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Medicare+Choice

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Summary: Recent and current developments in Medicare+Choice (M+C) are discussed. Topics include an update on the new health status risk adjustment methodology, the legislative history and other recent developments that are impacting the M+C program and measures taken by health-care companies to adapt to the changes occurring within the M+C program. Attendees gain an up-to-date understanding of the M+C program and the other recent changes that have occurred, especially with regard to the new health status risk adjustment methodology that is being implemented for 2004 and beyond.

MR. JOHN F. FRITZ: I am the chief actuary of PacifiCare Health System. My co-panelist is John Bertko, chief actuary of Humana, Inc. As billed, we will be discussing M+C, past, present and future. As you probably know, both of our companies are heavily involved with the M+C program.

Actuaries look at history and then try to predict the future from an analysis of historical experience. I'm going to begin with a brief history of M+C, especially since the passage of the Balanced Budget Act of 1997 (BBA). I'll cover the history of health status risk adjustment within the program, what changes we can expect for 2004 and some of the implications for the industry as a result. John will be talking more about some of the other aspects of M+C, including how Medicare reform may impact the M+C program.

What did the BBA include? Well, prior to its passage, local rates were based on 95 percent of Medicare fee-for-service (FFS) costs for each of the counties. The BBA broke that chain. Medicare FFS costs are no longer the basis for how the capitation payments to HMOs are determined. BBA also required the future implementation of

Note: The chart(s) referred to in the text can be found at the end of the manuscript.

health status risk adjustment and introduced the concept of budget neutrality. I'll be talking about these a little later.

After BBA, Centers for Medicare and Medicaid Services (CMS) payments are based on the highest of three monthly payment rates. First, the concept of a floor rate was introduced so that no rates for any county could be lower than a floor rate that was first established back in 1997, implemented in 1998 and updated annually thereafter.

Second, the minimum increase was set at 2 percent. This minimum increase changed only once (in 2001), when the Benefits Improvement and Protection Act (BIPA) set the minimum at 3 percent for the last 10 months of the year. The third payment option involved a six-year phase-in period. It basically blended a local county rate with a national average rate, gradually moving to a blending toward a 50-50 equal weight of the two. The local rate is calculated from the 1997 local county (pre-BBA) M+C rate, less graduate medical expense (GME), and increased by the M+C growth rate. The national average rate is the weighted average of all of the local county rates. The blended rate is subject to a budget neutrality requirement. I'll talk a little bit more about budget neutrality in a minute. First, let me describe the calculation of the M+C growth rate percentage.

While Chart 1 appears to be complicated, it's not quite as complicated as it looks. The first line is projected trend change in per capita costs on the FFS side. This is what the CMS release early in the year, March, on their 45-day notice, and projects what they think is going to happen to per capita costs in the Medicare FFS environment.

BBA introduced a statutory reduction for M+C. You can see the years that this reduction applied (1998-2002). There was a 0.8 percent reduction of that amount in 1998, so the projected M+C growth rate is 2.6 percent for 1998.

The middle part of the table shows how CMS calculated estimated changes to their per capita costs in each subsequent year. For example, following the 1998 row, there are three years of negative correction (-0.7, -0.6 and –4.5 percent), followed by three years of zero or positive correction (1.9, 0.0, and 0.1). The cumulative adjustment just for 1998, including the 2004 projections, is a negative 3.8 percent. That is, the current CMS estimate for the per capita cost increase for FFS Medicare for calendar year 1998 is now a negative 0.4 percent. That's a long tail and there could be more adjustment in future years. The M+C payment basis makes retroactive adjustments for these "corrections" from year to year, but applies the corrections to subsequent payment years, as shown in the table. For example, the 2003 M+C growth percentage was calculated using the FFS change in per capita costs published in March 2002 (0.9 percent) and adjusted this number for all of the "corrections" in the 2003 column for the years 1998 through 2002. Therefore, a negative 2.9 percent was used for the M+C growth percentage in the above blending formula for the determination of the 2003 CMS capitation payment rates.

Therefore, the key line in the table is the second to last row.

Chart 2 shows the percent of counties receiving the floor, blend or minimum increases. That is, 33 percent in 1998 were at the floor when the floor was $367. In 1999, it moved to 40 percent, when $380 was the payment floor. You can see what happened in 2000 (29 percent at the floor rate of $402). Gradually we get up here in 2004 where 84 percent are floor counties and 16 percent have a minimum increase, which at this point is 2 percent. However, CMS has introduced the concept of national coverage decisions (NCDs), which adds an extra 0.2 percent to the minimum increase for 2004. NCDs represent any decisions made by CMS to increase benefits for FFS Medicare, which M+C plans must also add to their benefits.

Let's talk about budget neutrality. In Chart 3, the first row shows what the Congressional Budget Office (CBO) estimated (at the time that BBA was passed) would be the BBA impact on payments to the managed-care industry (in billions of dollars).

The Balanced Budget Refinement Act (BBRA) gave some of this reduction back to the industry as the CBO estimate in the second row shows. BIPA came along in 2001, and the CBO estimated an additional give-back. The administrative calculation in row four was done by CMS, and shows the estimated reduction in payments to the industry for health status risk adjustment, which began in 2000. Remember budget neutrality? The government's definition is you can't get more, but you can get less, as the bottom line in this table shows.

Let's look at what has happened to the enrollment in M+C over the years in Chart 4. With those legislative and administrative take-aways, in terms of our payments to the industry, this is what happened. We were still growing in the late 1990s and leveled off in 2000 when we hit about 6.2 million beneficiaries. The enrollment has declined ever since and now stands at about 4.8 million beneficiaries. As expected, as the money went away so did the membership.

Let's move on to health status risk adjustment and what's happened since BBA. The original phase-in period would already have had us at 100 percent of health status risk adjustment, but with the administrative actions along the way the beginning of the phase-in has been delayed to 2004. So we're still using a 90-percent demographic/10-percent risk blend for the calculation of our payment rates. Risk adjustment started in 2000 and only used in-patient diagnoses data as the basis for risk adjustment. The base experience period used for risk adjustment started 18 months before the start of 2000 and ran through six months prior to 2000 (i.e., July 1, 1998 through June 30, 1999). That's the base year, the experience period on which our data is analyzed to give us the risk adjustment factors that will be used for that risk-adjusted period (year 2000).

I mentioned budget neutrality before and how it seemed to be one-sided favoring

the government. Well, this year, 2003, there was a rethinking of that take-away that you saw in the previous chart for the administrative action, which was really health status risk adjustment. CMS concluded that such a take-away from the industry was contrary to legislative intent. Therefore, since this was an administrative take-away, an administrative fix could be applied to correct for this. Budget neutrality should be budget neutrality, and that means no more, no less. As a result, the industry received an extra 0.64 percent to its minimum increase for 2003. The additional increase for 2004 is slightly larger.

I believe that things have improved at CMS compared to what it has been like under previous administrations. I have to say we're getting some of these corrections done because of the more cooperative attitude. They're of course not giving anything away, but they are starting to realize that if they want to continue with an M+C program, they have to be fair.

For 2004, CMS has introduced a more comprehensive risk adjustment methodology and uses physician and outpatient data, as well as inpatient data. The CMS/HCC methodology uses 66 disease groupings split into more than 3,100 diagnosis codes for the basis of risk adjustment. The blend now becomes 30/70, so health status risk adjustment is going to have a much bigger impact. Budget neutrality has moved up from 6.4 to 16.3 percent. At the same time, they introduced this "coding intensity" factor (1.05), which will reduce the 16.3 percent (i.e., 1.163/1.05 = 1.1048). This translates into about a 3-percent increase to the minimum for 2004. I'm not sure if any of us have yet figured out exactly how the coding intensity factor was calculated.

MR. BERTKO: Mel said that they graphed a series of points showing that upcoding became more intense over several years, so he fitted a certain polynomial to it and made it asymptotically slightly less. The 1.05 factor was apparently a little less than what a straight line would do, but it's meant to take out the effects of upcoding.

MR. FRITZ: I guess another way you could look at it is if we as an industry are looking for diagnoses that will give us extra dollars, we should be able to do a better job of it than FFS Medicare. And since the risk adjustment factors are based on FFS experience, where they are not necessarily looking for errors in the coding process as we are able to do, CMS developed a reduction of the budget neutrality factor to account for this potential difference. That's probably another way of looking at it. I thought it was coincidental though that the factor was 5 percent and recalling that there was also a 5-percent reduction factor used pre-BBA, the 95 percent of adjusted average per capita cost (AAPCC) basis before BBA. Your explanation sounds like there was more science involved than I was giving them credit for.

Another change occurring in 2004 is that the data lag is going to be eliminated. Remember I said that the normal experience period used as the basis for risk adjustment is six months. For 2004, it will start out as July 1, 2002, to June 30,

2003, which will be the basis for the first six months of CMS payments. That would be normal based on the historical risk adjustment experience period. That's going to be moved to calendar year 2003 as the basis for the last six months of 2004 with an adjustment in July 2004 for any differences for the first six months of the year due to the new updated experience period.

The current plans are to continue with this lag elimination approach in future years as well. In addition, we're going to grade from the 30-percent weight for the risk-adjusted premium in 2004 (and 70 percent for the demographic premium) to 100 percent for the risk-adjusted by 2007, so 2005 will be 50 percent, then 75 percent for 2006 and finally 100 percent.

Because of all of these complications, CMS indicated that they would like to help the industry try to estimate what the impact is going to be for all of these changes that are going to be happening. Here's an example for XYZ Company. XYZ operates in eight states. CMS asked for claims history and encounter history for the experience period, July 1, 2001 through June 30, 2002, and reported through September 2002. They used the cohort of membership for September 2002 as the basis for calculating the risk scores.

For XYZ, the risk scores varied from 0.74 to 1.02 across the eight markets. The percentage of members with risk adjustment varied from 39 percent to 58 percent. The CMS expectation is that there should be somewhere in the range of 50 percent of the members or beneficiaries, on average, that will ultimately get some kind of a risk adjustment.

XYZ, of course, wanted to validate that it all makes sense. Looking at county variations, these went from 0.6 to 1.08, where only counties with a credible number of members were considered. The lowest risk scores happen to be in capitated counties. The analysis is not yet complete. Generally relationships seem to be reasonable compared to the CMS results, which were statewide, not county-specific in any way. More work needs to be done in this area.

Basically the findings and conclusions from the analysis so far are that the low-risk scores correlated with highly capitated regions, and the problem is underreporting of encounters for providers that are being paid on a capitated basis. Much of the capitation is on a percent-of-premium basis, so the providers are going to suffer just as much as or more than the health plans, if the reporting does not improve.

High-risk scores correlated to FFS provider-reimbursement areas. I already mentioned underreporting of encounters where capitation was involved, and in a previous study it was found that greater than 30 percent more physician claims were found in the FFS environments than were in the encounter data in capitated environments.

What are the implications for us as an industry? Obviously, the underreporting issue

is a significant problem that we need to overcome. Otherwise, reduced revenues will be the result and this will be in addition to the reducing effect of the coding intensity adjustment introduced by CMS. There will be increased expenses to ensure that full reporting is happening. A great deal of provider education is needed. There will potentially be unhappy providers, especially where they are being compensated on a percent-of-premium capitation basis. Education is key. It can be a win/win situation for both the health plans and providers if we can overcome the underreporting problems, and we must.

Health plans are allowed to use alternate data sources including drug data, lab data or disease relationships. We can use whatever it takes to find the diagnoses that should have been in the experience period that were perhaps not reported to us or to CMS. When we're using alternate data sources, false positives may be found among the data. To obtain optimal results, it will be necessary to find the proper balance between finding an adequate volume of the true positive diagnoses and investigating too many cases that only appear to be positive but turn out to be false positives. There is additional administrative expense, so how do you minimize the number of false positives so you don't have an unwieldy amount of administrative work to try to track down these diagnoses?

Last but not least, there must be some way for the health plan to ensure that these true positive diagnoses are truly in the historical medical record. It is important to ensure that, if we receive the diagnosis information outside of the normal submissions of encounters and claims, we have some way to be sure that the diagnoses are in the historical medical record but have just not been adequately reported to the health plan in the first place.

There is a lot of work to be done and some interesting days lie ahead, but things are looking good, especially with Medicare reform and the potential drug benefits. I'll let John cover some of these and other aspects of M+C.

MR. BERTKO: First off, we have two different viewpoints. John Fritz did a really good job in particular of summarizing all that legislation onto a couple of charts. I have never seen it compressed like that before, so that was great.

What I intend to do is take a look at some of the current demonstration projects that are going on and talk in general about some of the possible Congressional actions. I'm going to take a broad view of what M+C is. I'm not going to talk about drugs at all, but rather any of the forms of delivering health care, including what may emerge on Medicare Advantage, which is essentially a PPO.

Let me first put this into a context. I don't know how many of you read the *Wall Street Journal* religiously like I do. Yesterday's *Journal*, in the section on legislation said, "There is a new aura of inevitability about Medicare legislation this summer." That's the direct quote out of it. You can count on it because groups like the pharmaceutical industry are beginning to hang little special-interest provisions onto

it, so they think that this massive bill has "left the station." In fact, it has in the Senate, and I believe it's almost ready to pull out of the station in the House.

Part of my comments today are interesting in the sense that I prepared this ahead of time, about four to six weeks ago. In looking at it, I think it still fits more or less with everything that's going on. I want to recognize Cori Uccello, who's the health fellow at the Academy. She, I and a number of other people have been speaking off the record to various Capitol Hill staffers over the past six months or so about things that may emerge.

For about three years, I was a member of what's referred to as the Competitive-Pricing Advisory Committee (CPAC), which was meant to run a demo of competitive pricing at that time in Phoenix and Kansas City. It was both an illuminating and extremely frustrating experience because, like the other two demos scheduled, it "blew up" due to political pressure. However, it gives some indication of the various pulls and pushes that are going to happen as we go into the future.

What's next? Let me set the stage for this. I'm going to be succinct. Basically, about a year ago some researchers from Mathematica called up about 20 health plans. The researchers (off the record) asked the plans, "What's going to happen?"

Assuming only current law of what would happen, we collectively reported that we would continue to get 2-percent increases in the high payment counties. The rates would also be adjusted, and in some cases reduced by risk adjustment as it is phased in. In my opinion, and as the researchers reported, enrollment would melt away. Many of the other counties would have perhaps a 5-percent increase, and this goes along with the national growth rate that John Fritz showed. In an environment where health-care costs are really going up at a minimum of 8 to 10 percent, we'll get more benefit reductions and continued slow membership erosion.

At the end, most of the contractors—and I'm paraphrasing this study—will stay a few more years, and then at some point the last plan will "turn the lights out" on the M+C program. That's without changes in current law.

Again, keep in mind I did this four to six weeks ago. At the time, the Bush administration was proposing "Enhanced Medicare," and it's now called Medicare Advantage as it emerges from the Senate bill. The three bills that are emerging from the Senate, House Ways and Means Committee and House Committee on Energy and Commerce are all different and have different wording, but basically there is a PPO in the proposals and prescription drug programs. Importantly, it goes in some cases away from an administered pricing system and toward a competitive payment mechanism.

Those of us also in the commercial world know we face competitive pricing mechanisms everyday. We bid against each other sometimes in certain markets. At the Federal Employees Health Benefit Plan (FEHBP) program, the government takes

the bids, but people move and vote with their pocketbooks. That's the way this could emerge.

The Senate Finance Committee has been sometimes called the "Senate Committee of Northern Plains States" because most of the Senators are from rural states like Iowa, Kansas, Montana and North Dakota. They are extremely concerned about having PPOs or whatever new emerging products in rural areas. We've already had a failure that even with the high "floor rates," M+C plans have not gone into rural areas.

Under the new law, there are many discussions about how big these rating areas would be. They're unlikely to be as small as a county and unlikely to be a metropolitan statistical area (MSA). The rating area might be a state. Some of the proposals say that 10 or more regions are contemplated. It may be likely that they would have to be multiple states, which makes life interesting. Another implication of this is whether it is fair to have different premiums and benefits in different parts of the country. We have that today in M+C, and there's a lot of disagreement.

John Fritz and I have friends up in Minnesota who keep saying, "Why should Southern California and south Florida have drug benefits available to M+C enrollees, and we have none?" Those are the kind of questions coming up. If we have this, and it's a competitive bidding system, it may mean that somebody in New York will have a premium of $100, and somebody in Southern California will have one of $20 for benefits that might be remarkably the same. Is that fair? Under FEHBP, benefits vary all over the country. There are a lot of differences.

Going to the future of M+C, how do we learn what happens? First, the Health Care Financing Administration (HCFA) and then CMS have a long history of using demonstration projects. The original Medicare risk program dated back to a Tax and Equity Fiscal Responsibility Act (TEFRA) demo from the early 1980s with three sites. After those were more or less successfully implemented, the program was rolled into legislation and thus emerged as the Medicare Risk Program, until BBA changed it into M+C.

We've had social HMOs (SHMOs) that continue to this day with Programs of All-Inclusive Care for the Elderly (PACE) and On Lok, and I believe those programs have such a big constituency that they keep getting themselves grand-fathered over and over again in almost every bit of legislation. However, this two-market pricing demo for Phoenix and for Kansas City turned into an utter failure. It followed early attempts, first in Baltimore, which local politicians ended, and the one in Denver, which was ready to roll until a federal judge intervened. Again, this was due to pressures from some of the local folks.

I will tell you that having sat on the CPAC panel, we thought we did a pretty good job of designing a demonstration. However, in a short period of time, we had everybody against it. The beneficiaries were worried that their drug cost would go

away. The plans didn't like it as a group. Providers were up in arms during our sessions and saying, "No, this is the end of it." Not only did we have four or five congressmen, but because it was Kansas City, we had four senators from the two sides of the river, plus the two senators in Arizona. Included among those six senators was one who had been a huge proponent of this until it was in his backyard. We learned a lot of lessons. In fact, if any of you are interested, I think it's still on the Web site. There is a "CPAC lessons learned" kind of document. It's about 180 pages long and is a fairly useful summary of all the agony we went through as a group.

I'm going to move forward now and talk about things that are emerging today concerning current Medicare reform. We have demos underway for private FFS. We have a number of PPO demos, some disease-management demos and a variety of disease-management demo requests for proposals (RFPs).

The demos have had a goal of showing how the M+C program might evolve. First, in both the private FFS and the PPO, there are risk corridors in the demos. I believe at least two of the bills that I know of have risk corridors as a way to enhance plans to participate. Essentially, a risk corridor for those of you who aren't familiar with the term says choose, for example, 2 percent plus or minus around what the bid would be, and the insurer would then be responsible for 100 percent of the risk within that.

If the bid was wrong and costs are too high, CMS (i.e., the federal government) and the plan will share at some point and then perhaps go to a 90/10 share. The usual share is 50/50 outside the first level of the corridor and then 90/10 outside the second level. However, most of the corridors are symmetrical, meaning that if you have done a wonderful job at pricing, execution or risk selection, you have to send some money from positive results back to CMS.

Second, the PPOs have shown the possibility of how out-of-network benefits could be put into a benefit for people who otherwise would be in a coordinated care plan. Last, adding disease-management programs and determining how to apply those to the Medicare FFS population were goals of the disease-management demos.

I'm going to describe the Medicare private FFS demo that we at Humana are involved with in a couple of words to show that this is also being tested. First of all, when the BBA was implemented, Medicare Plus and Medicare Choice were combined into M+C by the conference committee in 1997. There were four options included: M+C HMO, which is the one with the greatest membership; M+C PPO, which I think had a couple of experiments; M+C private FFS, and that one I don't think has ever seen the light of day; and M+C MSA.

As far as I know, Sterling Insurance Company, which is or was a subsidiary of AON, was the only one that did much in the private FFS. To the best of my knowledge, it was sold in perhaps 200 counties. It had 15 members here, 20 members there and

100 members somewhere else. It was essentially invisible in any particular market.

In our private FFS demo, we had been in DuPage County, Ill., as an M+C plan. We had difficulties matching revenue and provider reimbursement, so we moved and terminated our M+C contract as an HMO and offered instead a private FFS plan in a demo version to the 7,800 members there. We had roughly 2,000 takers. That sounds pretty good. I would describe us as having some terminations and some modest sales, and today we have approximately 1,900 people enrolled. What we did do was get some experience with risk corridors. This was what we wrote into our proposal for a demo with CMS, so if we blew through the risk corridor in one direction or another, CMS would share the pain or gain.

Guess what? The actuarial work by several of us was good enough so that as of the end of 2000, with runout, we were inside the risk corridor. We may even have made a little bit of money. In other words, it was a successful demo in the sense that it proved that it could work. One of the important values of this demo is that there is a provision in private FFS that says you may deem providers to be part of your network without contracting with them.

By deeming providers, you trigger the ability to pay them under a prospective payment system. In other words, hospitals get paid using Medicare diagnostic-related groups (DRGs), and doctors get paid using resource-based relative value schedule (RBRVS). I would suggest that in communities with sole providers, you can thus change payment demands, which might be as much as 150 percent or higher of DRGs from sole community provider hospitals back down to 100 percent of DRGs and get to a reasonable payment level.

On a policy basis, I would say that's not a bad thing. We were ready to "turn the lights out" on DuPage County, and those folks would have all come back into the FFS traditional Medicare program. Those hospitals would have gotten paid exactly 100 percent of DRGs. Instead we were able to do some care coordination and to offer them a little bit of a drug benefit and perhaps a slightly better than traditional Medicare FFS system. We seem to be inside the corridor right now. As a side bar, this was good enough that we have decided to expand it somewhat in 2003 on a non-demo basis just using the original BBA.

The more interesting and presumably much bigger demos were the PPO demo programs that became effective on January 1, 2003, essentially a brand new option. I've looked at publicly available information and asked, "What do these new PPOs look like?"

The premiums range from a zero-dollar premium to $184 per month. For a PPO demo, is it really competing against M+C HMOs? In some counties or markets it is, but in my mind, it's more of a competition against Medigap insurance. When that happens, the premiums, because they're under M+C, have to be community-rated. As most of you probably know, and I'll say this broadly because I'm not a Medigap

expert, many, if not most Medigap premiums, are attained-age premiums. The moment I turn 65, I will have one premium, and those who are 75 will have a higher premium.

It doesn't work that way for the PPO demo. You get to develop a regular adjusted-community rate (ACR) proposal. You come up with a premium—and it is the same for everybody. What happens is you get more money through the ACR process because through the combination of the BBA plus the blend, as you enroll older people, you get anywhere from a little to substantially more money.

That's an anomaly of this whole program. What do the benefits look like? They're all over the place again. The prescription drug benefits have some generic or brand; others have no prescription drug coverage. On the inpatient side, there are various per-day co-pays; on the outpatient side, it's mostly co-insurance. To summarize, it looked like the average co-pay was about $10 for an office visit. It sounds like a normal PPO benefit.

In what locations are PPO demos offered? I didn't make any real attempt to be precise. Many of the major private-sector companies have tried these out. United has the most of them. We have one, and John's company has three. The total enrollment about six weeks ago was 38,000, but most of those were "rolled over" from a closed M+C contract. The observers and critics on the Democratic side of the aisle said, "See, it isn't going to work. You didn't get any enrollment." Let's just say that at this point in time the restrictions on doing these demos are fairly significant, in particular the premium, involving attained-age versus community rating. An important point to note, and this goes back to the questions of rural providers, is where can these be successful? I think out of the 30 or so demos that are up and running, most but not all of them were in urban areas because it was the combination of the floor payment being sufficient and the contracts through one form or another with providers not being exorbitant. But there is a valid question about how much low enrollment says about viability of PPOs.

Many of us are learning things from the demos. Now we get to Medicare REFORM. This is the future of M+C, the Part A and Part B benefits as they seem to be emerging today. Again, the words here are six weeks old, so I'll try to update them as we go. It generates a lot of discussion, and it may include competitive pricing or bidding instead of administrative pricing. I need to caution you on that. My only reading of the Senate Finance bill is that it is not competitive pricing. It is instead somewhere in between. It's not administrative pricing per se; it's different from the BBA provisions.

The committee is going to add perhaps a fourth prong, and John Fritz summarized the complicated formula roughly into one paragraph. Well, he needs another clause on that paragraph that may say: "And you may pay the maximum of all these, including 100 percent of fee for service updated annually by the national growth vector, error corrected."

There are other folks on the Hill who want to make that be competitively big. Among the points of discussion right now is that one of the bills says there may be only three winners per region, that the competitive bid will be benchmarked to the middle one and that will equal the Part B premium. If you're cheaper than that, 75 percent of the money gets saved, either to beneficiaries or in the form of a rebate against Part B premium; 25 percent goes to the government. If you're over that, the whole amount gets added to your Part B premium. That would be true competitive bidding somewhat similar to the way the FEHBP payroll deductions are calculated.

My point on several of these issues is that few people will find them easy to understand. We're going to have a huge communication issue.

Second, this bill is intended to include PPOs in all regions. A point I would make here is that by implementing a PPO with selected providers rather than all providers, it has a chance of working. There's a paper out done by the CMS Office of the Actuary that talks about the analysis of the roughly 30 demos and lines them up. To the best of my recollection, the paper shows five PPO demos showing savings, five showing no effect and the other 12 or so being more costly. That's under the current law.

This part about getting into all areas is going to become important to all of us in the room who work on these programs. There could be an enhanced prescription drug benefit, separate stand-alone drug for people who remain in traditional Medicare combined either for M+C or must be combined in Medicare Advantage if it's the Senate Finance version. There would also be care coordination and disease management.

It may be tied to an enactment of a prescription drug bill for seniors. Six weeks ago, this was my reading of it, and I believe that Ted Kennedy was quoted as saying, "This is our down payment for a prescription drug benefit." The next question is: What happens in the House?

My editorial comment here is that the potential for change is enormous. Medicare pays out about $400 billion a year out of the $1.4 or $1.5 trillion that we spend on health care in the United States. If you take the $400 billion over a 10-year period that's allocated toward drugs, roughly $40 billion a year gets added to that.

What's going to happen here? For many of us in the room, this is our benefit. But the flip side of that, at least for my daughters and I suspect for a lot of your kids, is that they're going to pay for it. We need to be cautious. As all of you know, U.S. Medicare is inevitably moving toward this demographic cliff. Whether it's the year 2020, 2025, 2028 or 2030, it doesn't matter. Many of us I hope will be around, but the kids are going to pay for it.

I would just point out the options that we have, at least as many as I can think of. Concerning private-sector competition, is there a chance for it to work? Again, I would say there is some possibility that new provisions could make it work. Care coordination in the FFS sector is important. We can eliminate more overpayment and overuse. That was demonstrated in the early years of the decade, when Medicare came in and cleaned up payment issues for home health care and others.

Can we reform and reduce benefits? Nobody wants to touch that. I suspect we may need to at some point. Can we increase payroll taxes? That isn't going to happen with this administration, but again, I personally don't want to see our kids having a 10-, 12-, 15- or 20-percent payroll tax for the combination of social security and Medicare.

In regard to means testing, let me raise the issue here on a personal basis. I suggest that everybody in this room earns enough to pay more than the Part B premium. Ten million people today probably can't afford it. When we retire, most of us could afford it. Is it coming?

Do we have to do all of the above? Probably. But we won't do any of the above right away. Let's see what happens this summer.

MR. HARRY SUTTON: I have a question about the health risk adjuster. With the old health risk adjuster, even though it was only 10 percent, how wide were the variations between plans and the options within plans? Looking at the new ones, do you have any feel for a 100-percent risk adjustment? How wide would the variations be with the new formula?

MR. FRITZ: First of all, the variations under the old method involved only inpatient, and the reporting was better than it will be now that we add physician claims to the mix. I can't quantify the differences exactly. There were obviously some differences. The problem is magnified when you move to including the outpatient and the physician piece because, for example, the number of members that ended up with a risk adjustment under the PIP-DCG method is somewhere in the range of 10 percent compared to the expected 50 percent under the new method.

You can see that there's going to be a huge amount of variation. For XYZ, you saw the range of 60 to 108 percent, and I think a lot of that is the under reporting issue. I suspect that there will be easily a 20-percent spread from high to low, especially when dealing with smaller entities.

MR. BERTKO: Let me answer that differently because I agree with everything that John said. Harry, if your question meant to ask what the difference in risk adjustment in plan options is in the same market, I think it's relatively small, but there is a huge difference potentially that might be from the capitation across markets. You go from one market to another market, and you might get a different

answer. But then capitation confounds the issue.

MR. FRITZ: I have to make this comment. I sat in on the Medicare Supplement session yesterday, and it was interesting to hear one of the comments that one of the panelists made, which I'm sure was true. When the company had bad experience for its Medicare Supplement and the costs went dramatically up, one of the main factors attributed to it was that a competing M+C program closed its doors and put lots of Medicare beneficiaries back into FFS Medicare. The Medicare Supplement carriers then picked up their share of this M+C terminated population and found that their claims experience worsened. This is of course counter to the reasons for which Congress and CMS wanted to implement risk adjustment for the M+C program.

MR. JEFF SANDLER: This is a question for John Bertko. You put up some options here for the M+C program and things that we can do to fix it both in the longer term and shorter term. Do you think that we can get the program fixed up and sustainable enough to continue to build enough critical mass that it's really viable in the long term?

MR. BERTKO: That's an excellent question. I'll use sustainable in the sense that it's not actuarially in balance, but it works for a while. In my opinion, there is consideration of adding additional money to the revenue in the current bills. The numbers sound big, and I've heard numbers that have been as small as $5 billion and as big as $15 billion, which would in fact be an incentive to participate as a PPO.

It will start slowly. You look back to TEFRA, which became MedRisk, and growth was small for a while. Will we ever get up to 40 percent? In my opinion, perhaps not, but it could be big enough to be significant. At least in California, FFS benefits from what's called the spillover effect of heavy use of managed care and HMOs and capitated doctors who do an excellent job keeping people healthy with less utilization. That's a very long-winded answer to say maybe.

MR. JOHN LINDSTROM: John Fritz, I'd like to turn the question back to some of the risk adjustment comments you made. You mentioned that the budget neutrality factor for 2004 was going to be 6 percent. Is that consistent with an assumption that the average risk will be 84 percent, and what does that mean relative to 100? I assume those are national numbers.

MR. FRITZ: Yes, but the 6 percent referred to 2003 and I think that's true that the average risk calculated by CMS is in that range. In fact, the risk factor across all plans that we just got back from CMS was 85 percent on average, so it's in that range. However, I don't believe that the whole underreporting issue has been taken into account for calculating the 84 or 85 percent.

MR. BERTKO: The only thing I would add to that is to the best of my knowledge the number is a projection by CMS of data that came in, recognizing that some plans, regions and markets were incomplete. They got to choose which ones they thought were complete. I believe they projected factors from others and came up with that 0.85 number, which then turned into the 16.3 percent budget neutrality adjustment factor.

Chart 1

Medicare+Choice Growth Rates* for Calculating Blended Payments, 1998-2004								
	1998	1999	2000	2001	2002	2003	2004	Cumulative
Projected trend change in per capita costs*	3.4	4.0	5.8	6.0	5.6	0.9	3.7	29.4
BBA Statutory Reduction (Lag)	-0.8	-0.5	-0.5	-0.5	-0.3	0.0	0.0	-2.6
Corrections For Previous Years' Forecast Errors								
1998	-	-0.7	-0.6	-4.5	1.9	0.0	0.1	-3.8
1999	-	-	0.5	-3.6	-0.9	0.7	0.4	-2.9
2000	-	-	-	1.5	-2.1	-1.1	-0.3	-2
2001	-	-	-	-	4.0	-1.6	1.1	3.5
2002	-	-	-	-	-	-1.9	2.1	0.2
2003	-	-	-	-	-	-	2.2	2.2
								-2.8
Projected Change in National Per Capita M+C Growth Percentage	2.6	2.7	5.2	-1.3	8.3	-2.9	9.5	24.1
Actual change in per capita costs (corrections for forecasting errors)	-0.4	1.1	3.8	9.5	5.8	3.1	3.7	26.5

* Data based on CMS 45 day notices. Final rates may be slightly different.

Chart 2

Percent of Counties Receiving Floor, Blend or Minimum Increase, 1998-2004

Year	Floor	Blend	Minimum Increase	Floor Payment
1998/1999	33/40	0	66/60	$367/$380
2000	29	63	8	$402
2001	31	0	69	$415
2001 (Post BIPA)	70 81%L/19%H	0	30	$475/low $525/high
2002	80 81%L/19%H	0	20	$500/low $553/high
2003	0.2 100% high	0	99.8	$495/low $548/high
2004	84 81%L/19%H	0	16	$536/low $592/high

Chart 3

Impact of Legislative* & Administrative# Changes On M+C Payments

(Billion) $$	1998	1999	2000	2001	2002	2003
BBA '97*	-0.9	-2.4	-5.0	-5.8	-8.4	-10.0
BBRA '99*				+1.5	+1.2	+1.2
BIPA '00*				+0.6	+2.5	+2.4
Admin.#			-0.2	-0.7	-1.5	-2.5
TOTAL	-0.9	-2.4	-5.2	-4.4	-6.2	-8.9

*Based On CBO Reports;
#CMS/ HCFA Estimate

Chart 4

M+C Enrollment

(in Millions)