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Carriers' Choice on Medicare + Choice: Its Future Viability

Track: Health

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Summary: The Medicare + Choice (M+C) program has experienced significant withdrawals in numerous geographic markets over the last year. Panelists discuss the developments that led to the withdrawal of various plans and how the withdrawals have affected the viability of the overall M+C program with response of the Centers for Medicare and Medicaid Services. Attendees are informed of the history of the M+C program and the challenges faced by plans offering the program, as well as the challenges faced by those interested in entering the program.

MR. ROBERT COSWAY: Clare McFarland is deputy director of the Medicare and Medicaid Cost Estimates Group at the Centers for Medicare and Medicaid Services (CMS). She has been an actuary with CMS since 1986. John Fritz is senior vice president, chief actuary at Pacific Care. He's responsible for all their actuarial functions. He'll talk a bit about some historical legislative changes and risk adjusters. John Bertko is vice president and chief actuary with Humana. He oversees their corporate actuarial group including M+C. He also works with government relations concerning proposed legislation and regulation. We'll start with the CMS perspective from Clare.

MS. CLARE MCFARLAND: I'm going to talk about where M+C Plans are today as opposed to where they were when the Balanced Budget Act was passed in 1997. I'll be referring to that as the BBA. I'm also going to talk a little bit about what CMS can or would like to do for the plans.

Enrollment in M+C Plans reached its peak at 6.3 million in 1999. This number has dropped to slightly over 5 million as of April 2002. Access to these plans has changed since that time. In 1998, about 74% of Medicare beneficiaries lived in a county with at least one M+C Plan available. In 2002, about 61% of Medicare beneficiaries had at least one plan available in their county.

In 1998, about 45% of Medicare beneficiaries lived in an area where there were at least four organizations offering M+C Plans. In 2000, about 19% of Medicare beneficiaries lived within an area with these same options.

I point out these changes in access because access to benefits currently plays a big role in determining Medicare policy. If there's an area where beneficiaries don't have access to the services they need, or access is limited, then there's usually a lot of political action to try to increase payment in those areas. They tried to do that in 2001 by raising the floors, but I don't think it worked well since plans were still dropping out.

In 1999, 85% of the Medicare beneficiaries were in plans that charged no premium for the basic benefit. In 2002, only 39% of enrollees are in plans with a zero basic premium.

In 2001, plans that have zero premiums had an average cost sharing amount of $17.29 a month. In 2002, this amount went up to $30.13 a month. The situation was similar for plans that charged premiums. Their average cost sharing went up from $12.98 a month in 2001 to $23.20 in 2002. Their average premium went up from $22.90 in 2001 to $33.87 a month in 2002.

Miami-Dade County has only a $5.15 a month cost sharing and zero premium. That is well below the average of $30.13 for zero premium plans in 2002. In the New York counties, the cost sharing amount is closer to the average at $29.70 a month, but the premium is far below at $2.26 a month for the Medicare-covered benefits.

I want to share some thoughts on drug coverage in M+C Plans. Some people think that drugs are really what killed the program; maybe some would disagree. I guess for the ten years prior to the passage of the BBA in 1997, Medicare benefits were going up at an average rate of 10% a year. The Medicare Risk Plans were getting increases that were related to that level of payment increase, so they were able to include drugs and all those other benefits in their benefit packages, often without charging a premium. Then the level of increases in Medicare came to an abrupt halt in 1998. The drug prices, however, continued to increase, making it pretty difficult for plans to continue to offer the benefits they had before. In 1998, 84% of enrollees were in plans with some kind of drug coverage in the basic plan. In 2002, 72% have some drug coverage in a basic plan. Drugs just became too expensive for plans to offer. In 1999, 19% of enrollees in M+C Plans had drug coverage with no cap in the basic plan. By 2002, only 0.02% had this type of coverage.

Let's compare the growth rates in Medicare fee-for-service with M+C rates since the program was established by the BBA. If you're not familiar with the BBA, you wouldn't believe these could be health spending increases, even for a program that doesn't cover drugs. The BBA actually cut Medicare spending in 1998. It was followed by a minor increase in 1999. Most of you probably know the history here. BBA cuts were much more expansive than was anticipated, and in 2000, legislation was passed to increase payments to most types of Medicare providers. That's why you have some increases in 2000. At this time also, new floors were established for the M+C Plans, and the minimum update was changed from 2% to 3%. That's why there's a big increase in the growth rate in the floor counties in 2001.

You may wonder how any actuary would be projecting a health spending increase of 0.93% in 2003? This is due to Congress. Some of the Medicare providers will be facing a big payment decrease in 2003. Home health agencies were scheduled to get a 7% decrease in payments in 2001, but legislation delayed that until 2003. Skilled nursing facilities were also scheduled for a significant decrease in 2003, but I believe the administration has gotten that delayed for at least another year. I think the biggest driver of the low increase in Medicare spending is the cut in physician payment scheduled for 2003, which is going to be over 5%. This is the second year in a row that physicians will have this kind of a hit unless Congress does something about it.

If you look at these increases on a cumulative basis, you would have done better as a floor M+C plan than a plan that received Medicare fee-for-service increases. If you're a non-floor county, where most enrollees are, you're likely to be slightly worse off. I don't think that in 1998 anybody would have ever expected this was going to be the level of increase they were going to receive.

Here's what we're projecting for the future if no legislation passes: a 2% increase for the M+C Plans, and blends will begin to gradually kick in after 2005. The increases in the Medicare fee-for-service weren't much higher than market baskets or CPI levels since the BBA moved almost all provider types from a cost-based reimbursement to perspective payment systems or fee schedule systems.

There's currently a lot of action on Capitol Hill to give back money to various Medicare providers because this is an election year. President Bush's proposal would give counties that had a minimum update in 2002 a 6.5% increase in 2003. It would give the floor counties an update of USPCC -0.5% in 2003. In 2004 and later, it would give all counties an update of USPCC -0.5%. There's one other thing that's been added, a minimum update of 3% as opposed to 2%. But for 2003 and 2004, it adds a fourth payment category on which to base the highest payment level. That highest payment level would be an average per capita cost based on 100% of fee-for-service cost in that payment area. It also requires using M+C enrollees only to determine the national average part of the blended rates instead of total Medicare beneficiaries. It also eliminates the budget neutrality requirement for calculating the blended rates.

After 2005, the M+C Plans would be folded into this bigger Medicare reform. They want the plans to compete on quality and price as opposed to benefits. There would be a drug payment piece, but they would want that to be used only for drugs so the payment they would pay to the plans, which is the per capita amount that they get now, would be used only for the traditional Medicare fee-for-service benefits. I don't know how many plans think that's a good idea, but that is what that bill has in mind.

What is CMS's response to all the plan withdrawals? CMS supports the President's plan to increase payments to the M+C Plans. The details of this are still in the works. The administrator said when he first came to the job that he wanted 30% of enrollees to be in the M+C program. He definitely realizes he can't do that unless the payment levels are increased. CMS also initiated a PPO demonstration. The payment level is the higher of the M+C payment or 99% of fee-for-service in that area. They also allow risk-sharing arrangements. I think these PPO plans are expected to attract people who aren't currently M+C enrollees. They're people who are in a fee-for-service plan, and I think that's why they're assuming these are going to be budget neutral because they're not expecting to take people out of current plans. They're also working on administrative reforms to reduce burden.

MR. JOHN FRITZ: I'd like to talk about three areas for M+C. First of all, I will discuss some of the advantages and why M+C is an important option, especially for the population that it has served over the years. Second, I'd like to talk a little bit about the capitation payment history from HCFA/CMS. Then finally, I will discuss the changes that are about to be made to these payments and some of the issues involving the health status risk adjustment changes about to occur.

Why do I think this program is important?

Statistics show that M+C enrollment is largely among low income individuals. The average family income for a M+C member is $20,000 or below. Certainly, the industry provides a tremendous service to this population that can't afford Medicare supplements or the out-of-pocket costs of Medicare fee-for-service. So in that regard, M+C has been a very important part of the overall Medicare program. It provides not only affordable care, but also additional benefits beyond FFS Medicare to this population.

We found that M+C enrollees are highly satisfied with their coverage. In a recent study, in 18 of the 24 quality of care measurements, M+C plans were rated as good as or better than fee-for-service Medicare. Also, the satisfaction level in terms of quality of care and access to care has been very high, between 90 and 100%. Also, in terms of the care being delivered through M+C programs, the availability of preventive health care services and the coordination of the care were rated highly. Our health care system is very complex, and it can be especially confusing to our seniors. Through managed care, beneficiaries are able to receive health care

services that are coordinated through primary care physicians. Those aspects of the system are in place to help the individual navigate through the system.

In terms of preventive health care services, the statistics show that their utilization is much higher among M+C Plans than it is in fee-for-service Medicare. Sixty-two percent of women receive mammograms on a regular basis within M+C programs, versus only 39% for FFS Medicare. There is much earlier diagnosis of cancers in M+C as opposed to fee-for-service Medicare. Beta blocker therapy for patients that have had heart attacks is much more highly utilized within M+C programs than it is outside of the M+C program. So as the above discussion illustrates, there are many good reasons why M+C programs have been a very valuable coverage for the population that has been served by these programs.

Clare has already discussed the CMS capitation payment history, so I don't want to get into a lot of the same details. I only want to cover a few points in order to put recent market exits and reductions in benefits into perspective.

Until the Balanced Budget Act of 1997 became effective, health plans were paid at 95% of fee-for-service Medicare. That changed in 1998 when the BBA changed the way the payments were determined to the three basis method described earlier by Clare. The minimum increase in all years, except 2001, has been 2%. In 2001, it was 3%. The only time that the blend was really a factor was the year 2000. In all other cases, those entities that did not receive the floor increase received the minimum increases. Also as a result of BBA 1997, the health status risk adjustment methodology must be changed for 2004. Until now, final CMS payment rates have been calculated using a 90% weight for the demographically adjusted rate and a 10% weight used for the rate calculated using health status risk adjustment. For 2004, physician and hospital outpatient diagnoses will be added for the basis of risk adjustment and the 10% weight moves to 30%.

As a result of the changes introduced by BBA '97, the M+C payments from CMS in aggregate have increased by only 16.6% between 1997 and 2002. During that same period of time, as a measure of how much health care costs have been increasing, the federal employee health plan payment rates have increased by almost 60%. So it's no wonder that health plans have had to reduce benefits, have gotten out of certain geographic market areas and/or have increased member premiums. All that has been necessary in order to survive in this environment. Clearly something needs to be done in terms of payment rates in order to save what I think is a very valuable coverage within the overall Medicare program.

Just recently, I was very surprised to see the CMS projected 100% (or 99%) of fee-for-service costs for 2003 that were published for the PPO demonstration RFP in May. I saw counties where M+C payments were already well above what these projected costs were expected to be for fee-for-service Medicare. In some cases, they were as much as 25% above fee-for-service. Remember, I just cited the fact that M+C payments had only increased by 16.6% over the five-year period of 1997

to 2002, and in 1997 M+C payments were calculated to be 95% of FFS Medicare. So in five years (or actually six, to 2003) CMS is projecting that M+C payments in "non-floor counties" were now going to be as much as 25% higher than the CMS fee-for-service costs in these counties. I began to have grave concerns about the accuracy of the CMS projections, since they seemed so far different from the realities of medical cost experience for the industry.

One of two things was happening. Either CMS is wrong, or if they're right, heaven help us. If those are truly what fee-for-service Medicare costs are going to be in 2003, then we're likely to see cost shifting to the private sector the likes of which we have never seen before. In fact, I think we're seeing some of that already with the commercial rates going up as fast as they are right now.

There has been quite an impact from the legislative changes starting with BBA 1997. This Act started taking money away from the M+C program, and by year 2002, based on congressional budget office (CBO) estimates, that reduction would have been $8.4 billion for the year. Fortunately, the Balanced Budget Refinement Act of 1999 (BBRA 1999) and the Benefits Improvement & Protection Act of 2000 (BIPA 2000) added some money back. The net decline is still $4.7 billion based on those CBO estimates for 2002. Based on CMS estimates for 2002, health status risk adjustment is projected to take another $1.5 billion out of the program. That's a total estimated $6.2 billion taken out of the program, according to my rough calculations. That's a reduction for that year of somewhere in the 14–15% range.

So what about health status risk adjustment? We've had the PIP-DCG methodology since 2000, which uses inpatient data only for the basis of risk adjustment. That will continue through 2003. However, in 2004, the new system will kick in and use not only inpatient data, but also physician and outpatient hospital diagnoses. I believe that this can create some serious dislocations and possibly some additional problems in terms of capitation payments or revenues for health plans.

The phase-in of risk adjustment so far has only applied a 10% weight to the rating based on health status risk adjustment through 2003. For 2004, when we begin including physician and outpatient diagnoses, it's going to jump to a 30% weight. Only a legislative change could delay this increase to 30%. The increases in the weight will be 50% in 2005, 75% in 2006, and 100% in 2007. Risk adjustment for 2004 will be based on the 12-month experience period that starts 7/1/02. We will need to start gathering the outpatient, as well as the inpatient hospital and the physician utilization/diagnoses data through the next 12 months. This data will then be used as the basis for risk adjustment and will be given a 30% weight in the payment rate calculation for the year 2004.

Basically, all we know about this system right now is there are 61 disease groups included for risk adjustment, and these groups include about 3,100 ICD-9 codes. However, the methodology is not yet finalized. This means that the risk adjustment factors are likely to change from those recently published by CMS. We also don't

yet know where the base rates will be before risk adjustment is applied, since no ratebook has yet been made available. So, as an industry, we really can't make projections of what's going to happen to us in the year 2004. I think that uncertainty is, to say the least, very concerning. The current schedule calls for the methodology and the factors to be finalized sometime in the second quarter of 2003. By that time, the experience period is almost completed and we will be only a few months from the date our ACRs will need to be completed and filed.

In addition, I believe that many health plans will have great difficulty in collecting all of the appropriate utilization/diagnoses data, especially where providers are capitated. This will be especially true for physician capitation, where I believe there is generally a great deal of underreporting occurring. In these cases, the industry will be relying on the physicians' systems capabilities in capturing and submitting the appropriate encounter information. As I'm sure we are all aware, in many cases the physician capabilities in this area fall far short of what is needed. I acknowledge that CMS has agreed to allow the industry to use alternative data sources to help track down the relevant diagnoses, and this will certainly be helpful.

For example, we will be able to use pharmacy records to track down individuals if we don't have the physician or the hospital data to tell us if any of the relevant 3100 diagnoses were actually present for members that had none reported. However, we can't use that as our final proof. We need to go back to the provider, and have the medical record confirm the diagnosis and keep that in our records for CMS audit purposes. Other alternative data sources may be used (e.g. disease management programs, Disease Registries, etc.). Being able to use these types of disease identification methods is of course very helpful. I'm just concerned about how quickly these can be adequately implemented in order to avoid as much underreporting of the relevant diagnoses as possible. It's going to be an interesting time, to say the least.

I do want to acknowledge that CMS has done some good things in this whole process. Clare mentioned the reduced administrative burden. I think CMS has done a lot in terms of reducing what the administrative burden would have been with this new methodology had these changes not been made. For example, only five data elements need to be submitted and only for those individuals with diagnoses that will result in a risk adjustment. If a diagnosis for a member has already been reported, it need not be reported again for the same experience year. So as you can see, a great deal has been done by CMS to try to reduce the administrative burden for the industry to help ease the transition to the new method.

In order to illustrate the potential impact on revenue due to underreporting of data, I'll use our company as an example. Recently, we took part in an industry study. We did not yet have any details of the new CMS methodology, so we developed our own approach.

We used a hierarchical condition category (HCC) approach (as did CMS), and used hospital in- and outpatient and physician data to test what risk adjustment might do to our various populations. In our company's case, we used claims and encounter data for 100,000 members from two different regions. One region was highly capitated. There was some fee-for-service, but in most of the capitated situations our company was not the claims payer. Claims were adjudicated by the providers and encounter data should have been sent to us by those providers. The other region had much less capitation, but even where there was capitation, we were in control of claims payments. So we had virtually all of the claims data for that region.

The results were very interesting, but not unexpected. In the first case, we were counting on encounter data coming from the providers to a large extent. When we added physician and outpatient encounters to the inpatient diagnoses, our payments went down dramatically, which means we've got a lot to do in terms of gathering more complete data and perhaps using alternative data sources to track down members with relevant diagnoses. I can't imagine what the administrative costs are going to be for that. It's unacceptable to us to have our payments go down that much, especially since we're going to a 30% weight in the payment calculation.

In the other region where we had access to all of the claims data, the payment rate was almost flat when physician and outpatient hospital data was added to the mix. As a matter of fact, our payments actually increased slightly over what our PIP-DCG payment would have been for the sample because the new method included one-day stays and multiple diagnoses, as does the new CMS methodology.

I don't know if others have the same data problems that we have, if we only use our current routine method of gathering claims and encounter information. I suspect that we're not alone in this. We obviously need to get to the bottom of our data problems and soon, since we need to start collecting the data in a few days. Time is not on our side, so I'm worried about that. The use of pharmacy data as an alternative data source is not a complete panacea either, since our pharmacy benefits have been greatly reduced over the years and can no longer give us a complete picture of total pharmacy use for our members. Of course, moving to the 30% weight just adds to the problem. In addition, I'm concerned about the potential increase in administrative costs that may occur as a result of this change in method. Needless to say, we've got our work cut out for us.

JOHN BERTKO: I have overall responsibility for programs like this inside of Humana, although I'm lucky enough to have several other people doing all the real day-to-day work.

One of the things that we ought to be asking ourselves is: Is there going to be a M+C option for us when we retire? What happens to the rest of you in the 20 or 30 years you've got ahead? Let me just give my take on this. For the industry and the

program as it exists today, there really is not much of a future in the counties where most of the members live, mostly in the 2% revenue increase counties. There's a sprinkling of people in the "floor" counties and elsewhere, but why should we pay $400 or $500 a month for people in the middle of Wyoming or Alaska, or at that rate, northeast California?

Second, a number of plans in the industry were interviewed by a research firm. I don't think they have published the results yet. We saw a copy provided to us to look at our responses, and I picked a couple of key points. Most of the contractors, namely plans like John's, mine, Kaiser, and the others, said that they are going to have continuing exits from the M+C program. Some of us in some markets may survive a few more years, so it's not all complete gloom and doom. However, there's a cliff out there, and we're all going to fall off of it if the program continues as is for the next 2–4 years.

In the real world outside of Medicare, costs are going up very fast. The Federal Employees Health Benefits Program (FEHBP) arguably is among the best contractors in the country, and its cost went up enormously. Our reimbursement has only gone up 11%. A policy issue here, I think, with which I'm sure Clare would agree, is that the government shouldn't pay more than what it would pay in fee-for-service to plans like ours. I think that flip side needs to continue, which is kind of my theme today — either you get the same benefits for less, and I think some of that has happened in the past, or you get more benefits and better quality for the same amount of money. I don't think your administrator at CMS would disagree with that, so let's aim in that direction for the next couple of minutes.

I'd propose there's no silver bullet out there. That is, we're going to have a mix of different options. Let me just warn you that the people designing the program didn't like math in high school. They liked history and English; that's why they're in Congress. Let's just say that our voices have got to be heard one way or another, whether directly or through our constituencies or our vice president of government affairs. The total goal ought to be improving Medicare's overall outlook. There's a lot happening in our health care world, both on the commercial and the government side.

One thing I want to mention: we are currently under an administrative pricing system for Medicare. Congress, in its wisdom, said to HCFA, now CMS, here's a set of rules, tell people what you'll pay them, see if there are any takers — administrative pricing. The flip side of that, and I'll use FEHBP as opposed to anything else, is you set some rules and then folks come in like my plan. We come in and we say, "Here's a product; here's the price we're going to take; let's see if anybody takes it." Whether it's called "market-based" or "competitive" pricing, those perhaps are the two fairly realistic extremes out there today.

Let's start on the short-term fix. It's meant to be short term primarily because it helps for a while, but it is definitely not a longer term fix. First of all, use the risk

adjuster. Most of us say there has been some risk selection in the past. I will tell you right now that compared to the early days of the program, the early 1990s, most of us are left with people who have been in M+C programs for a lot of years. I would submit to you that there is much less risk selection today than there was five or ten years ago, but we may need to get rid of that 5% cost savings reduction.

Second, the folks at CMS, Office of the Actuary, have been "bad actuaries." Part of it is that they've got a denominator that essentially includes everybody who is a senior who is eligible for the program, but they don't have all the claims in the numerator. The VA and DOD claims are missing. Now the problem is that these data are hard to obtain. It is not impossible, but it is difficult, because CMS actuaries do a lot of very difficult kinds of calculations, but all of the claims haven't been in the calculation. On the whole, how big is it? I've heard numbers in the 1–2% range across the country. However, on a county-by-county basis they could be considerably larger than that, so Clare, are you going to nod on that one?

MS. MCFARLAND: One argument against that is maybe there are people who are still using those services, so to that extent maybe you wouldn't want to include them.

MR. BERTKO: This is not to be quite a crossfire, at least not yet. What I've done is just got a hodgepodge of things.

"Urban legend" has it that a couple of years ago the Office of the Actuary recalculated all the demographic factors, whether for the aged, the disabled, or the institutional populations, and was set during a previous administration to recommend a change. On average it didn't change the payment rates, but it would have increased the payments to aged and perhaps decreased the payments to institutional and disabled. That was frozen. Did that make any difference to plans like us? Yes. We have proportionately fewer disabled, institutionalized and more aged. We would have been paid more money. What's that worth? Maybe another 1% in higher payment.

There is a very good rule for working aged. I mean, CMS should not be expected to pay for people who have coverage elsewhere. The problem is in the working aged and among others, we have a cash flow problem because too many people are identified as working aged, at which point our payment is cut way back. We spend the next 3–15 months convincing the folks at CMS or their contractors that, in fact, these people were really retired seniors and not working aged. Then there are a bunch of other factors. John alluded to some of the things that looked a little fishy there. I certainly think that the home health care payment stream over the last couple of years, which kind of bopped up and down, was peculiar. I don't know whether it was wrong, but it was definitely peculiar.

All right, fix all things — what do they amount to? I don't know. Perhaps they add up to 1–7%, if you cleaned up all the actuarial things. This is something where I

think the group of actuaries would say, "They're theoretically the right thing to do, but they still haven't happened." They are short-term only.

Let's jump to the other side of the fence. One of the problems that our plan is having, and I'm going to propose that it probably happens with other plans, is that providers are difficult to deal with these days. I think actually you have some similar difficulties, similar to physicians on Medicare fee-for-service. Why don't we try looking at how fee-for-service Medicare deals with some of these problems? There is, I think, a reasonable expectation that Medicare costs shouldn't vary as much as they do from region to region. John Wennberg from Dartmouth has done study after study on these.

For instance, in 1979, I believe, he did a study to say that there are just these completely inexplicable variations. I've done a little bit of a look on a risk-adjusted basis. Again, that's tempered by the fact that when more "medical stuff" is done the people look like they're higher risk, and in some parts of the country even after risk adjustment are still way too high consumers of services. So maybe we ought to have fee schedules that vary by market to reward efficiency and penalize over-utilization. The people in Minneapolis will jump up and down in applause for this one. Maybe we ought to adjust hospital DRG payments for excessive admissions. Are doctors doing more things in New York City? Should we, in fact, penalize beneficiaries? Should we make the Part B premium more expensive where doctors are not behaving as nicely as they do in some parts of the country?

There are all kinds of quality measurement requirements that for the most part are addressed only to M+C plans. What's going on with the other side of the fence? I'm sure you can come back and say on some provider basis, there are some initiatives for quality on the fee-for-service side, but maybe we ought to go much further and impute care systems. Figure out which doctor or which specialist a Medicare beneficiary goes to mostly, and then find out what the claims and the experience are around that particular physician or group of physicians.

Medigap in the United States is a problem. It induces demand. When you fill in all the cost-sharing blanks with one of the plans, even the ones that are non-drug plans, you get people not to worry about costs like this. I should say this differently. There's got to be at least one under-65 program that still pays everything. We've left those, for the most part, far behind and, in fact, maybe Medigap should be fixed and fixed substantially with co-pays and deductibles of some moderate level put in front of every plan.

What are the results? I think we need some savings to Medicare's fee-for-service program. Providers would say that M+C contractors aren't so bad to deal with because they are a little bit more coordinated than this fee-for-service thing is.

So let's go a little bit further along the spectrum of making changes. John provided a good summary of what the BBA and other statutes did. One of the things that I

would propose is there's an incredible lag because of the five-year moving average in the way that the payment rates are calculated. What I am facing personally is a recognition that some hospital in Texas has said they want their rates to go up 30% July 1st. Five years from now, that will be baked into our payment rate. (I'm exaggerating just a little bit, but it's entirely different). The payment rates then should be increased at some much more current factor, whether we do it at the national update or maybe some different but much more current index. The big question there is, what's the right index? How do you pay no more than what you'd pay under Medicare fee-for-service? Some dialogue on this, I think, could be quite useful.

The next comment then reflects a little bit on what John said in a different way. Why don't we think about rebasing the rates? When we went into the BBA in 1998, essentially the rate book for payments to M+C plans got split off from what were then the fee-for-service calculations. They've gone in different directions. There is incredible controversy about whether they actually split this way or whether they split that way. I would completely agree that the floor rates in those rural counties are way above fee-for-service, but from a practical purpose, who cares? There's nobody there. In any case, if we throw everything up and we eliminate those high payment rates in the rural counties, it won't matter. We may be able to fix it, and again we want to have something that will work for as many seniors as possible. That's my proposal.

What we've done is just worked around the edges of this thing. Let's suppose we get down to something that is closer to comprehensive reform. The Competitive Pricing Advisory Committee (CPAC) did considerable work in thinking about it for two years, and in the third year, when it was supposed to go into effect, Congress said, "Oh, no, it's not my district." We had two senators from Arizona and their representatives and then a total of four senators from the Kansas City area involved, plus all their representatives, and everything was backed off. However, in going through that process, let me just alert you that rolling out a competitive pricing model in a couple of sites, let alone the whole United States, would be a massive, huge undertaking. Now, FEHBP works pretty smoothly. I understand there are perhaps 100 people there that operate the program, but it's been in place essentially forever as far as health care goes. They know what they're doing.

What would we do? In the right aspect, payments would be tied to market-based rates. Plans like John's and mine would compete; we'd offer up a plan of benefits, and the price for that plan of benefits is $635 this year. That would be enough to pay our providers. John, of course, won't be as efficient as we will; his will be $675 and so there would be some premium rate there. People are willing to pay for things, but keep in mind that I've seen that same study that John has. We would be looking for membership. We would be driving price down. Low-income people would look to us to try to have smaller total out-of-pocket than in Medicare fee-for-service.

The bids here would be holding steady. There would be some ability to hold down costs because all of us on the for-profit side. I'd even suggest those on the non-profit side would want to be maximizing surplus if not profits. The beneficiaries would have the ability and flexibility for choice. If they wanted all the providers in the world, they could choose the high-cost plan. If they wanted an extremely tight network, they would choose a lower cost plan, at least that's the theory for it. If we ever have a prescription drug benefit, this also might solve the problem of which formulary to use. One of the shortcomings of our governmental system is we can't make very good choices. I'm one to say that, at least, you can't let the market do everything, but where actions are not going to have a major impact on beneficiaries, why not let the market handle it?

Most importantly though, what would be the reference premium here? In other words, how much should the government pay? Should it pay the same amount that they're willing to pay on fee-for-service? What happens when fee-for-service shrinks to under 50% of the folks in a particular county? What should be the area? Let's consider tri-county area in Oregon. Should it be all of Oregon? Should it be places where people live and then fee-for-service elsewhere? Should it be some average as you get more M+C Plans or more membership in M+C Plans? There are lots of decisions there. Should it be the low-cost plan? In some cases, the low-cost plan will fill up instantly and have no more capacity. The CPAC went through all of this. We decided it would be an enrollment-weighted average. We didn't have Medicare fee-for-service in it, given our charter, but if you rolled that it in then you could see the way the calculation would work.

What's the role for traditional Medicare? There is a millionaire congressman, who lives across the Bay on the Democratic side of the fence, who says that M+C Plans aren't good for anybody; that fee-for-service Medicare, traditional Medicare, is the only way to go. Now, he, of course, doesn't have to worry about this; he's got plenty of money and he's got the congressional retirement plan to take care of him. Real people out there are going to make decisions on this, and there will be a group of folks who need to make this decision. Some of them are the frail elderly. Some of them wouldn't be able to figure out whether it would be Plan A, Plan B, Plan C, or regular Medicare. Some, in fact, think there's no health care outside of the plan. If you go to Alaska, there aren't any providers there. Do you make it a default option? If someone can't make a choice, do they just pop into or remain in traditional Medicare? Do people in traditional Medicare have to pay more than they do now under the Part B premium? These are all really crucial issues of how hard we really want to push people.

To sum up, should we even preserve the M+C program? Three of us (and I don't know about you, Clare) are biased one way. We think that M+C offers something that is (a) useful to beneficiaries and (b) useful to the country. In some cases, it also makes money for some of us. With the perspective of Congress, things are going to change. Medicare isn't working quite right. If we're going to have some options in the future, we're not going to just start them up and flip a switch and all

of a sudden programs emerge. I think the debate on prescription drug coverage is one of the most useful ones today. If congress passes a bill, will anyone come to that party? We have no clue right now. So, keeping a reasonable M+C program running would be a pilot from which you might be able to grow options.

From the beneficiary's viewpoint, we give generally more benefits for the same price. There is maximum out-of-pocket protection in a number of plans.

Coordinated care on prescription drugs, and on disease management for a number of things, I think is a very valuable tool that is still emerging. It is also one of the reasons why we ought to keep the M+C program around.

MR. DAVID BAHN: John, we've had the same demographic studies that you have that showed that the M+C beneficiaries tend to be the lower income. I'm wondering if we have some implicit "cost shifting," just to give it a label, going on now between the Medicaid program and the M+C program. My sense is that many of the M+C beneficiaries, if we didn't have M+C, would be on a Medicaid program within their state, so we would have a combination of federal and state programs coming in. I'm wondering if we have actually looked at that kind of a situation. How close are these beneficiaries who now have $20,000 income to going into Medicaid in two years if we didn't have a M+C program? That gets into some policy questions about shifting back and forth between different aspects of which government pays for this care.

From the difficulties, if you will, in terms of dealing with "the government" and, I like your phrasing, "administrative pricing," we have experienced, for many years, difficulties within the M+C program. I remember some 15 years ago now, we were putting together a bid to provide CHAMPUS coverage on an underwritten basis to several different states. We did all the actuarial work, *et cetera*, using consultants, and got our bid all done. At the last minute, the Department of Defense changed the rules of the game on us by adopting the then Medicare DRGs and basically gave themselves a much bigger discount than we were able to get to provide underwritten coverage. Dealing with the government, dealing with that whole aspect of Medicare, of administrative or legislative pricing, makes it very difficult to run a long-term private business.

MR. FRITZ: I shared David's thought that in many markets there may be folks in M+C programs who would otherwise qualify for Medicaid and perhaps just don't because of their own cultural biases. I personally have not seen any studies. I've looked for them a little bit.

MS. MCFARLAND: I'm not aware of any studies. It sounds like that's a plausible thing that would result if there weren't any plans in the area.

FROM THE FLOOR: Clare, you spoke of some projections of Medicare spending per capita, and there's some information that looks similar on the CMS Web site that I

believe goes out with the national health care expenditures through 2011. Is that data consistent with what you presented?

MS. MCFARLAND: To the extent that that includes Medicare, which it does, but they have other health spending in there obviously.

FROM THE FLOOR: Right, but they also break it out by payer source, which shows Medicare?

MS. MCFARLAND: Right, they would use those numbers as a base.

FROM THE FLOOR: I'm thinking of this in the context of private retiree medical plans, which are also a significant source of coverage for retirees. A lot of those have been terminated since 1993, but I guess those projections per capita show Medicare spending per capita increasing at a rate that is higher than the rate from private sources per capita. I was wondering what that said or what CMS thought that was saying about a reverse cost shift and how realistic that is.

MS. MCFARLAND: I guess we really haven't thought about the cost shifting aspect, what we're projecting for the group in Medicare.

FROM THE FLOOR: I think those projections go out to 2011. The 2011 increase over 2010 was showing something like a 5.4% increase for Medicare spending per capita, whereas the private pay increase was something like 4.7–4.9%. I thought that seemed very unrealistic, but I wanted to get your thoughts. Maybe I was missing something.

MS. MCFARLAND: Actually, Kent, do you have any comments on that?

MR. M. KENT CLEMENS: We look at the comparison between private and Medicare and, at the end of the period, we had the real per capita age/sex suggested group rates, at the same rate for both Medicare and the private. That's one of the comparisons we do when we do the forecasts. With the adjustments there when you do it just on per capita basis or a total basis, there will be a difference.

FROM THE FLOOR: Those projections are updated every year. One of the things that I noticed with the Medicare spending projections per capita was that the increases in the near term year over year, 2004 over 2003, *et cetera*, as you get closer to them the percentage increase actually declined. The projections that were released in 2000 versus the ones in 2001 versus the ones that were just released are changing. It seems like the projections, particularly for Medicare, seemed rosy further out ,and then the closer you get to them, the more that increase seems to have been squeezed down.

MS. MCFARLAND: Yes, and I think all of this is due to remnants of the BBA and moving to all these prospective payment systems. The last couple of years, we

overestimated what we thought Medicare spending was going to be. If you're looking year to year, you're going to see that it's coming down. It's taken us a while to actually figure out how people are going to react to these payment systems, and hopefully that will level off.

MR. CLEMENS: One final comment is that for those of us who do retiree medical evaluations for FAS-106 or other compliance accounting, we need to comply with other accounting standards that we have to take into consideration for those plans that coordinate with Medicare for their retirees, what Medicare will pay, not just today, but tomorrow and years into the future. We do rely on those rates as kind of the best estimate of what Medicare will pay, but if, in fact, Medicare is going to pay substantially less in 2011, then the employer's liabilities, correspondingly, will be significantly greater, and we need to account for that.

MR. KIRK A. TWISS: I'd like to pick up on John Bertko's comment about Medicare supplement policies increasing demand. In my opinion, once Congress understands that, there could be the risk of legislation either modifying the Medicare Supplemental policies or even significantly altering or eliminating them. If you're a carrier that wants to be in the market of providing health insurance to seniors, you have so much uncertainty about all of your product options such as M+C and Medicare Supplement. What kind of planning can you do?

MR. FRITZ: First of all, I will say, Kirk, you made one assumption there that not everybody would agree with, that is "when Congress understands it." I think there have been some proposals already to perhaps add a couple of options on Medigap. I think people currently eye those options. The ten most popular ones would probably be grandfathered in so that group of plans might continue on until literally everybody dies out of them. They may be perhaps closed off to new entrants at that point. Planning will be difficult. There's a lobby of people like us that work for plans that are Medigap carriers, and certainly they may not want to see the status quo change. I think the whole process is pretty messy.

MR. BAHN: Years ago, before Congress decided to get into the plan design business with the standard products, we offered a portfolio of products. Our biggest seller was one that actually had a $200 Part B deductible consisting of $100 of standard, $100 Medicare deductible, plus $100 made up out of the 20%. That to me is the kind of very simple plan design, if you will, none of the, "Well, we'll only pay for claims submitted on every other Thursday" that some companies were engaged in at that time. I think we can work with Congress and consumer organizations to try to educate them. Let's say M and N just has a $200 deductible on the Part B side and N may pay 50% of the Part A coinsurance inpatient and then maybe $200. We come up with a very simple, very understandable design, one in which the beneficiary can plan and budget and know that the maximum payment for this coming year is going to be such-and-such. One of the difficulties, I've heard, if we go into the co-pay route, is that a senior on a limited income has difficulty planning and budgeting in January. If you do something like a fairly simple

design, but more cost sharing, you may help address the induced utilization and make a product that the seniors would like.

FROM THE FLOOR: Most of the discussion so far has been about M+C HMO. I'm curious if any of the speakers have thoughts on PPO, fee-for-service options and whether those are viable long term.

MR. BERTKO: We do have the PPO demonstration that started. We're all anxiously awaiting what CMS's decision is going to be on July 1, 2002, in terms of who's been accepted. Then I think we've got our work cut out for us in terms of how we move forward after that. I believe that it's an option. One of the cost-controlling methods that we used on the HMO side is lots of capitation, but as we know, we're moving away from capitation as an industry. The providers want less and less capitation, so as we do that we become more like a PPO type environment. I would think that there's a way to do that. We'll have to change with the times and be able to apply some of the cost management techniques, disease management, and so on that will make those kinds of products viable. I think definitely that could be part of the overall program.

MR. FRITZ: Let me just add a little bit to that. Like John, we are awaiting the July announcement. We actually have a private fee-for-service demo in one county. I would highlight that there's another issue there that we weren't sufficiently aware of when we opened it up, which was provider education. We knew that there would be a fairly big rollout or outreach to try to enroll members, but when providers found that we were in private fee-for-service they expected to be paid their normal, fairly outrageous rates. We said, "Oh, no, you didn't read the contract. It says you get paid Medicare rates." We've had to do a fair amount of education to go along with all of the other parts of coordinated care we put into operation. We're seeing how that works out now. All I could offer you today, about six months into it, is so far, so good.