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Session 101 PD

Medicare Modernization Act (MMA) - The Biggest Challenge to Medicare Since 1965

Track: Health

Moderator: John F. Fritz

Panelists: Corey N. Berger
Patrick J. Dunks
Steve Lieberman†

Summary: The Medicare Modernization Act (MMA) implements major changes to the Medicare program. In particular, MMA added a Medicare prescription drug benefit and made significant changes to the Medicare Advantage (formerly called Medicare+Choice) program. The panelists will overview the MMA and then discuss the major changes for the 2006 plan year in more detail. Key topics include:

- *Medicare Advantage Changes*
  - *o Nonbidding issues*
  - *o The new bidding process*
- *Part D*
  - *o Competitive bidding*
  - *o Plan design and actuarial equivalence*

†Mr. Lieberman, not a member of the sponsoring organizations, is a partner at The Moran Company in Arlington, VA.

NOTE: The chart(s) referred to in the text can be downloaded at:
http://handouts.soa.org/conted/cearchive/neworleans-june05/101_bk.pdf.

MR. JOHN F. FRITZ: I'm with PacificCare. We have three distinguished presenters. I'm looking forward to their presentations because of their background and experience. Steve Lieberman is a partner at The Moran Company. He joined that company in October of last year after retiring from the federal government. He has an interesting background for making this presentation because of his experience with the federal government. He was an important member of our PacifiCare consulting team to help us strategize our thoughts for Part D these past few months. In 2004, he was a senior advisor to the administrator of the Centers for Medicare & Medicaid Services (CMS) and led the drafting of the Medicare Modernization Act (MMA) regulations and other MMA implementation efforts.

From 1999 to 2004, Steve led the health staff at the Congressional Budget Office (CBO) serving as the assistant director for health and human resources and CBO's executive associate director. In addition to guiding a staff of over 30 analysts concentrating on health, Social Security, human resource and microsimulating modeling, he led CBO's team working on the MMA. Steve also has extensive federal and private sector experience in health care, Social Security and federal budget issues. In fact, he started his career with the federal government back in 1976 with the Office of Management and Budget (OMB).

Corey Berger is a consulting actuary with Reden & Anders and has been specializing on the Part D side of late. He was intimately involved with a number of clients and did quite a bit of work in helping them with the development of their Part D products. I often heard his voice during the conference calls that CMS held with industry actuaries discussing Part D over the past months.

Our third panelist, Pat Dunks, is a consulting actuary with Milliman, Inc. The most interesting part of all the changes in this whole MMA and Part D area has been the addition of Part D. I appreciate the fact that Pat was willing to talk about the less interesting, but also important, parts of MMA.

MR. STEVEN LIEBERMAN: I feel a little odd talking to people, many people, I suspect, who just spent an ungodly amount of time on the topics we're about to talk about. My task is to try to put the MMA in context, and I want to do that in a couple of ways. The first thing I'm going to do is highlight Part D from my perspective at a high level, and part of this is trying to bring people back from preparing bids and talk about some of the key features from a policy perspective of the drug benefit.

Having spent a good portion of my professional career on budgeting and finance issues, I'd like to remind you of the larger context for Medicare. I'd like to then point out some of the key features of MMA and remind you that, even if there hadn't been the Medicare Advantage (MA) program changes and even if there weren't the Part D changes, the MMA would be in and of it itself a significant piece of legislation.

Then I want to briefly talk about whether MA is repackaging old wine in new bottles or whether something significant has changed here. Probably the most unenviable task is to try to explain why Part D is so complicated and, frankly, so weird and try to put some of the political forces in perspective that drove some of those outcomes. Last, try to start thinking about the question of, if in five or 10 years we're going to look back at the MMA, how would we assess it?

From my perspective, there are three key pieces to think of in terms of the new Part D benefit. The first is the most obvious. It rationalizes the benefit and design that was created in 1965 and largely reflected BlueCross BlueShield plans of the 1940s. In that sense, it is reflecting the massive changes in the role of pharmaceuticals as part of the delivery of health care.

The other interesting piece of the rationalization, which is less obvious to some, and there would be less of a consensus because proponents of social insurance might have different views on this, but for the first time a Medicare benefit is differentiated based on income.

The second feature, which is somewhat more abstract but I think critically important in some sense, is the biggest watershed that this statute creates; its reliance on competition and its departure from relying on administered prices.

Last, the piece that I think everyone would agree to regardless of whether one thinks expansion of the benefit is appropriate, regardless of whether one believes that the competitive model will work or not, is that without dispute, the new Part D benefit has added significantly to the cost of the federal budget and essentially is redistributing money from our children to ourselves. I am speaking as somebody who's in the baby-boom generation and is close to being eligible for Medicare. At least it's in my reasonable horizon.

The postwar federal budget has averaged slightly more than 18 percent of gross domestic product (GDP), about 18.2 percent. I believe counting the years of World War II, there have only been three occasions where our willingness as a society to tax ourselves has exceeded 20 percent of GDP. It's never hit 21 percent of GDP. Spending in the federal government is generally 18 percent to 20 percent of GDP.

The compelling point is the three entitlements for seniors, and to a lesser extent disabled—Social Security, the federal share of Medicaid and Medicare (and I've differentiated Part D)—will essentially triple over the next 75 years. The scary part to me is that in approximately 50 years, these three entitlements for the elderly will consume the entire federal budget; what we currently spend, by the way, exceeds what we're willing to tax ourselves. The question of whether we can afford adding 3.5 percent to GDP over the long term by adding drugs to the mix is an interesting question.

As actuaries, you are aware of the projections that over the next 30 years, according to the Social Security Trustees Report, we'll be literally doubling the number of Medicare beneficiaries whereas, at the same time, we're going to be increasing the work force by a projected 15 percent. That, coupled with the fact that we're having increasing longevity, explains the increase in the Social Security line as a share of GDP. The scary part is that the combination of the twin demographic effects of the baby-boom generation and increased longevity only accounts for about 30 percent of Medicare's cost growth over the 75 years. Seventy percent of the projected growth in Medicare costs is associated with the fact that cost per capita are growing faster than the economy, faster than GDP per capita, and is what many people refer to as the excess cost growth factor.

The good news about excess cost growth is something we've done by construction. We assume now that excess growth will exceed the economy by only one percentage point. Up until 1999, in spite of the fact that there was a 35-year history of health care costs exceeding growth in the economy by something like 3 percent, it's averaged over 3 percent since the inception of Medicare. If you go back to the mid-1950s, it's averaged over 3 percent. Over the past two decades it's been about 2.5 percent.

The people who know Medicare understand that the excess cost growth in Medicare has been despite virtually continuous efforts to hold down the cost of Medicare. The good news is we assume excess cost growth is 1 percent. The bad news is we never empirically attained that in any period of time. Bending the cost curve down, I would argue, is a critical piece because what we're talking about over the next 75 years is Medicare consuming roughly 75 percent of what we historically have been willing to tax ourselves as a society.

Let me now turn to the MMA and suggest that beyond the first three points (the creation of the new drug benefit, the almost unique reliance on competitive bidding coupled with sending strong price signals to beneficiaries to drive both enrollment and market behavior, and the MA program and the question of whether there's much beef there or not is), which are the headline parts of the MMA, four other key features of the MMA are worth noting and are significant in and of themselves.

A title of the MMA created health savings accounts (HSAs). Another title created an income-related Part D premium. Again, while the thresholds are high and the dollars generated by this are low, from a social insurance perspective, having a differential financing linked to beneficiary income is a major departure. It's one that having created the precedent, one could imagine the amounts being ratcheted up. Similarly, there are varying benefits by income. and that was done for jurisdictional reasons to keep the Ways and Means Committee having jurisdiction over the benefit because the Ways and Means Committee doesn't have jurisdiction over Medicaid. Within the Medicare statute this is the first time that benefits are linked to income.

While people can argue about the significance of it, there were reforms that will promote generic competition against branded drugs. There was a significant change in how Medicare pays for Part B drugs, primarily chemotherapy drugs.

Let me just say a word about MA and try to frame a portion of what I think Pat is going to touch on, although he will speak in depth on many other subjects. From my perspective, the three key things about the MA title is that, first, it increased payment rates. Second, it created regional PPOs. Third, it purports to move in the direction of competitive bidding and away from administered prices. I leave it to you as experts to figure out how much of that was rhetoric, how much of that was real, and how much we moved to competitive bids either in local MA context or in the regional MA PPOs.

For regional PPOs at the time of the legislation, and this is one of the places where my former colleagues and I may, in retrospect, have some estimators' regret because what we clearly thought was being done in the statute is not what was clearly done by the statutory language, it certainly is not what is being done by CMS and the way it's implemented the program. CBO assumed that, in essence, you could not create geographic arbitrage; that the statute did not allow the effect of the regional PPOs to have averages that were based on regionwide benchmarks that would then be distributed in ways that plans could game so that you get an average reflecting high-cost and low-cost areas that would payable for enrollees only in low-cost areas.

The Office of the Actuary had a slightly different expectation. CBO basically said if you didn't have geographic arbitrage, even though the new payments rates would be above fee-for-service, they would still generally be below plan cost. The actuaries had a different view. They thought that clearly payment rates would be above fee-for-service, but they would also be above plan cost. As a consequence, the actuaries assumed that there would be a major change in enrollment and the associated increase in cost, and CBO had minor growth in enrollment.

The real issue is whether geographic arbitrage is being created. I believe that with the way the benchmark is calculated on the beneficiary distribution and the way the bids are calculated based on enrollment, it is still possible to have at least in a technical sense a sustainable gaming ability of the geographic factor. The question whether that's politically sustainable is another interesting question.

Explaining Part D is perhaps the most unenviable part of my task. Part D is exactly the benefit that a committee of crazy people trying to design something would come up with, and not something that most rational people would come up with. The biggest factor driving the design of Part D is that it was an entirely budget-driven exercise. Over the four years that the Congress was considering a drug benefit, the number ratcheted up. Congress and the administration decided that they were going to spend $400 billion on creating a drug benefit. Images come to mind about

trying to get 20 pounds of sugar into a five-pound sack. You can change the substance in your mind about what people were trying to get in. It became increasingly almost litigated in a lobbying sense. A lot of the odd provisions about medication therapy management and any willing pharmacy and so on were attempts to play bait and switch where the Congressional staff was responding to interest group pressures to liberalize things without having CBO score it as increasing costs. There are some fundamental laws of nature that don't work there.

What people wanted was a benefit that would cost $1 trillion, and the House democratic alternative cost over $1 trillion. It was a standard 80/20 benefit with about a $25 premium and $100 deductible. A bunch of conservatives either wanted nothing or maybe they were willing to spend $100 billion for some form of catastrophic relief. The political compromise was $400 billion. Most of the weird features were driven because people were trying to maximize the political attractiveness of what they were able to offer within the $400 billion budgetary envelope.

A secondary and fundamental ideological issue that had gotten fought out a year before the MMA passed was the issue of whether there would be multiple competing plans that would be at significant financial risk or not. You may recall that the Clinton administration, which opened the current round of debate on extending prescription drugs to Medicare, proposed having one regional carrier, which was not at financial risk as their model. The Clinton plan featured only prepayment and only covered initial expenses, and it had no catastrophic feature.

But the Republicans and enough of the Democrats in the Senate agreed to a system of multiple competing plans. For those of us who staked our professional reputations on the fact that if we gave the $50 billion party, people would come, I would note that the incredible workload that many of you have experienced over the past several months in getting your bids done has the implication of, first, making me feel vindicated in that projection but, second, makes me wonder how beneficiaries are going to navigate through many thousands of plan options.

The low-income subsidy was driven by the fundamental point that we didn't have enough money to spend. Under the standard benefit, the beneficiaries pay the first $250. Of the next $2,000 of the drug spending, the plan pays 75 percent on average. The beneficiary will pay 25 percent. Of the plan portion, obviously the beneficiary premium is going to add to its share.
From the plan perspective, the projection is that CBO at the time was a median drug spending in 2006 that would be around $2,200. Right around the fat part of the distribution from a plan perspective, it's as if you get 100 percent reinsurance, and from the beneficiaries perspective, it's as if they no longer have any insurance.

After $2,850 for those people who don't have third-party coverage, a reasonable catastrophic benefit kicks in where the beneficiary pays 5 percent, the government

through reinsurance pays 80 percent, and the plan through its premiums pays 15 percent.

The political compromise that was made to avoid crowding out preexisting private insurance was to give everybody who had third-party coverage the direct subsidies associated with the first two of the benefit, but that the beneficiary qualified for the catastrophic part of the benefit only to the extent that the spending was out of the beneficiary's pocket. By the way, not that everybody would know this other than those of us who were involved, in 1987 the Reagan administration proposed true out-of-pocket as its way of dealing with catastrophic that was being discussed at that time. The reason for true out-of-pocket (TrOOP) is, I think, due to the estimates that showed that only 25 percent of beneficiaries had no drug coverage. The question was how to avoid crowding out the 75 percent who had coverage and not just federal government replacement. It was already in existence, and TrOOP was an attempt to do that.

I mentioned catastrophic. For those of you, again, with long memories, the enactment of catastrophic in 1988 was met with great expectation, only in 1989 it was repealed. Probably the best projection that I've done in my career was before we went to conference in 1987 and 1988 I wrote a memo to the director of OMB and the Chief of Staff of the White House predicting the repeal of catastrophic. The only thing I was wrong on was I thought it was going to wait until April 1990 because of the tax structure.

But the lesson that came from that is that catastrophic insurance isn't popular. One hundred percent of beneficiaries know what they are going to pay, and the 7 percent who were going to benefit didn't know who they were, by and large, and weren't vocal. Part of the reason for the bizarre enrollment features are as a matter of ideology, but also a matter of politics. Congress wanted to be able to say that it wasn't forcing any seniors to buy into this new benefit.

The last point to note is that it was a straightforward Republican agenda item to take away the advantage the Democrats had as a straight partisan issue with social insurance in general and Medicare in particular.

Let me now conclude and frame the question of how we think about MMA. On the one hand, is it a far-reaching shift that is a pivot point from which we will have major reform that will start to bend the cost curve down? Clearly, the reliance on competition is the biggest single feature that could do that in my mind. It's probably the best shot we'll have for a generation to make a competitive system where we use market forces rather than administered pricing work. Making the benefits related to income reverses what it had been up to now. Shifting from universal social insurance to some sense of need is a major philosophical departure as is income related to Part D premium for the same reason.

We're taking away the universality that has been part of the mantra since 1935. The creation of HSAs from the proponents of people who believe in high-deductible plans is a major shift and is arguably significant. I'm more pessimistic, but I'm not nearly as active in that marketplace as many of you are. The creation of the Hatch-Waxman reform may, if we start to have quicker generic competition through branded drugs, be a significant reform. Clearly, if you listen to oncologists screaming about the changes in both how and how much Medicare is paying for drugs, it is significant. I think the jury is open on the MA reforms.

The case that I think is much easier to make, at least at this point, is that MMA, as part of its lasting legacy, will be a major expansion. Adding 3.5 percent or 3.4 percent of GDP is in most people's book a significant expansion. The other part is that in my terms the MMA has created an unfilled, unfinished and unstable benefit. Every year there are going to be efforts in Congress to fill in the doughnut hole and TrOOP to limit the increases in the annual levels of the deductible and premiums which go up at per capita drug spending. Please note that elderly income at best goes up with combined premium increase (CPI). I think that those will be continuing efforts for having a politically potent group, the seniors, get more and fill in the perceived holes. The only counter force will be some abstract notion of fiscal restraint.

The question in my mind is will reform trump expansion? The first part of the question is will Part D work as it's intended? There are two elements to that. Technically will it work? Will CMS be able to set up rules that are stable from a competitive environment? If that happens, will that competitive environment function? Then you get to the tough part. If the competitive environment functions, that means at some level people making drug purchases get steered away from what their native preferences might be. Will the Congress let that system be sustained? For those of you who went through the Patients' Bill of Rights debate and some of the issues on managed care, I would argue that the price pressures and the pressures to steer here are much greater than what we saw in the Patients' Bill of Rights environment.

The bottom line is, Will market forces be allowed to work and, if they work, will they bend the cost curve down? If they work but don't bend the cost curve down, the history will be we may have gotten the better way to allocate prices and allocate resources, but from a macro perspective, we'll have something that's unaffordable.

MR. COREY N. BERGER: How many people did bids? (About half of the audience responded.) I think the subtitle of the MMA was "Full Employment for Actuaries Over the Next Three Years." If you look at what's going to happen for the bids next year and the year after that, there's going to be a new process for each of those years until you have real data to look at.

I will give a brief agenda with some background on the MMA, Part D, and bid

development, and then I'll give you observations and strategies based on some of the things that, as we went through the process, we came to realize were going to be important in the bidding process.

There are many potential markets for prescription drug plans (PDPs). There are a number of different markets, stand-alone PDPs. The primary market is probably going to be the individual market in 2006, which would include the dual eligibles that will be autoassigned into the different plans whose bid prices end up at or below the mean bid price for a region. Employer groups have the option of becoming their own PDPs or contracting with a PDP to offer the basic coverage and then buy up supplemental coverage. How many employer groups take the subsidy versus the PDP is still an interesting discussion. I think a lot of employer groups are beginning to look at whether PDP might be an option as opposed to the subsidy. There are a number of different subsections there, as well, and I think Patrick is going to talk about that, so I won't go into that in any more detail.

Everyone has his own little version of what the benefit looks like. None of them is drawn to scale because if you couldn't see anything except for the catastrophic coverage. Even though there aren't many people out at the catastrophic end, they do drive a large portion of the total drug costs of the program. The basic benefit design is the $250 deductible, 25 percent coverage, from $250 to $2,250, and then comes what CMS affectionately calls the coverage gap. For the catastrophic coverage, once you hit $3,600 in TrOOP, the copayments are the greater of either 5 percent or $2 generic, $5 brand copayments, .

The list of Part D pricing issues kept growing as you dug deeper into doing this pricing. We had some data sources including some provided by CMS. I'm sure plans that had some senior members through employer groups or MA plans had their own data, but it was difficult trying to figure out how to use those data and apply it to this new benefit design. Each seemed to come up with its own formulary and came up with the USP Model Standard, but I don't know whether anybody used it. There were also generic usage and mail-order usage considerations. What could you do to incent generics, which would drive your bid price down? What if you came in with a low bid, and people didn't use generics as often as you assumed they would?

The type of benefits to offer is going to be one of the most confusing things because of the variety of benefit designs that seniors are going to be faced with. There will probably be at least 20 if not more options available in every region with different prices and different formularies. If people didn't sign up for the discount card, the big question is, Will people sign up for this when they can't decide what it is they need or want? What it's going to cost or what it's going to cover?

What is the impact on reinsurance? If you're offering supplemental coverage, what kind of adverse selection might this drive? This is still one of the biggest unknowns out there. What are the terms of your pharmacy benefit management (PBM)

contract, and how should you represent that in your pricing assumptions? The risk score also is an issue. Again, nobody's quite sure where those are going to come out. What is the institutional proportion expected to be in the population and your low-income dual eligibles who are eligible for the low-income subsidy? You also need to consider your administrative cost and profit requirements.

TrOOP is the way that the government determines when you will be eligible for the catastrophic coverage. It counts how much money the member has spent. There are certain items that count toward TrOOP, such as what the member spends and what a family or friend spends. State pharmaceutical system programs and charities and a lot of other items mainly related to other insurance or employer payments don't count toward TrOOP, so until the member spends $3,600 in a year, he's not eligible for the catastrophic coverage, and it can end up with some interesting results depending on your benefit design whether you hit TrOOP at the $5,100 of total pharmacy spend for an individual, which is the number most people talk about, or above or below that level.

There are additional Part D features. The plans must offer single uniform premiums to everybody in their region, although you can have a different premium and a different bid by region. One of the most interesting things will be to see the range of premiums by region because CMS had published on its Web site some geographic utilization factors, and there were clear differences by region. You may see some regions with $10 and $15 premiums and other regions that don't have any premiums below $25 or $30. The political ramifications of that will be interesting to see, as well.

My blue state/red state analogy is if you look at those utilization factors, all the ones below one are blue states, and all the states above one are red states. It may be a slight exaggeration, but it's close. It could be interesting come December 2006 if there are a handful of states that all have premiums that are $10 or $15 higher than other states.

There are different risk sharing features; the risk scores which get applied. I've got a discussion a little later on that. With the reinsurance, once somebody hits the $3,600 in TrOOP, the government pays 80 percent of the cost, and then there are risk corridors which are the aggregate stop loss. If your bid came in, and you thought you did it right and then end up 10 percent above cost, the government shares some of that extra cost with you and vice versa if you end up 10 percent below your bid. You have to give money back to the government in the latter case.

I'm going to skip over formulary provisions except to mention that there were requirements regarding what had to be on the formulary. Steve talked about the fact that there was another requirement that you had to perform medication therapy management for people who were either high-cost or used a lot of drugs. A lot of Part B-covered drugs are not covered under Part D, although there's still a

question of whether the providers will somehow figure out how to move these costs from Part B to Part D, especially in light of the reduction in payment the providers are going to get in 2006. You had to also do an actuarial certification for the Part D bid.

One interesting point is that competition may have worked in this case because the estimate from CMS as shown in the trustee's report was that the national average bid would probably be between $107 or $112. Looking at what we did and talking with other individuals who did bids, we now believe that national average may be at or below $100. There is definitely some incentive among plans to try and come up with creative ways to either incent generic usage or come up with others ways to bring that level down. Some of it was because the prospect of autoenrollment of the dual eligibles was enticing because there will be little, if any, marketing cost for these enrollees. Part of it was just a competitive reason. From a competition standpoint, CMS may be pleasantly surprised with where that national average comes in. Basically, it's an overall weighted average of all the bids with the weights being an allocation of the number of Medicare eligibles in each region divided by the number of plans that submit bids in that region.

CMS is one-sided as far as bid negotiations. If it doesn't like your bid, it may come and talk to you about it. If it does, you may never hear from it.

General strategies and observations are the more interesting part of how all this played out. One of the items is the impact of MA enrollment and penetration on the low-income benchmark. To be eligible for autoenrollment of the dual eligibles, you have to be below a certain premium level in the region. Premium level is going to vary region by region. In a region that has high MA penetration where there's also high reimbursement on the AB side, there's the opportunity for an MA plan to buy down the Part B premium conceivably to zero and conceivably even on a supplemental plan to zero, and that will be weighted in to this low-income benchmark. So in a state like California, which has 25 percent or 30 percent MA enrollment, you could find that the low-income benchmark is $15 or $20, whereas in another state it's $30 or $35.

The low-income benchmark is the lesser of the weighted average of the MA plans and the PDPs in a region or the lowest standard PDP bid in a region. For example, in 2006 there are two plans that are eligible for the low-income subsidy autoenrollment. If you project it out to 2007, where a couple of the PDPs dropped out maybe because they didn't get any enrollment, and you look at site growth in MA enrollment and the PDPs that had a premium below the low-income benchmark, the predominant ones in 2007 got the autoenrollment. When you do a weight on actual enrollment in 2007, you see that low-income benchmark number driven even lower, in which case only one plan would be eligible for the autoenrollment, although conceivably at that point CMS is not necessarily going to move all of the people that were in the plan that's no longer fully eligible for the premium subsidy.

Another item that was an interesting aspect of the benefit design is that the standard Part D benefit is a front-end-loaded benefit. If somebody has $4,500 in allowed claims in a year, he's exhausted his benefit by June. From July through December he's getting no more payment. It's all out of pocket. So if that individual knows about what his spend is going to be, he could sign up May 15 for June 1 enrollment date because there's no reason for him to be paying the $35 premium for five months to then pay it for the last six months of the year and get no benefit. He'd rather just pay his own claims and then start paying the $35 premium in June and get the maximum bang for the buck.

If the discounts are significantly better than what the member gets by paying cash, maybe that argument falls hard. On the opposite end if people are trying to figure out 20 different benefit designs, it may take them six months to figure out what they want to do anyway. What's interesting though is in that situation where someone has $4,500 in allowed claims, if he signs up on June 1, the payout date, the incurred liability is the same as if he signed up January 1. We collect only seven months of revenue both from the member and from the government in the latter case, which has a huge impact on what the actual per month per member (PMPM) liability is over the course of the year. If you're looking at average spending and doing some projected enrollment that starts in January and goes through June, it could increase your basic bid by as much as 10 percent if people don't show up in January.

When CMS did its risk score development, it came up with two lines that trended up slowly, and it said. "Our risk score looked pretty good." But what it was comparing was if you have a risk score of 1, what's your average claims? They had people that were below 1 and people that were above 1 on plan liability, and on average it looked pretty good.

The problem is if you flip that. If you've got claims in excess of $5,100, what's your plan liability relative to average versus your risk score? Those people have a risk score of 1.25, but their actual claim liability including the catastrophic is more like a 2. Imagine one that's basically your normal time series that trends up slowly and another one that starts at 0 because if you have no claims, you still have an average risk score of about 0.6. Then it looks like what all our stop charts should look like, which is it basically goes geometric. If you're off on the right end of that chart, and you've got a lot of people with catastrophic claims, you're not going to be made whole by the risk score.

For people who had claims over $5,100 on average, you get paid about 65 cents on the dollar to what your actual costs are. Whereas people between $250 and $800, and the $800 was kind of an estimate of who will sign up because they know that the premium plus the benefit is a win for them, get paid about four times in terms of revenue of what their actual costs are. There's definitely some risk in this.

Obviously, the risk scores would mitigate some of that, but all you end up with is people above $5,100. You can still lose money on this, so it's no guarantee that you're going to make money.

Some of the risk scores show that if you're enrolling people with higher than average claim costs, the risk scores won't pay you adequately. If those same people, the ones who are above $800 in cost, are the only ones who enroll, if you get enough people between $800 and $2,000, you'll end up okay. But if you end up with only the catastrophic people, it's not going to be pretty. Is the late enrollment penalty going to be understood by Medicare members? Will it incent people who have no claims to sign up? Nobody's sure.

I talked a little bit earlier about geographic factors. There's significant variation by region across the country. If you've ever looked at studies of geographic factors, Kentucky is always the highest. The lowest is Alaska. The bids could vary widely by region and could result in varying member premiums by region. There could be some political fallout from that.

There are two options for rebates: either to do them on a point of sale or on aggregate. If you filled out the bid form, the aggregate was one number that got allocated partially to the bid and partially to the reinsurance. The point of sale reduces member out of pocket but increases the bid because if you did the allocations on aggregate level on the bid form, it reduced the premium so that it gave you a better bang for your buck if you were trying to come in with a lower bid.

There are no risk corridors for employers. CMS is figuring if you're an employer, and you offered a drug plan, you don't need the risk corridors. You already know what your drug spend is. If there's a noncalendar-year plan, there's no government subsidy for the reinsurance, which could be a big deal. CMS is saying that it expects all employers to offer rich benefits, and no one would ever hit $3,600 in TrOOP anyway. The payment is based on a risk-adjusted national average instead of the employer bid, which is I think an interesting concept. I haven't figured out exactly how all that math works yet. The application was due April 25. The formulary was due when all the bids for the normal PDPs were due. The bids for the employers are due July 1.

There are going to be a number of competitors. I heard CMS for both the Part B bids, for the MA plans, and the standalone received somewhere between 3,000 and 5,000 bids. It's a shockingly high number, but it shows that people are interested. The formulary will have an impact on your success. The premium level will clearly have an impact on your marketing. The MA penetration will have an impact on the number of people, the pool you're available to draw from, as well as that low-income benchmark, what employers do. In 2006 a lot are still indicating a subsidy, but that may change over the coming months. Benefit design can also drive people to or from your plan based on what your generic cost sharing is versus brand.

Some areas to be reviewed are still applicable even after the bids are in. Look at your membership enrollment projections. What does that do to your bid and your cash flow and your overall liability? Look at cash-flow testing, dual eligibles, what the low-income subsidy benchmark will end up being, rebates, geographic adjustments, selection and your benefit design impact. How that increases or decreases what you collect on your low-income subsidy is important.

MR. PATRICK J. DUNKS: I will get right into the MA or Medicare+Choice, as it was formerly known. The government, CMS, will pay you a capitation for a member. It'll pay that amount, which represents in a loose way its expectation of the cost to that person in that cohort for the year. that you, as a plan, take as risk.

It's all risk-adjusted. You may or may not have a member premium depending on your market and the cost in your area. What you provide is traditional Medicare costs. There may be additional benefits, as most often is the case, and you usually have to squeeze your admin and profit out of that also. That's your flat amount of money per person, although it varies by person. You have to live with it for the benefit promise you make.

What are the issues that MMA brought up? MMA brought payment increases, very significant increased payment trends and a new regional PPO option, which was added to the old option, HMOs, local PPOs, private fee-for-service and medical savings accounts (MSAs). We saw some change in the market. We saw a lot of local PPOs come in for 2006. One of the things the law did was to start the regional PPOs. If you're not in by 2006, you have to wait two years. A lot of people rushed to get their local PPO plans in for 2006. We saw an increased interest in private fee-for-service plans with the payment changes, and MSAs remained, as far as I know, completely dead in the water with the present rates. I don't know of any real bids or activity there. It's possible there's one that I don't know about, but the rules don't make a lot of sense for those currently.

Every MA plan had to offer at least one plan with the mandated prescription drug coverage, that or greater. Risk adjustment, although it's not new to MMA, would emphasize it's going to continue on its existing course, and it remains a key element of MA plans both on the drug side and the medical side. Bidding process replaced the adjusted community rate proposal (ACRP). It is a different process. It's run by actuaries rather than accountants. It remains to be seen how CMS is going to review them, but the actuaries are in charge. I suspect the accountants will get their fingers in the review somewhere along the way, but we won't know until we get our feedback.

Previously, it was clear that the accountants planned to leave it to the actuaries until the end on the ACRP review. By the time we got to the end and had findings that CMS thought were significant, the actuaries there were saying it's not

important; a nickel on $800 a month is just noise. Now we have to have those people upfront, so we'll see what happens in the review.

There were other things that changed in the bidding process. CMS shares its savings, and I'll go into an example about that. There are a few other changes, which I'll mention along the way. I think the most important provision was the change in payment rates. You bring money, and guess what? Health plans go where the money is. That additional money was enough to bring a lot of interest in health plans. There's money on the MA side, plus on the Part D side there's a funding source for drugs that are packaged together in many markets that have significantly more revenue, others with the savings feature you may not have a whole lot more, but those markets were generally pretty well off in terms of payment rates, so at least managed care costs in the area anyway. Another key element is that future payment rate increases will be linked to Medicare fee-for-service trend. That means, in the long run, revenue and costs should trend similarly.

Previous to MMA, we had a market where cost had trended faster than revenue, and we, as actuaries, know in that market that it's not a long-term sustainable program where our costs are going up more than our revenue. Up until MMA, the program was a death march watching to see who would come along. As an actuary specializing in Medicare, I wished that Congress would do something that it indicated it would do for a long time, and that was that it was going to do something to help fix the program. I got what I wished for: the Full Employment Act for actuaries. I think toward the end there was a two and one-half time full-time employee (FTE). I'm sure most of you actively completing bids experienced similar occurrences as CMS issued guidance sometimes about certain elements a couple of weeks before the bids were due. You can tell that the actuaries at CMS had not worked for a health plan.
How have the payment rates changed? Before MMA, we had a lot of areas, a lot of counties in the country, where the payment rate was less than the projected fee-for-service rate. After MMA, we had no more. The average is 107 of the population. Previously it was a 102. On average the starting payment rates increased about 5 percent throughout the whole country. That's not insignificant in a program with the enrollment of Medicare. This had a lot to do with why a lot of health plans got interested in Medicare.

The costs were increasing faster than revenue. That's the business model that doesn't work in the long run. In the new picture, they should trend similarly. If you come out with a benefit package that works in terms of cost, your revenue should increase similarly. Things like competition could change that, but at least as a starting basis you're in a reasonable starting point, or you make a big investment in this product and then in the long run have an expectation that it could continue, at least subject to the next congressional act. There is an expectation somewhere along the way that Congress may take some of this money away. But as we get more seniors in the program, it makes it more politically difficult to do so. While as

a taxpayer that may worry me, I'm less concerned as somebody heavily involved in the Medicare market.

The other reason people care about this market is the population is exploding out here. As an insurer in the health market, it's hard to ignore the fastest growing segment of the population. It's hard if you are an insurer and not in the Medicare market to just turn your head away from it, ignore it when it's growing revenue and cost, and you could be in a place where you can make things work.

As a MA plan, CMS made some projections. With all our changes, it estimated that 31 percent of market share of Medicare eligibles would be in MA by 2009. Given it was at 12 percent in 2004, that's quite a leap. CMS has no interest in understating this estimate, however, we're seeing a tremendous growth in the number of plans. As individuals from the commercial market aging into Medicare and the use of health plans, HMOs, PPOs and those kind of choices, it'll be more readily acceptable of these new options. It's not unreasonable to expect the number to grow a lot. While you may not agree with 31 percent, even if it's 25 percent or 22 percent, that's a significant growth from where we were in 2004.
What has the market done? We've seen a lot of new organizations leap into the MA market in the last year. A lot of them have gone to service area expansions. Many organizations have expanded back into areas they had previously left. We've seen many new benefit offerings, particularly the local PPO offering. There has been a lot of activity for existing HMOs having that local PPO option if they have the appropriate life insure. That seems to be the latest trend. This market is funny. It runs in what I call the herd mentality. One starts running toward something, and then they're all doing it. When one starts leaving, they all start leaving in the same mentality whether it makes sense individually in their local markets or not. I've seen it happen through various cycles of Medicare. It should come down to a local market decision in general because health care still is a local market. Payment rates vary market by market. Competition varies market by market. But it will be interesting to see what the market does and how the market adjusts over time.

Regional PPOs were added beginning in 2006. I don't know how many bids CMS got for regional PPOs. I expect it has a smattering based on what I hear in the industry. I don't think every region will necessarily have a regional PPO. I'm not certain about that. A lot of the big organizations like PacifiCare, for instance, don't hire a lot of this work out, and it's pretty tight-lipped about what it does, at least until such time that the competition doesn't have time to adjust, and justifiably so. What that meant for regional PPO is, as I already mentioned, if the local PPOs had a moratorium on starting, they had to be in operation in 2005 or they could not start in 2006 or 2007, and they couldn't expand the service area. That's why, in part, we saw a big bump in local PPO activity: the rush to beat the deadline. The other part from a marketing point of view is it attracts a different segment of the Medicare population than the HMO market may, particularly in markets where PPOs are more dominant on the commercial side as opposed to HMOs.

There are regional PPOs in CMS in 26 regions. The regional PPO has to cover all of the states and counties within a region, every nook and cranny. CMS is liberal. In fact, in terms of the provider networks for regional PPOs, at times, I didn't recognize them. This is what the regulators alluded to almost 20 years now. However, of late they've come around a little big and starting to turn askew toward organizations. They're still being receptive to weak provider networks for regional PPOs, but where there isn't a real network choice for people in more rural areas, they're saying you can cover a network. As long as you cover benefits in network in those areas where your network is too thin, we'll let it go. That's an acceptable solution. So they came to the industry and almost begged for regional PPOs.

Steve mentioned that regional PPOs could develop county-specific, regional adjustments that CMS could readjust for county rates. Steve indicated he thought it might be an opportunity for gaming the system. I'm going to disagree with that. The plans have to be actuarially supported by your underlying costs in the area while you can pool CMS for a year or two while you're a startup. Over time, that's going to shake things up. You also have to use a projected enrollment with that. When you do that, all that it does in total is a zero sum game to recomposite what you had at different adjustments. In the absence of developing your own rate, you use the difference between the local county rate and the published county rate from county to county. The CMS can help if you have an area with particularly high costs relative to what CMS publishes and others that are lower. You can help limit your enrollment mix risk. Your risk there is that you enroll people differently from your expectation and end up with different underlying costs. By matching your payments to your cost better, you can limit the risk that you get people in higher cost areas. But, again, it's a zero sum gain, so I don't think any gaming is sustainable in the long run.

There are some specific benefits to benefit design consideration with regard to regional PPOs. There are also some interesting provisions. Congress did want regional PPO participation. It had risk sharing where regional PPOs will share risk with the government if their cost falls outside of certain corridors. They'll provide additional hospital payments to what are critical hospitals, those hospitals that are essential to the network if the health plan is offered and Medicare reimbursement, and they refuse because Medicare reimbursement is lower than their costs. If they can demonstrate that, they can get extra payments from CMS to be included in that regional PPO network.

There are largely one-time incentive bonus payments. First they have to have a nationwide plan in every one of the 26 regions. Those people get a one-year bonus, and there are some retention bonuses that might stretch two years if they had otherwise intended to leave. In general, those bonuses are nice, but they usually come in your first year when your enrollment is low and then go away. They're not a reason to do it in and of themselves. There was a lot of discussion of

organizations wanting to do regional PPOs because of the bonuses early on. Unless you're going to go into the area anyway, it doesn't make a lot of sense. The bonuses are nice, but I don't think they're enough to tip the scale.

We have mandated drug coverage for it. Every MA plan has to offer at least one plan in each service area it's in with drug coverage at least as rich as the standard Part D coverage, the exception being private fee-for-service plans. It does not have to offer drugs. It could offer other plans with richer drug coverage, at least as rich as Part D, to account for at least one plan. It could have, if it were richer than Part D, if that added to member premium and it wasn't paid for by AB rebate, you had to have one also as standard. It could offer richer only if it paid for the marginal fees for AB rebates. It could also offer plans without drugs. What I saw in the market is that most organizations or most of the benefit plans offered it with and without drugs because it was easy to do. It might not be the case where they had Medicare Advantage Prescription Drug (MAPD) with a zero premium where benefits were already rich, for example in Florida or New York.

Risk adjustment is important, particularly in the capture of appropriate diagnosis information, and it also impacts the drug, the Part D reimbursement. It only emphasizes how important that is for a health plan to collect diagnosis data appropriately. The industry remains vigorously at work in spite of all the changes at gathering diagnosis data better than it used to.

While the law said the bidding process was based on a national profile, what happened was if you did your bid on the MA side, it's on your profile. Then it took some elements that it brought it back to a 1.0 nationwide average, but, in essence, you did it on your expected profile, your cost projections, and the stuff that went through a nationwide average is more window dressing than anything for most plans. The bids previously were due in September. Every year from now on they're going to be due the first Monday in June. Payment rates will be announced the first Monday in April. CMS has the authority to negotiate bid amounts in portions including supplemental benefits.

When I read the law, first of all, it sort of scared me. CMS keeps referencing the Federal Employees Program for its ability to negotiate there. and the way the federal government operates is a little scary from a health-care plan point of view. It tends to go back in time and ask for lots of money in the Federal Employees Program when it audits you, which doesn't make for a good business partner. It also has the ability to negotiate as it's reviewing these bids. It's not going to negotiate a lot, but if it thinks you're out of line in your estimates, it will intercede. We have actuaries who are doing things now in preparing bids. I think it's a much more difficult sell. In ACR there wasn't an actuarial certification required, and health plans often filled their own ACRs out. Sometimes I would see ACR with such silly things in them. When the accountants reviewed them, they wouldn't catch them, but I don't expect the actuaries to be fooled similarly, so we'll see about that. Those

of you that submitted bids will feel that over the next several months.

Basically, if you bid below benchmark, you create savings. If you bid above, you create a premium on traditional Medicare benefits. Your bid is based on traditional Medicare benefits, and you also include a Part D item. As you bid, you bid at traditional Medicare. You come that to benchmark, which is essentially the county payment rate adjusted to your population. The difference is called saving. That's a new term in CMS's world. You bid with the Part A deductibles, a 110, Part B, and I guess it would be projected at 123 for 2006, and 80/20 coinsurance on Part B. That's how you prepare your basic bid. You compare that to the risk-adjusted payment, and the difference is the savings. CMS keeps 25 percent of that savings. I think that's where the saving terminology came from. The other 75 percent is labeled as a rebate. You have to spend that rebate on the member for extra benefits covering cost sharing, buying down the Part B premium, buying down the Part D premium or any of the above. You get to decide how you spend that. It's all justified in the market.

There are other long-term changes. MSAs were made permanent for the experiment. Nobody cares yet to my knowledge. Private fee-for-service had a clarification in the law that they can, indeed, have a network. That wasn't a change. That was just clarifying something that already existed. Medicare is going to have an open-enrollment period each year. The lock-in is going to change the market a lot. Marketing is going to be concentrated on the annual enrollment time except for people aging, and many organizations are going to have some sales representatives not having a lot to do outside of that lock-in period. It may change how people market. It may mean that people start looking more at agents who could do something else the rest of the year in the MA market. I've seen the market move toward almost exclusively being in-house marketing and in-house sales staff to starting to include brokers and agents in many organizations with MA.

One of the big new areas for 2006 and 2005, besides local PPO, are special-needs plans. A couple plans that are deemed in the law were for dual eligibles and institutionalized people. A special-needs plan is allowed to limit its enrollment to just those special populations, which is different from a regular MA plan. Special-needs plans can also cover people with selected diseases. The organization that wants to be a special-needs plan has to make its case to CMS that there should be a special-needs plan and that it will provide a better program for that population. Cost contracts will fade away if there are at least two competitors in the area.

The market is changing, but the changes vary a lot by geographic area. Your strategy is to respond and realize opportunities will also vary or should vary by market. I'd consider five considerations. The first is payment level. We're still in business. It's about money in many, many ways. Second is the ability to contract out of a low Medicare at all the levels, fee-for-service or utilization patterns. Third, consider your competitors in the area: MA or Medicare, Medigap. I don't know how

you can beat them or likely other future competitors, and you may hear about that through the providers. Fourth, watch out for the savings recapture and phase out of budget neutrality in terms of the risk adjustment. It has a potential to take some money out of the program relative to what's been in there this next year. They'll start phasing that out next year. They sort of started this year, but more officially next year. Finally, you need to watch out for risk adjustment. Watch out for special-needs plans. They could cherry pick the best risk and a one-time regional PPO bonus. The population is growing. The market is changing, and it's competitive.

FROM THE FLOOR: You mentioned that there have been several thousand bids submitted. Do you have any idea how many different companies or plans are represented by those several thousand? Is it 100 plans per company average?

MR. DUNKS: I think that the larger plans probably did submit a lot. We did a lot of plans. It probably varies. The consultants who have dealt with some of the smaller companies can maybe address that also.

MR. LIEBERMAN: What I saw was a range of probably three or four bids through an organization up to over 100 if they were going to be a nationwide PDP. We see a wide range, and I would expect Corey saw something similar.

MR. BERGER: I think PacifiCare indicated that it had done five bids per region, so that would be 180 right there. I would imagine a lot of the national players that were going off for national PDP probably had a minimum of two or three per region, which is how you get to such a high number.

MR. TIMOTHY N. JONGERIUS: It was mentioned there are going to be a lot of options for seniors to consider with perhaps a lot of confusion. Did I hear that there was a certain amount of money that is going to be spent by CMS to try to educate seniors? What are the hopes for seniors to get a firm enough understanding by 2006 to make decisions? Will they come in in droves or be completely baffled?

MR. BERGER: CMS is definitely going to be spending a significant amount of money on outreach and marketing and education. I think there will be money spent from CMS's perspective. I think somewhere between six and 12 million people will be autoenrolled. Nobody's sure how many dual eligibles there are that would be autoenrolled. My sense is if you end up with $10 or $15 premiums in certain areas, that's probably going to attract enrollment that might not otherwise have happened in the $35 premium because then it's just buying something to avoid the late enrollment penalty, whereas $35 a month may be more than somebody wanted to spend. I may give the general population too much credit, but there will be people who don't use drugs who will shop on price, and people who do use drugs who will shop on formulary and benefit design. I think that it will make for an interesting dynamic in terms of who buys what.

MR. DUNKS: I think the administration is committed to making this understood by seniors as best as it can. I think we're going to see a blitz of the order of magnitude that we've never seen, at least in my working lifetime, in terms of getting people understanding their options, and that will all happen this fall. It'll be fast. The seniors will be confused, and there will be states that are confused by this. They're supposed to help on the effort. I'm not sure they will. Some states might hinder the effort, but there will be a lot of confusion. When the dust settles, it's an attractive benefit, Part D, for seniors. It's highly subsidized, and it's pretty hard for the majority of seniors to walk away from it.

MR. LIEBERMAN: It's important to think about distribution channels. The people who are, as Corey indicated, dual eligibles are going to be autoenrolled. There's something called facilitated enrollment, which requires identifying people as being low-income subsidy, but once they're identified, they will also, in effect, be put into plans. HR departments are going to heavily steer people who are in retiree-based coverage, which is about 30 percent of the population. I see the business imperative for MA plans as retaining their existing enrollment so that the question of how that works and how the role of Medigap companies as being able to market to their existing members if they're offering Part D is addressed. Large groups of the population will have active marketing efforts that will steer them. The question is, Who remains up for grabs?

MR. TRACY E. MAPLES: For the supplemental carriers that are going to be out there trying to compete in this market or just service this population, how are the products going to be marketed to this 25 percent of the population that's got the supplemental coverage? Is it going to be agent-driven? Do they need to be licensed as an insurance agent with the carrier that they're representing for the PDP plans? Is there room for compensation?

MR. LIEBERMAN: On its Web site, CMS put out phase one of the marketing guidelines. Phase two is yet to be issued. It's supposed to be issued shortly and will deal with the issue of agency brokers. There's an internal set of disputes about what the rules will be. My anticipation is that they will look much like the rules for agency brokers in Part C.