative nightmare to keep track of these handful of people. There were a lot of ACR benefit plans filed that covered maybe one member or something, and we still have that issue that it covers one, two, or five members. But if you have a 10-county service area, and you're filing ACR in each and every county that's distinct, you can easily combine all of those, and offer one Part B only plan that covers all 10 counties.

The ACR was also changed to show more service categories than had been used historically, and this really only shows up in the calculation of your copays. This was done strictly from the standpoint that when an auditor is trying to compare what benefits are described in the plan benefit package, all of those benefits, are they really getting valued in terms of copays in the ACR?

And sometimes that was difficult to assess when you looked at the two documents. With a matching up of all these service categories, it's now pretty easy to see, and they're developing, an edit validation tool, just released last week, that will go through and print out all the edit checks of where they think there might be a mismatch between the two documents. Then it's your job to either get rid of the edit checks or explain why it's not a problem.

Unfortunately, this expanded service category is more than 100 different service category lines, and almost nobody I can think of would actually collect utilization data at that level of detail. That presents its own problems.

Then there were a lot of administrative and practical considerations in the upload process to HCFA that I think were addressed for this year. Since I haven't done an upload, I don't know how well they were addressed, but it looks like it'll be a lot easier than last year.

I wanted to go through some of the potential issues that might come up when you're pulling your ACR together. Probably the biggest one is data collection issues. If you have this 10-county service area, and you're going to file an ACR in every county, and let's say in one of those counties you're going to file two benefit plans. You should be collecting your actual data for all those subsets for your Medicare experience. You would have 11 different data subsets, the 10 different counties, plus the extra benefit plan in one. That's a difficult thing to come up with

at some point in time. You probably have some idea of how costs vary, but it's always from a variety of sources, which makes it a little difficult to go through an audit process with.

The copay calculation. We talked about the fact that people don't collect utilization in 100 different categories. What are you going to do about that? My own personal recommendation is, don't try to get rid of all the edits or you'll go nuts. Or you'll be in an audit situation where the auditors will ask, "How did you decide how much of your emergency room utilization that you allocated into worldwide care?" And you probably made it up, and it probably doesn't matter from a bottom line because you have the same copay assess whether it's in the U.S. or a foreign country, and so mathematically, it makes no difference. But the auditors are going to ask, "How did you make this allocation?" And, personally, I wouldn't do it if it doesn't make any difference; if you don't have any basis for doing it.

Coordination of benefits (COB) is another area that has always been out there. With the audit issue there's a potential for it to become a little bit more of a sticky point. But the instructions have always indicated that you shouldn't put in what you collected on COB, but what you should have collected. Now if you have in place really good COB processes, maybe there's no adjustment. There could be errors out there, but if you've made a best effort to reflect what should be in there, if you think you have really poor processes, and you've never really worried about COB too much, then maybe you need to make some adjustment. That adjustment is a very difficult thing to try to come up with.

Another difficulty is that the data is often collected on a service-category basis, but the ACR makes you worry about whether that service that's being provided is a Medicare-covered service. An example is inpatient. Medicare only covers 90 days plus 60 lifetime reserve days. If you cover all inpatient, then you have to take a portion of that cost and spread it out into the column that's a non-Medicare category, and most of the inpatient data that comes through, which is the end total.

Probably the biggest issue, and not one that we can necessarily shed a lot of light on here, is the administrative expenses. The industry has been getting a lot of bad publicity on administrative expenses as a result of some of the OIG audits that have taken place over the last couple years. If you read far enough into those reports from the OIG, they're not saying that the managed-care organization miscalculated what it should put into its old ACRs because there was a set format and formula for how you had to do that. What it's saying is it doesn't think that should be included in there. It's more of dispute between OIG and HCFA at this point in time. Unfortunately, the 2001 ACR instructions gave little, if any, guidance on what you should or should not put in there. I think it's something that will, unfortunately, be played out in the media in terms of what ultimately gets decided as common practice.

Another problem that probably doesn't matter hugely from a big-picture standpoint, but actuarially I think it's the incorrect treatment, is that the instructions indicate that on reinsurance you should put the reinsurance premium in with administrative

expenses, but your reinsurance recoveries should be netted against your claims costs. To me, it shows like the worst-case scenario. You've got high administrative expenses, which nobody wants, and you've got lower medical benefits that you're providing. I think the two should have been matched up better, and should have shown a net cost of reinsurance and the administrative costs.

Another potential problem area is the line on Worksheet B that's called amounts collected. I think it's line 29, and what you show here is your member premium and cost sharing that you collected in 1999, and it's on a per member per month (PMPM) basis. It's in the audit guide that they will audit this number, and they will compare it back to what was filed two years previously on you ACR. Right now we're collecting 1999 data, so you should look at what's going on that line, and compare it to what was in your 1999 ACR.

Now, from an actuarial perspective, if the number is different on a PMPM basis that doesn't necessarily present a problem from our viewpoint because the issue to us is, if you had a $10 office visit copay every time you went in for an office visit did you get charged $10 or $15. If it's $10 then it was simply PMPM-wise a bigger number because you had twice as many utilization or visits as you expected, then we would say that everything was working the way it should. I'm not sure that HCFA would reach that same conclusion. I think it would look at it on a PMPM basis, and say you collected too much, and we should consider refunds.

Value-added benefits are benefits that you cannot include in your benefit description, plan benefit package, or in the ACR. Sometimes it's difficult to decide whether its cost code is a value-added benefit or not, but typically it would be something where you're paying some really small dollar amount to some sub-capitated vendor to provide maybe discount services.

A really important one is, with the audits coming along, if you weren't in an audit this year, you will be in the future. I think, we need to do a much better job than the industry has done historically in terms of our documentation process, and be ready for those audits from the beginning.

With that in mind, HCFA has indicated that they sent out all the audit announcements that will occur for the year 2000 back in January. There were 81 of them I'm told, and so if you didn't get a notice now you're off the hook for 2000. Potentially, it has the right to come back for six years, but the probability is fairly low. But it also means your probability for getting audited next year just increased quite a bit, and if you don't get it next year, then the third year, I'd say, you better count on an audit. It's not a three-year cycle of every MCO, at any point in time, one-third of them have to be audited.

It's being done by the OIG and a subcontracted CPA firm, and last I heard it had not been awarded yet. Maybe it has now, but the audits take four to six weeks, and are very labor-intensive. For the clients that we've worked with (we've probably worked on eight to 10 of them at this point in time), an awful lot of work is being done in terms of supporting the numbers and preparing exhibits to give to the auditors when they come in. We have typically spent two to four days on site

with the auditors, and at some points, it's frustrating because you're explaining basic premises, like describing how you calculated premiere-pre-month cost and what it means. Sometimes you have to make these descriptions more than once. Or if you did some weighted average calculation, and why you did it, and having to go through the explanation multiple times because it's just not picked on. It's not something that they're used to seeing. Over time, I would expect that this would improve.

There is a guide out there for the 2000 ACR. It was released in March. It's on the Web site at HCFA.gov if you want to look at it. HCFA has indicated their goals for in coming up with the audit.

In terms of the focus areas, from what we've seen most of the emphasis is being placed on Worksheet B or your historical data collection, and how that reconciles to your GAAP or audited financials. Or if it doesn't, why? A lot of the ACRs we've filed for clients show restated data in Worksheet B, and then you have to do the reconciliation between what's in there, going back to the financial statements. If you don't show restated data, then you have to make some adjustment for restated when you make your projection.

Likewise, Worksheet B-1, which is all the ratios and statistics that don't really enter into the projection process, is a focus area for the audits, as well as the projection assumptions, especially trend rate.

The potential remedies are the ones that HCFA indicates at their conference that they are considering, and apparently there is at least one case where they're considering some civil penalties, but I haven't heard anything more on this since then.

HCFA periodically releases these operational procedure or operational policy letters. They are really good sources of information for gray areas, and you are not sure how to handle them. I would encourage you to look these up periodically on the Web site, and make sure you're up-to-date. I just tried to classify them into different types of issues that are covered, and not all of them would be ones that we as actuaries typically have to worry about, but you should review them.

OPERATIONAL POLICY LETTERS

Enrollment Issues	73,87,95,98,99,100,105, 109, 113
Marketing Materials	99, 106, 108
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M+C Instructions	89,

The last one line says M+C Instructions. The number 89 is the instructions for 2000, and I've seen a draft OPO for 2001, which was close to 90 pages long, but I haven't seen a final release on that yet.

I thought I'd take a shot at what I think might happen over the next couple years in this marketplace. I think we'll still have positive growth in membership. I'm not sure that that will necessarily occur for 2001, because there have been several rumors recently. I had my "predictions" prepared six weeks ago, and I'm becoming a little less optimistic that that growth will occur for 2001. But, I think it will grow because this is a market that people can't afford to ignore. It's going to be too big a portion of the U.S. population, and if they get out, they have to stay out for at least two years. If they can figure out a way to weather the storm until their payment rates get better, I think that that's what will happen. However, I don't think it will happen in the rural areas. There's just too much uncertainty in the areas that already have higher payment rates, and so there's not much incentive to go into these lower-payment rate areas.

I would like to think that there's going to be growth in the employer market, but unless HCFA changes some of their policies on this, it's very difficult to get the flexibility that you want and need to react to employers' desires to do it through this product line. I think the employer group will remain a relatively small portion of the total. Plus, you've got employers who are trying to get out of that marketplace to the extent possible.

I think HMO will remain the primary plan type that's offered, but I think there'll be a slow, but steady growth in the PPO market. And there was an announcement just in the last couple of weeks that one company, Sterling Life, has introduced a private fee-for-service plan. I think it's in 17 rural or semi-rural states, and I think it had a $55 premium rate to compete against like a Plan F kind of fee-for-service-plus-med sub kind of scenario.

I think the PPO will grow because ultimately there's not too much further we can go in terms of dropping benefit levels and increasing member cost sharing. I think we'll have to increase premiums, and probably a nice way to transition into that is to

have a new product. That doesn't really mean much on the bottom line, but I think it presents better in the marketplace, and we'll do it through offering a PPO product with a premium attached to it.

I think the payment rates will show relatively moderate growth. Med PAC released a report in March of this year, where they were predicting 5-6% growth rates through 2010. That's still going to be restricted by other considerations and the phasing of local and national brand, and the huge problem in potential restatements of earlier estimates. But I think we're going to start to see better growth rates than just 2%, but it will take a period of time. And because of the minimum 2%, we'll still have a fairly wide range in the high to low counties. When it was fully implemented, the risk adjustment method set us back about one year in payment rates.

Benefits, premiums. I think Medicare will continue to tweak the Medicare-covered benefits along the lines of preventive care kind of stuff, and then the really big one issue out there is will there be a Medicare covered drug benefit. I hope, actually, that does not occur. I think it's something that is being looked at for more of a political standpoint than anything else. Even though it's certainly a huge concern for the elderly, I'm afraid it'll be implemented too fast if we try to get it in this year for political purposes, and there'll be a lot of things that need to be fixed after it's in.

We'll drop benefits and increase premiums to offset the lower payment rate increases. As much as HCFA allows us to, we'll continue to see mid-year changes, which typically means February. I don't know if HCFA will allow people to change after 2001.

Finally, with all the changes going on both in terms of payment rates, phasing GME, and things like that, what's covered, what's not covered, you're going to need to keep up-to-date, and continually change your provider contracting as well as what's being paid in the fee-for-service market. If Medicare payment overall is going down, then your contract should react to that. And offsetting that you've got a lot of fear by a lot of the providers out there now in taking capitation contracts, but I still think capitation will be out there. In fact, I saw something that indicated that despite all the negative publicity in 1999, the group surveyed held its own in terms of number of capitated contracts these organizations were holding.

Ms. Suzanne Daly: Two years later it is a little bit clearer, but still I think a challenge, as Lynette mentioned, in trying to understand that the constant tweaking and changes have real impact to both health plans and providers.

A little bit about my background. PacifiCare is the largest Medicare+Choice contractor in the country. We have over one million Medicare+Choice members enrolled, and the vast majority of those are enrolled in capitated delivery systems. What is that looking like going forward? It's not all bleak.

A trend that is influencing Medicare contracting is the aging population, which creates some uncertainty. I think from an actuarial standpoint the uncertainty is

that historical costs are going to be good predictors of future costs for us. What will physician practices look like as the balance starts to shift between younger, healthier patients to older, sicker patients? And how do physicians manage that?

Increasing technology development is driving up costs at a pace that's hard to predict. For example, self-injectable drugs are becoming a huge issue for our providers in how do they manage new drugs coming onto market. Are they reflected in the premium and the underwriting? And how do you know that that one person in 20,000 who will need a medication every month at $20,000 a month for the rest of their life, is or is not going to end up in your enrolled population?

Third, pharmacy expenditures are increasing as a percentage of the total cost of care. I think physicians have historically done a good job of understanding how to control and manage institutional costs, but how to control and manage pharmacy costs is proving more difficult as drug companies are getting savvy about direct-to-consumer advertising.

Disempowered physicians are feeling a loss in control. Physicians are starting to throw up their hands and saying, "Members don't like this. It's getting very complicated. I'm not sure I really need this in my life right now." And consumerism is part and parcel of that. More and more members are taking their health care into their own hands, and saying managed care is purely an economic in the minds. They are coming to their physicians' offices armed for battle with demands for that referral to the specialist or that drug that they want to get, and that again is proving to be challenging for physicians to react to.

In the environment, we have a low APR, Medicare APR, in many of our markets as PacifiCare. We're in Los Angeles, Phoenix, Oregon, and Washington state. That's a very challenging environment, especially with a BBA to operate in.

We're seeing more and more hospital consolidation, which intuitively you would think would be a good thing, because it would create efficiency by squeezing excess capacity. But what we're actually seeing is hospitals are buying their competitor, and behaving more like monopolies in terms of their pricing strategies. It's becoming more and more difficult to negotiate discounts. We're looking at more and more diagnosis related group (DRG) or DRG-equivalent per-diems on the hospital side. As you know, the play in the Medicare pricing has always been to gain efficiencies by doing a good job of medically managing on the institutional side and to be able to transfer that to the ambulatory side, where you can provide more benefits, including preventative health care.

Hospitaling systems. More and more are selling practices to hospitals for the security that it entails, but were finding that with hospitals having an objective of remaining full, and physicians in a managed-care model having an objective of managing those resources as tightly as the possibly can, hospitaling systems prove to be a little bit difficult to manage.

Provider and stability has been all over the press nationally. There have been approximately 700,000 members impacted last year from provider bankruptcies, and provider termination of their Medicare contracts. Not just the big announcements like FPA, and Med Partners, but small individual practice associations (IPAs) in rural areas that thought they could handle global cap, and it turned out that they couldn't have impacted our market substantially. Again, we're also seeing that in many markets the dominant payers are fee-for-service models, the Blue Crosses of the world. It's difficult for providers to gear up the infrastructure and the medical management expertise to run successfully in a Medicare-capitated program when so much of their business comes through another mechanism. That's a challenge in capitated Medicare.

Managed care challenges, in general, have excessive administrative requirements. Our program tends to favor a delegated approach, but simply because we would delegate claims to a provider, doesn't mean we get to close down our claims shops. There is a fair amount of duplication in the system and administrative complexity is very real, particularly as BBA requirements increase, and then state and local market reform is becoming a politically ripe climate for state legislators.

For those of you who took economics in college, you'll know that health care looks nothing like an Adam Smith-type market. It's a very inefficient market. Health care is unique in that supply creates demand. There are numerous studies out there that show geographic practice and utilization patterns vary based on the number of specialists in a given area. That's unique to health care and, again, presents quite a challenge.

The consumer is not the purchaser. The consumer may demand increased service, while the purchaser may demand low cost. That sort of economic disconnect□the person who is utilizing the services is not the person who always pays for the services□creates some strange incentives that materialize in the physician's office.

There is imperfect information out there. As a consumer it's difficult to assess the quality of provider A versus provide B. I think drug companies have done an excellent job of getting their message to consumers. Consumers have proven that they will respond to information, and they take their coupons to their doctor's office. I think they do that because it's some of the only information on health care that they get. We need to do a better job of informing consumers about quality of care.

There is increased regulatory scrutiny, and this may be a made-up word, but it's one that we use a lot, and it's "disintermediation." Disintermediation is a real challenge for managed-care companies. There are all sorts of high-tech start-ups out there that that want to get between the health plan and own that data. As a health plan that's a very significant threat in that the data is what we use to managed care. We manage at a population level, and without that data or access to that data, it becomes very difficult to predict costs or manage performance of the network. That's a very real threat normally.

Consumerism. I mentioned before that there is a huge managed-care backlash out there. Ten years ago when I started working at PacifiCare, people would ask where I worked, and I would tell them. And they would ask, "Who? What? What is that?" And now I tell them, and they ask, "Oh, is that an HMO?" kind of a thing. Everyone now knows what managed care is, and I don't think it has positive connotations for most people outside the industry.

Again, provider, stability, and insolvency have been real challenges. What we have found in PacifiCare nationally is that of our provider dissolution or bankruptcies 19 of those were IPA models. What we are discovering is that for Medicare managed care you need to look at the organization of your delivery system. Medicare managed care requires a health-care delivery model, not a Wal-Mart model which can negotiate the lowest discounts. You really need integrated providers that work together well. That's been a significant learning, although not an easy one.

Challenges on the provider side are that primary-care practices are not self-sustaining. There was a Towers Perrin paper that essentially indicated that primary-care physicians require a subsidy every year from $20,000-100,000 if they're practicing independently. We see more and more primary-care physicians succeeding who are affiliated with multispecialty practices or who sell their practices to hospitals.

We're seeing more and more specialists demand income protection. They're tired of being treated like commodities, where the health plan says, "We'll pay every orthopedic surgeon $43 per relative value unit (RVU)." And many throw up their hands, and say, "Fine, you take the orthopedic surgeons you can get at $43 per RVU, and if you think we're all equal that's great, you can contract that way." A lot of specialists are really trying to flex power in the market.

There is some oversupply in certain areas for specialty care, however, that's not universally true. The Portland market actually has an undersupply of certain specialties, and that's proving to be a challenge. Hospitals, as I mentioned, continue to consolidate and price monopolistically. There continues to be excess capacity. In Seattle, we have an occupancy rate of 52% in downtown Seattle for our institutions.

Then, Ambulatory Payment Classification (APCs) are coming July of this year, the ambulatory Medicare fee schedules, and I think hospitals are somewhat nervous about seeing their outpatient pricing subject to a Medicare fee schedule. I think that we can expect that many will have a difficult time in the initial periods of APCs, just as they did with DRGs. But a year or two down the road we'll start to see coding issues occurring, and more and more scrutiny and audit of what's going on with APC pricing.

Ancillary services, such as skilled nursing facility and ambulance, are also subject now to Medicare fee schedules for the first time. Within eight months of the Medicare prospective payment fee schedule for skilled nursing facility, the largest facility chain in our area filed for Chapter 11 bankruptcy. I think we will start to see some impact to Medicare fee schedules on ancillary providers.

Pharmacy costs, again, are trending in excess of 20% over the past three years, which is again, challenging to control health care. We can't pass costs on or raise premium quickly enough to deal with that trend.

The provider response to all this, as you can guess, has been risk avoidance, and we see more and more physicians questioning why they're doing this. There's a sense that the up side does not come anywhere close to the potential down side, and in our market in Washington on the managed care side for Medicare we're running under 1,000 bed days per 1,000, at a fairly low APR. What we've uncovered through a lot of work with some modeling is that if a provider manages very efficiently, and only takes 7% to run their administrative services and manages to about 925 bed days, they can achieve a whopping surplus of about $0.58 PMPM. I think that's real.

It's one thing to do a lot of work if you know that you can do *x*% better than Medicare. It's another thing to do a lot of work just to know that you're not going to go bankrupt. We see a lot of providers throwing up their hands.

There's a 1,500 bed-day problem and a lot of providers. For example, in northern California have not been able to penetrate that level of utilization below 1,500 bed-days per thousand for Medicare. We've really been trying to understand which DRGs have the most play in them. Do we focus on cardiac surgery DRGs if we really want to penetrate bed-day utilization? But it's gotten down to where you can't just focus on length of stay and bed days in using DRGs. We really need to kind of get down to DRG-by-DRG. What is the opportunity? And that, I think, is going to be critical to further movement in bed-day reduction.

There is a "my patients-are-sicker" argument, which, again, requires really good data to assess, and we don't have very advanced risk adjustment tools right now that we use for our data. When a provider does come back to you and says, "But my utilization is this way because I really have enrolled a sicker population," we have a difficult time kind of really getting down and understanding the meat of it. There have been some interesting studies which suggest you can use pharmacy and encounter data. That is typically very good to assess the health status of the population and risk adjust, but we're just now beginning to experiment with that. I shouldn't have to say "not actionable," but there's very little actionable information to manage risk. It's hard to sit down with a provider group, and say, "Here's what you need to do to manage this risk." We've kind of hit a wall in terms of the low-hanging fruit and are getting at the high, hard stuff now. A lot of physicians wonder why they should bother.

BBA, as you've just heard, was passed in '97. The intent was to extend the viability of the Medicare Trust Fund, to expand competition for Medicare plans, and to undo historical inequities and payment rates. I think one of those three objectives has been achieved, clearly, which is the extended viability of the Medicare Trust Fund. Expanded competition has not really materialized, although HCFA is optimistic that competition will begin over time. The historic inequities and payment rates have continued to be borne out as New York still gets a 2% increase on their $1,000

capitation rate, while Seattle gets a 2% increase on their $450 payment rate. Two percent of 1,000 is a lot better, if you do the math.

Challenges for post-BBA are a lot of providers are uncertain about the impact of risk adjusters. The methodology is in question as we collect the data from 1999 or 1998, and that's what will impact 2000. It's difficult to know if you had a bad year in '98, is that good or bad for 2000? It's hard to predict what the impact of risk adjusters will be.

The good side of the impact of risk adjusters is it has improved our data collection efforts substantially. The 2% rate increase in the blend counties have been challenging for plans to manage. In 2000 when we actually did get to take advantage of the blend, we saw rate increases of an average of 6-8%. Certainly our health care costs are not trending at 2%. The challenge is if health care is trending at 6-8% and we're only getting 2% from HCFA, where does that other 4% come from? And if you're already in a well-managed market approaching aggressive utilization benchmarks, the challenge becomes, how much can you pass through to the member, and still maintain a fair balanced value equation for them? And again, there's the increased complexity of regulatory compliance.

The response from health plans to BBA has been, without the requirement that you be contiguous, to exit low growth or unprofitable counties, and to let those networks that are not doing well in Medicare to fail. It's a survival-of-the-fittest Darwinism effect there. Plans are also seeking to differentiate not through price and benefits which plan can offer a zero premium program with full pharmacy coverage, but more through which plan has a differentiated network that would be appealing to providers and what kind of service initiatives it has. For example, express referrals are on the minds of seniors. What type of open access model could you provide, and not compromise costs?

You'll see more value-added benefits, as Lynette suggested, which are basically access to discounts. A lot of dental companies or hearing aide companies like access to that distribution channel of seniors. Then managed care is going to need to develop proof points that managed care is better care, not that managed care is less expensive care exclusively, but that it is, in fact, better care.

The increased cost shifting to members is real through increased premium, and we're also seeking increased copayments and per-admit coinsurances looking more and more like Plan F.

We're rethinking benefits, reducing benefits, and putting lower limits. We may have, for example, on the behavioral health side, something that approximates Medicare's behavioral health institutional service, and service initiatives.

To keep this square in balance□we call this the square deal□where the member, physician, hospital, and health plan all are participating in the challenges of health care today. For a number of years at PacifiCare the members were not as participatory in the cost as they needed to be, and that part of the square is coming

into balance. We're seeing that the hospital side is still a little out of whack, and how we figured that out, we don't know.

In terms of preparing for the future, as Lynette indicated, there's another 10% impact to the risk adjuster for 2001, which is good news. Right now, it's targeted to be 2004, but there's also a thought that there will be a new methodology by then. Medicare will look more like a commercial program in 2002, with an open enrollment period and members locked in and not allowed to switch plans every 30 days as they can now. That's going to have a huge impact on how plans market themselves to members and how providers treat members. The challenge will be that we need to now sell the value of being a member, much more than just focusing on growth and getting that next new member in the door on the sales side.

BBA also allowed us to develop provider-specific benefit designs. For example, if we have an integrated system in downtown Seattle, we can take the University of Washington, for example, which is very interested in a Medicare+Choice contract, but because of the kind of population it attracts, the hospital wants to have a hospital-per-admit coinsurance, we can now structure a benefit design around that delivery system that no other delivery system in Seattle would have. It could be unique to that particular delivery system. The challenge, of course, is to find the different cost shifting to the member, and the true cost for that provider is different. There's an unique ACR that would have to be designed. But I know plans are beginning to experiment with that.

In terms of predicting the future, again, I think managing care is going to have to become synonymous with managing quality or consumerism will cause the managed-care industry to open wide up and become nothing but PPOs again. We're moving towards identifying high-volume hospitals as centers of excellence for certain procedures like bypass and angioplasty, where volume is highly correlated with a positive outcome.

We're really looking at systematically reducing variation in outcomes for our most frequent procedures so that we can identify not all providers are created equal and not all outcomes are the same at each facility. Why do we let our members go everywhere? We should be able to narrow our panel around those high-quality providers that can deliver.
We want to reduce variation in cost, so if we pay $20,000 for CABG with cap here, and $25,000 there, why does it cost $5,000 more in one place? We want to reduce the administrative complexity, or at a minimum centralize it, so that providers are not having to deal with that. Again, improve outcome as well as managing costs.

I agree with Lynette that there will be fewer Medicare HMOs in the future, although I think many will stay in urban areas, and that's where there will be Medicare+Choice competition. I think you will see more experiments in private-fee-for-service plans. Sterling was mentioned, and it's the first one approved by HCFA. Again, I think we'll have to develop proof points for members that essentially says it is better for you to be a member in a managed-care plan, than a patient in a fee-for-service world. It is because of the advocacy that you get from

our member services department, and because we believe, we can deliver better outcomes. Those are the challenges.

Dr. Marvin S. Segal: When I was a medical student, quite a number of years ago, we were taught that the pediatric population was significantly different than adults. They were not just small adults, but quantitatively and qualitatively they were different. But they didn't tell us that that was also the case with the senior population. I came to learn that later, as many of us did. This is something that is very important for us to be aware of as time goes on, as we manage this population. They are truly unique in characteristics and needs in a clinical sense, and that clinical sense translates into a business or fiscal sense as well.

Health plans do have a good opportunity to do well financially with a Medicare Risk product, however, excellent medical management is absolutely a central element in the success. Doing the right thing at the right time in the right place is part of that medical management, and that will probably translate into success both in a quality and fiscal sense for the health plan. If it's not done, be prepared for a very harrowing ride. It is not easy to manage these folks.

We talked a little bit about Medicare beneficiaries and the size of the Medicare+Choice plan. The number of beneficiaries will increase. The baby boomers are aging, and soon enough there will be 80 million people eligible for Medicare. We must be able to take care of that population. We will all be a part of it very soon ourselves. It is growing. It's not growing as quickly as we would have expected, as Lynette mentioned, and a significant part of that is the relatively small payment fund from HCFA. However, we would contend that if it were left up to the seniors themselves, they indeed would be flocking to plans such as this. The opportunity just isn't there because the health plans aren't there.

Most of the people who are going to be joining these plans were part of an HMO and are pretty used to getting care from an HMO and a managed-care organization. The patient- or member-satisfaction information seems to indicate that they are very satisfied with that kind of care as opposed to strictly fee-for-service type of care. Disenrollment rates are very low from an HMO-type managed-care situation in the Medicare population to a fee-for-service situation. In general, the members are comfortable with the plans that they have had.

In managing the seniors, and Suzanne and Lynette both alluded to this, it's very important to have good data to manage the cases. This is an area that I would contend begs for actuarial collaboration. You folks are well aware of data and its importance. Providers are increasingly becoming aware of how important this is and having greater expectations for good data. But good data isn't a large data dump, it is rather appropriate dicing and slicing with key indicators and benchmarks being associated with it. The team that manages the cases, providers, medical management departments, and actuaries can be reading off the same data sheet. The medical management approach will be dictated by the data that is generated.

Probably the most important critical success factor in the success of a managed-care Medicare+Choice risk plan, is physician or provider involvement. I recently worked with a health plan that was having some utilization and financial difficulties. We looked at specific DRGs and medical-surgical medical management per se, and things weren't too bleak, but there was an across-the-board slight overutilization. We talked to them about how the relationship was with the hospital and physician partners. It became very evident that the plan was operating almost independently. There was very little collaboration between the hospital and the plan or between the physician providers and the plan. The reason we suggested that some of those bridges be built was so that this could be a team, a collaborative kind of partnership.

Physician buy-in is easy to talk about, but not so easy to do because the physicians probably haven't been educated. They don't realize how important appropriate medical management is and how that is translated into their own success and the success of the health plan. Perhaps physician champions should be a part of that program and lead the rest of the physicians there.

Regular performance data should be disseminated among the team members so that we are all working together, and we can indeed have a proactive response to the care of the patient.

On primary care, physicians are important, but specialty physicians are, as well. However, in the Medicare population there are some areas that are particularly important, and this is true in the contracting realm. Hospitals, Durable Medical Equipment (DME) and home-health providers, and chronic-care facilities must be a part of the organization and be working towards the same collaborative event.

If at the beginning of a program the panel size is limited, it is probably beneficial for the eventual success of the program. First of all, more patients will be channeled to the existing providers. This is one thing that they are very interested in, having sufficient volume. Second, for the health plan the attention of the physicians for the various procedure and policies of the health plan come to play much more efficiently when there are smaller numbers of physicians or hospitals.

Geographic access is very important. Transportation, as we'll see a little bit later, is important. It's an issue with the older population, and putting off coming to get hospital or ambulatory care can lead to much more costly and then increased burden of illness kind of situations.

More and more hospitalists are becoming a part of the medical management plan, and, of course, these are inpatient physicians in leadership roles who care for the patients as they enter the hospital. Their efficiency is basically unchallenged, even though there is some controversy in the medical arena about hospitalists, but they certainly have lead to decreased length of stays and a decrease in inappropriate admissions to the hospital, both of which are very attractive for us.

Reden & Anders has done a database in specialty care for the managed-care and Medicare population. This seems to indicate that both in frequency and cost these

specialties are very important. We know that cardiology is important as people age. Myocardial infractions and congestive heart failure, particularly, are very significant drains on the system. In general surgery, their domain is the abdomen, and a lot can go wrong with the abdomen as individuals age. In ophthalmology, cataracts are very important, and this is totally, essentially, an outpatient procedure at this point in time. Total hips and knees for orthopedics. Nearly all cancers increase as age occurs, and therefore oncology is terribly important. The same can be said for urology and gastroenterology. These are very important groups to watch for.

There can be a number of risk arrangements, and I will just simply say it can go anything from a discounted fee-for-service, perhaps with a withhold or a variable fee schedule, all the way to a full-risk capitated kind of arrangement. As you all know, probably, once you seen one arrangement, you've seen one arrangement because they vary so very significantly. They're one of a kind. Risk is probably the most powerful support for medical management compliance.

What really is medical management definition? Doing the right thing, at the right time, and the right place, but it is the appropriate, efficient, and effective of utilization of resources. Appropriate is indications. Should the coronary artery bypass graft have been done or could that patient had been managed as well and as safely with medical nonsurgical management? Efficiency deals with value. The quality of care divided, if you will, by the cost of care. And effectiveness meaning the outcomes, both clinical and cost. All of this should be within milieu of quality. Many times we talk about cost and utilization and forget that quality is almost a given and important.

Know disease management programs. These are care over the breadth of time for a given diagnosis. It could be prevention, a screen for a disease, treatment, or secondary preventive treatment, but it should be data-driven. If we have a large population that has significant cardiac disease, for example, with congestive heart failure, it is very worthwhile to do a congestive heart failure disease management program. I have seen in a Medicare+Choice program, an asthma disease management program. Asthma disease management is in vogue, however, the senior population really isn't significantly afflicted with that. That was an instance of not being data-driven, not being responsive to what the values and figures and experiences really are.

You know that clinical care guidelines hope to narrow the gap between actual current experience and care and ideal or best practices. It has been shown time and again that with compliance, protocols, and guidelines, that efficiency of care is improved. The quality goes up and the cost goes down.

Why talk about preventive care in the senior population? They're old. That which is going to happen to them has happened to them. Not true. Immunizations, influenza, and pharmaceuticals for pneumonia are very important in preserving the health and decreasing the cost of senior care. Accident prevention. A year-and-a-half ago I worked with a client who had an unusually high number of fractures and extremity injuries, and as a result of determining that it was from falling, they

instituted a fall prevention program, which has resulted in a decrease in those hip fractures and in that kind of diagnostic formulation.

Secondary prevention□a huge grant was just given to Dr. Dean Ornish□who has proposed that dietary manipulation can indeed reverse the coronary lesions. Just by simply following a very low-fat diet. Utilization management. It's costly, it's important, but it should be data-driven. If 96% of requests for hysterectomy are granted, should we continue to ask for approval for that? The answer is probably no.

Probably the most important thing we can do for the seniors is to assess their risk for future care and get that information to the physicians. Good case management in a catastrophic and chronic area will lead to efficiencies in care.

Home health care is increasingly being used, and can be used, and should be used at the front-end of an illness, as well as at the tail-end. I recently worked with a client who had an unusual number of hospitalizations for community-acquired phenomena. The primary care physicians were afraid to keep the patients out of the hospital during the early acute phase of this phenomena by instituting home health care at that time. By giving support to the member and to the family, many hospitalizations were avoided.

We've talked about demand management in transportation. We've talked about pharmacy being a very important part of this whole picture, but I would like to conclude by saying that we feel that actuaries can and should play a role in the medical management and be an important part of the team. This will be beneficial to the overall efficiency of the system. If we do the right thing for the patient, the cost will take care of itself.

The future. We believe that economics will dictate the future of this kind of care provision. Medical management will play an increasingly important role in managing this population. We predict early identification of high-risk individuals. Guideline and protocol compliance will increase. Disease management programs will become more mature and utilized more effectively, and that provider involvement and philosophical buy-ins will actually play a more important role.

Mr. Robert E. Himmelstein: When selling Medicare plans, if you went out four years ago does that mean that you can come back in or do you have to wait until the end of the original period?

Ms. Trygstad: I don't know. I would hope that that situation is addressed in that OPL.

From the Floor: Could you please elaborate on why employer group still remain a small portion of Medicare+Choice plan?

Ms. Trygstad: Currently, employer groups in most of the organizations that I've worked with have been a pretty small portion of the total from almost non-existent to maybe 3-4%. I guess it'll stay low because people are continually

battling this issue of making sure they comply with HCFA guidelines. The HCFA guidelines are if you want to differ for the employer group, then it has to be better in every way. It has to have lower copays and premiums, where you can add a benefit and you could charge for that extra benefit.

Also, there's an issue when you develop your ACRs. I know of one situation where there's a large employer group, and that's pretty much why they're in that area. That employer group, a union group, has adverse experience, not just for the extra benefits, which is typically an unlimited drug benefit, but its medical experience is a lot higher than what they would find in their individual membership population. And how do you figure out how to charge for that? If you let the ACR work like it normally would that would mean that your individual members are subsidizing your group members and that just doesn't feel right.

If another competitor comes in and doesn't have that group basis skewing it, they should be able to provide a better product, and you couldn't compete. There's some indication that HCFA might allow you to pull out that adverse cost and charge it only to the employer, not to the employer members. But I think there are a lot of issues tied up in what they allow, and I with not being sure of getting the full flexibility wanted for this marketplace, I think it'll just be a slow-growth area.

Mr. Richard J. Irwin: Two questions. Do we know if the Med PAC expectations are to have risk adjusters that weight out to a zero overall for the industry?

Ms. Trygstad: I'd say it's definitely not something that they're planning on. The intent of the risk adjuster method is to pay the quote and right level the payment. All the reports show a wide range of what they think the overpayment has been, but it's been as high as 10-15%, some people have said. If that's the case, then they're assuming that they're going to be able to recoup that dollar so that they should never have been paying in their terminology.

Mr. Irwin: That's sort of what I figured, but in earlier years HCFA had indicated that there would be small effects of the risk adjusters.

Ms. Trygstad: Well, in the report that they put out a year ago, Med PAC's report indicated that there would have been, I think, an overall 7% reduction in payment if you were 100% risk adjustment at that time.

Mr. Irwin: One other thing. When you're increasing membership share of costs, how far can you increase the premium before disenrollment becomes an issue?

Ms. Trygstad: Now we really have to get out the crystal ball, but I would say if you're going to offer a product where you're increasing your cost sharing and increasing your premium in order to have a financially viable product, if it gets to the point where a member is better off to just go purchase a Medicare Supplemental Policy plan, that's what they'll do.

Ms. Daly: You also have to weigh the fact that, in a Medicare Supplemental Policy plan they're not restricted at all. At what point are they willing to give up choice to go into a managed care plan? What is that cost differential?

From the Floor: My question is about Sterling Life. How are they going to make that work? Little discounts and no medical management, the game doesn't work.

Ms. Daly: We're very curious about it as well. In our region HCFA contacted our plan president to ask if we would go meet with Sterling because HCFA is concerned about their ability to medically manage. For those of you that aren't familiar with the construct of Sterling, it's, I think, a $55 premium. There are copays; it's $300 per admission. Any Medicare participating provider is part of the network, and there are services that require pre-authorization, but there is no medical management.

Ms. Trygstad: I think it says notification and I'm not sure what that means.

Ms. Daly: I don't know if they have hospitalists. I think there's a lot of concern. I think everyone wants it to succeed at a policy level, but there's a lot of concern about how it's going to succeed given the markets that they're going into tend to be the rural markets with low payment. And what they're requiring in terms of premium is not substantial enough to offset the lack of medical management.

Ms. Trygstad: Although they're also going into the more rural areas, which typically already in a fee-for-service market is showing lower hospital days per thousand. I don't know if that's due to access or stoicism.

Ms. Gail M. Lawrence: How did Sterling deal with the provider's right to balance bill another 15%?

Ms. Trygstad: Well, they can balance bill at 15%. Let's see, I have to get the terminology right. If you're participating provider, you can't balance bill. If you're just accept assignment, then you can balance bill.

Ms. Daly: There's language in BBA that's required if you're a private fee-for-service contract in all of your provider contracts that basically says for private fee-for-service contracts you forego you're not allowed to balance bill. HCFA comes and audits your contracts before they approve that. Now for these providers that don't have a contract, I don't know quite how that education is going to occur, but it is a preventor.

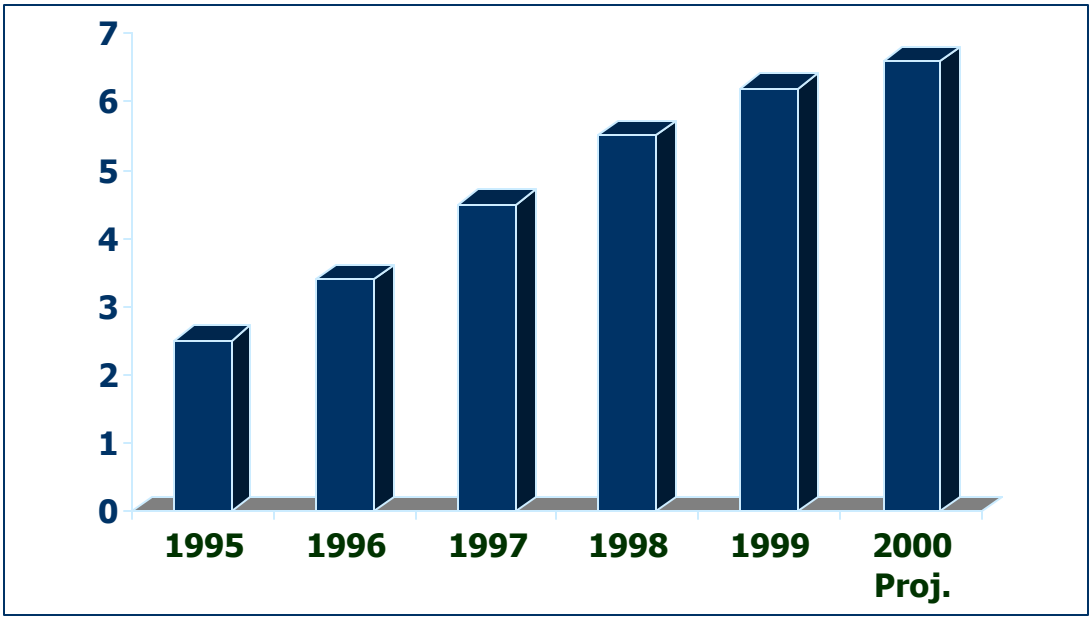
Mr. Richard H. Sweetman: Suzanne, you talked about an aging of the population. Did you mean aging of specifically your Medicare+Choice population or the generally aging of the overall population?

Ms. Daly: Both. What we've seen in rural markets, for example, Walla Walla. Walla Walla is a county that's been below the floor ever since BBA was passed. Walla Walla has enrolled 1,400 members, and they have had roughly those same 1,400 members. I mean there's minimal exist or disenrollment and re-enrollment.

But essentially, it's the same population they've been managing for five years, and they recently came to us and said, "Look, we're ready to get out. Unless you're going to substantially grow it, we know who we got. We know it's just going to get sicker and sicker. There's not a lot to backfill, we think we want out." That's a real issue.

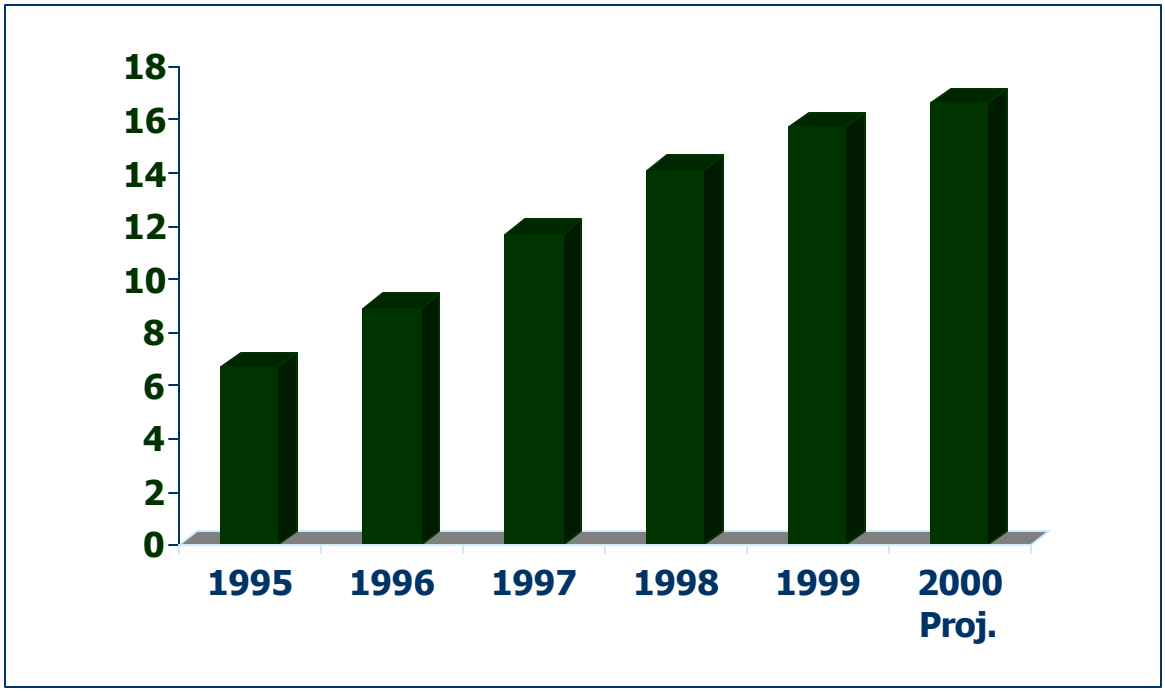
But this issue of the whole population aging, and the change in the mix of provider offices is also real in that we have family practice physicians, who have historically limited their work on Medicare populations, now finding that they're having trouble filling up a practice if they want to continue to do that. I think it's real on both ends.

CHART 1
MEDICARE RISK ENROLLMENT



Source: CBO

CHART 2
MEDICARE RISK-ELIGIBLES ENROLLED



Source: CBO