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Session 107PD
Medicare Modernization Act (MMA)—Changes to Health Plans

Track: Health, Pension

Moderator: JOHN S. CATHCART

Panelists: PATRICK J. DUNKS
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Summary: Panelists discuss current implications of the MMA on insured health plans, including: Medicare Supplements; revisions to standard plans H, I and J; new Medicare Supplement plans K and L; and market penetration of Medicare Advantage Plans (Medicare HMO products).

MR. JOHN S. CATHCART: Today we'll talk about the impact of the MMA on three sets of constituents. There's some interaction among the three, and I think that some of the presentations will get into that. But in general, we'll discuss the impact of Medicare modernization on Medicare Advantage (MA) plans, what was referred to in the past as Medicare HMOs or Medicare Plus Choice. We'll discuss the Medicare Part D plan, the new Medicare drug benefit. In particular, we'll discuss how health plans are dealing with that. And we'll talk about the impact on Medicare Supplement plans. For a lot of the first two constituents, the impacts spill over into Medicare Supplement plans, and we'll get into some of that.

Let me briefly introduce the speakers. Stephen Wood is a managing principal with Reden & Anders in Chicago. He leads the senior market and individual market practices. He's worked with most major insuring organizations serving the senior

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Note: The chart(s) referred to in the text can be downloaded at:
http://handouts.soa.org/conted/cearchive/neworleans-june05/107_bk.pdf.

market to develop strategies, conduct new product feasibility assessments, improve performance and implement new strategies. Before working with Reden & Anders, he was a principal with Tillinghast. Before that he was the managing director of strategic consulting services at the Blue Cross & Blue Shield Association. He has extensive experience in managed care, government programs, senior markets, MA, disease management program evaluation and implementation and Medicare Supplement product development. He's done everything with the market that we're in, I think. He is a graduate of the University of Chicago, holds a master's degree from the Harris School of Public Policy at the University of Chicago and has co-authored a book, *Implementing a Successful Medicare Managed Care Product*.

Patrick J. Dunks, who will be speaking first, is a principal in the Milwaukee office of Milliman, where he's been since 1985. His area of expertise includes health care programs with an emphasis on managed Medicare products. He's also worked with clients with Medicare Part D and all MA issues. He has worked with HMOs, insurers, provider organizations, employers and as a resource to other Milliman consultants, providing input to the Centers for Medicare and Medicaid Services (CMS) in developing managed care products for Medicare. Pat is a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries and a member of the Wisconsin Actuarial Club and the American Association of Health Plans. He completed his undergraduate work at St. Norbert College in De Pere, Wisconsin, and holds a master's degree in math from Purdue University.

Steven Keck is a principal at Wakely, where he has been since 2001. His expertise is in Medicare Supplement and other supplemental health products. Before working at Wakely, he worked with several insurance companies in the Southeast. He began his actuarial work in 1988. He is a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries and has a degree in math from Birmingham Southern University. Without further ado, I will turn it over to Pat to tell us all about MA.

MR. PATRICK J. DUNKS: The market is changing in 2006. Basically every Medicare benefit is up for grabs in 2006, so we live in interesting times in the Medicare world. At the beginning of 2006, every Medicare beneficiary should be evaluating whether they're going to be in a drug benefit. At the time they do that, they may reevaluate their Medicare Supplement coverage, as compared with MA, and how everything interacts. I think what we have is a market that's likely to change. We speakers may make predictions, but we really don't know where it will end up. We'll see a lot of jostling, particularly this year, and then there'll be some aftereffects as people settle down.

We saw some big changes with the MMA, and a lot of it had to do with money. What we really saw was that a lot of people entered the market. MA plans have to have mandated prescription drug coverage. There's a bid process replacing adjusted community rate proposals (ACRPs), and CMS will share in savings. We don't know yet how many plans we have for 2006. I saw something published by

CMS for the 2005 number. That's where I picked it up (Dunks Slide 1, page 2). The 2006 is just my guess of what the number of MA organizations will be. This doesn't include the Part D stand-alone carriers that don't do MA. Again, this is my guess based on the level of activity, so take it for what it's worth. But I'm certain it's a bigger number than 179 because the market's growing. How much greater, I don't know. It could be 250. There's really been a lot of activity, a lot of feasibility activity.

There've been new organizations, some of them coming in as special needs plans (SNPs). We've seen a lot of Medicaid plans come in as SNPs for dual eligibles. They take their Medicaid program and extend it to those also eligible for Medicare, which is almost a more natural extension for that population for the dual eligibles than commercial plans extending to Medicare, and then traditional Medicare, MA, extending over to dual. These are the same folks in the dual SNFs. They'll be caring for the same folks they did until they hit age 65, so it's a pretty natural transition. We've seen a lot of that activity.

We've seen activity just getting into new areas, a lot of local PPOs. There's a moratorium on new local PPOs. In early 2005, we saw a lot of local PPOs rushing to get into the market. Local PPOs specifically are most often—I can't say always—looking to enroll Medicare Supplement members. You folks who thought you won when you raised your hand for Medicare Supplement, guess what? MAs have their sights on you, the local PPOs. They have their sights on your members, and that's specifically who they're looking to target.

We've seen existing organizations add service areas and add plans. For instance, a lot of HMOs added that local PPO option in the last year, and new benefit plan offerings, particularly the local PPOs. We've also seen greater interest in private fee-for-service plans, and they seem to be expanding their reach, certainly marketing more actively than they used to. I've heard ads in various parts of the country for them, and two years ago I can't say I ever heard that happening. I didn't hear from local plans that they're either in or out of the MA market. I didn't hear that they were active in their market. I might have heard they were in their market, but they'd tell me they, in essence, didn't have a place. They really weren't doing anything with their product. So things have changed. They've heated up. They're more competitive. Frankly, I think it's a lot of fun.

As I said, regional PPOs were added. I think for 2006 we'll see—and again, this is a guess—a limited number of regional PPOs. I'm aware of a couple going on, but I'm sure I'm not aware of all of them. Folks keep these under wraps. Each region is its own study. There is a school of thought that says as a local plan, you should be able to laser your service area, pick and choose those counties in your service area that are most favorable—the payment rates versus the underlying costs—and, given that, you should be able to be more competitive than a regional PPO that has to cover the whole region. I think the bigger impact maybe of regional PPOs is the local PPOs all rush to get their packages in. By February 15, 2005, they had to have

their applications in to be local PPOs. That deadline, because there was a moratorium on new local PPOs or service area expansions for the benefit of the regional PPOs, had the impact of getting people to act quicker. There's a tendency to put this stuff off until you have to do it. I think a lot of people wanted to get this in rather than wait until 2008 to have a local PPO. So, they got a lot of local PPOs in.

CMS said that more than 90 percent of Medicare beneficiaries will now have an MA option. That's a big number. So they'll have some choice. It might be a private fee-for-service plan. It may have premium. Some MA plans have member premiums, and some don't, depending on the market. What that says, as I said, is that Medicare Supplement carriers, they're coming after your members. They've always been doing that, but they're doing it in a bigger way. It remains to be seen whether seniors will move from Medicare Supplement. Some may, but some may not.

Mandated prescription drug coverage means that for every MA plan, they have to offer at least one plan as rich as standard Part D. They can offer other plans with drug coverage, but if they do, it has to be at least as rich as Part D. They can't offer any plans with drug coverage that is less than Part D unless there's no drug coverage. So, it's either at least Part D or not at all. What we saw MA plans do in terms of benefit offerings for 2006, in terms of filings, very few outside of the SNPs for duals, and they almost all filed standard. Very few offered the standard benefit plan package. The majority went to what's called a basic alternative package. Most of them went with no deductible and then co-pays on up to the $2,250 spend limit that were equivalent. The actuarial value was the same as the standard Part D plan. They had the coverage gap, and then they went with catastrophic coverage, like the standard plan. That was by far the most common design I saw out there.

I did see a few with the $250 deductible. I saw some as a standard, and they did a standard equivalent plan and used co-pays to replace coinsurance. Most of the co-pay plans were four-tier or five-tier. You had generic, preferred brand, non-preferred brand and usually something they called biologicals or injectables, often at a coinsurance amount or very high co-pay. Sometimes they separated those into four and five tiers, but that's sort of the structure of the plan we saw in terms of filing.

Other plan designs we saw included what I'll call a generic fill-in plan. Often this was an enhanced plan. Somebody would take the standard benefit design, translate the cost sharing, the 25 percent, to co-pays but then under the deductible cover generics at a similar co-pay and maybe through the coverage gap cover generics. There was some mild interest in that. It depended on the market. That was a more popular plan in markets that historically had very rich benefits and no member premiums or in markets where the prevailing drug coverage with the MA plans was generic-only. They previously covered generics without a limit. So for those plans, it fit for their existing members as a transition. It wasn't taking anything away. I

would say that's a characterization of what I saw MA plans do in their benefit package offerings.

Many of the SNFs went with mandatory generic. Most of the MA plans also offered their A/B options without drugs. They usually had what's called an MA-only, the medical-only benefit package with no drugs, just in case seniors would decide they don't want Part D. It was pretty easy actuarially to fill out that bid form without a lot of additional work. You could base it on the work you had done for the A/B plus Part D together to fill out a bid form and offer a choice for those. It was a little more troublesome in markets where we had zero dollar premiums for A, B and D, where the A/B rebates would pay for Part D. Then you had to add benefits to the A/B side so you could get back to zero. There were a couple of markets where people had Part B givebacks because the benefits were already so rich that was the only way they could get to an MA-only plan.

There are other things that continue in the MA market. This is critical. This isn't really new, but there's just more emphasis on it as we go forward. On the medical side, on A/B, the risk-adjusted payments will be 75 percent of payments to MA organizations in 2006. On the drug side, it's 100 percent. In 2007, it's 100 percent in both models. Both those models work on gathering all the diagnosis information for those folks, for the covered members, and it's a prospective risk adjuster. It looks at diagnoses. For 2006 payments, it'll pick diagnoses for 2005 claims, so it picks up basically hospital and physician claims, or 2005 looks at all the diagnoses, and the risk adjuster predicts what that person would cost in 2006, both on the drug side and on the A/B side.

Thus, if you're a MA plan and don't do a good job of capturing diagnoses—either your providers don't code them well or you as a health plan have claim adjudication where the folks go through and only pick up the first or second diagnosis because it helps them process a claim faster—you're shooting yourself in the foot with revenue. You'd better fix that. As you go through, this is one of the things you look at. MA plans are looking long and hard at this. They're trying to figure out which providers code well and which ones don't, so they can work with the ones that don't code well and get them to improve because it impacts their revenue in a big way.

For 2006, we had a bidding process. Early on I was a little concerned about this bidding process. I had a lot of chief financial officers (CFOs). As an actuary, I knew I would have to sign a statement. I knew there would be pressure from CFOs who didn't understand the process to bid right at benchmark. The savings are determined by, on the A/B side, taking the benchmark, which is the published rates adjusted to your population, and subtracting your bid, which is your cost for traditional A/B benefits for your population. The difference is called savings. CMS keeps 25 percent of the savings. Naturally no CFO wants to give anything back to the government. Even before we got into any numbers, they were saying, "Why can't we just bid at benchmark?" When you add back extra benefits you must have a cost of those extra benefits, and it all flows to member premium.

They wanted to make the A/B bid artificially higher to lower the additional benefit cost artificially to sort of game the system. We had to sign a statement, so it was tough. CMS did us a favor in the bid form. They told us, "You put in your gross cost. We'll use our percentages to determine what the A/B bid is. You don't have any judgment there really. It's pretty much that we've told you what to do." They really took all the potential judgment out of that process, and in some ways it made life easier. CMS just said, "This is how you have to do it."

I can't think of any plans I had that didn't have savings in terms of their bidding. Maybe there was one. All of them had savings. All of them had to give something back to the government compared to what they used to get, but many of the plans had drug benefits. The reduction in drug costs, because of a separate funding vehicle in Part D, often offset what they gave back in the savings calculation.

This is just a quick example. If we have an unadjusted benchmark of $680—this is from the rate book—you as a plan estimate, demographic and risk together, that your payment would be $612. That means your implicit risk factor is 490. If you put together a bid with allowed medical, took out traditional Medicare cost sharing, your admin costs and your target gain/loss, that brought you to a risk-adjusted A/B bid. Then to get your unadjusted A/B bid, you just simply divided by the risk factor. While the law said you had to do it on a 1.0, on the A/B side they really didn't do it. As I said, CMS kept 25 percent of the savings. Almost nobody bids above benchmark. That would almost be silly, so I won't talk about that.

I talked about the flexibility in terms of the bids. CMS will look long and hard at your administrative profit margins. How they'll do that isn't clear. They haven't provided a lot of guidance. I think we'll learn a lot through the review process. In general, plans were very uncomfortable with the lock-in this year. This is the first year that they had to bid and live with their benefit package. In the past they always said, "If I go out there with a premium and a benefit package that isn't quite attractive enough, I'll just bump it up for February." They could always do midyear changes, as long as they were enhancements from the member point of view. Now what you file is what you live with. It's caused people to be a lot more forward-thinking. They're very nervous about what they put forward. In markets where there's a big gap between the prevailing payment rates and what managed costs were, there were lots of savings. Most of those markets already had a drug benefit, so the impact to savings was offset in part by Part D initial revenue.

As for medical savings accounts (MSAs), I still don't think we've seen any activity. The rules aren't very favorable. I mentioned earlier we saw significant private fee-for-service growth. Plans are figuring out what to do with their sales staff outside of the lock-in period. This will be a late fall kind of open enrollment, and I think we'll see most everybody's advertising spent in a very concentrated period to target that open enrollment period. Cost contracts will be phased out if there's more than two MA plans in an area.

One of the concepts you might be concerned about as an MA plan is whether these SNPs, particularly the disease ones, might cherry-pick what's considered your best members. I don't call them your best "risks" because with risk adjustment, risk is different than it used to be. The best members are those on whom you think you can generate the most margin, and typically managed care can have more of an impact on a sick person than on a very healthy person. With risk adjustment, the world is tipped upside down in terms of how we think about enrolling people. As I said, all of this will vary by market, and the market's up for grabs.

One key point is that prescription drugs as a health plan may not be the magnet for an MA plan that it used to be because they can get stand-alone Part D now. You'll have to provide a total package as an MA plan to demonstrate your value to members.

MR. STEPHEN WOOD: I'll be talking about Part D, which is the prescription drug piece. I'll limit my comments to just Part D and then segue into Medicare Supplements. What happened over the last six months or so regarding Medicare Part D is that a party was thrown. The invitations went out about a year ago, maybe in December of 2003, and for about a year, it was uncertain if anybody would show up at the party. By December of '04, we're looking around, saying, "Hmm." Pharmacy benefit managers (PBMs) are saying, "Forget it. There's no way I'm going there. I'm not taking risk. I may contract with an insurance carrier to provide their pharmacy benefit, but we're not doing Medicare." Right?

I'm convinced there was a tent meeting somewhere in December 2004, and they all went to this meeting. They all got saved because by January 2005, it was all bets are off. PBMs are not only willing to take risks, they are looking for risks. Medicare Supplement carriers that hadn't really done much of anything for 10 years all of the sudden wanted to become a prescription drug plan (PDP). A what? MA plans are looking at themselves saying, "People enroll with us because of the pharmacy benefit, and if we have all these other things in the market, what's our value proposition? Where are we going to go?" People began to take a second look at regional PPOs. The last folks to wake up are the employers, and they've begun to wake up, I think, in the last month or so. So we'll see a fair amount of movement on the employer side, I think, as well.

Just in terms of timing, the majority of the bids—those of you who worked on bids know this all too well—were due on June 6, and that was a little tense. To be exact, they were due at midnight Pacific Daylight Time on June 6, and some of us were filing 15 minutes before then. It was crazy. We at Reden & Anders did about 1,500 or 1,600 bids, so we know that there were several thousand, and it was an overwhelming response. I mean amazing. I would never have guessed this, never have predicted this. In any particular region in the country, there'll probably be at least a half-dozen PDPs, the stand-alone pharmacy plans. You combine that with multiple benefit designs, I might add. Very few went in with just a standard benefit design. They've revamped their benefit design. They made it much more customer-

friendly, and they priced these very aggressively. So you'll have between half-dozen or so PDPs in the market, with maybe two or three or up to five, like PacifiCare indicated, offerings in each market.

We're talking about an enormous number of options. I don't know if any of you listened this morning, but President Bush was on the radio exhorting people to talk to their neighbors and their parents about the pharmacy benefit that's coming out later this year, so it's started. In the last session somebody asked, "Will CMS promote this?" Well, $200 million worth of promotion around Medicare Part D will occur in the last quarter of this year. In the spirit of all boats rise and fall with the tide, there will be a lot of activity. There will be a lot of potential market movement, and it will be simply confusing. For those of you who are sitting or working on legacy books of business of several hundred thousand Supplement lives or MA lives or what have you, the question is, where are my people going? If I have a Medicare Supplement individual whom I've had on the books for 10 years, and all of the sudden the American Association of Retired Persons (AARP) comes along and says, "I have a pharmacy benefit for you. Why don't you come up and sign up with my pharmacy plan?" I might not be real warm and fuzzy about that.

What are they doing? The legacy carriers and the folks in the marketplace are saying, "Oh, boy, I didn't file a bid. I missed the boat. I didn't think that this would happen. Now what do I do?" We're seeing all sorts of alliances or attempts at alliances or sort of post-mortem, which is sort of where this is going, between Supplement carriers and these start-up PDPs and distribution channels and the like. We live in interesting times. On the Part D response, there are lots of PDPs, lots of action, on that score.

Employers are reacting with, "Ho-hum, yes, something's happening out there. I can get 28 percent of the first $5,000 for a subsidy, and that sounds pretty darn good to me." That's the case until you tell the employers, and I won't belabor this because I did this a couple of days ago, that this isn't just like the feds writing out a check to you and you get to go cash it, with no strings attached. There's a big long string attached. Federal money doesn't come with no strings attached. It comes with False Claims Act. It comes with all of the acquisition regulations. It has all of that dandy stuff. Plus, do you think it will be easy to get the money in the first place? We'll see. So, employers are, by and large, going for the subsidy. There's a glimmer of interest among certain sectors, and I think that will be a 2007 play.

HMOs are trying to figure out who they are and what they represent in the marketplace, but they're certainly sitting on a huge stash of money this year and next year, so good benefits and attractive products. As Pat said, dual eligible plans, the Medicaid plans—the plans that a lot of us tend to sort of ignore—have come to life. SNPs are coming up like mushrooms. The fact of the matter is, there are a lot of duals. There are about 6 million duals out there, and they're all in play because the states are trying to get out of that involvement with the duals as fast as they

can. They're out of money. They want somebody else to take these on. And with risk adjusters, as Pat said, it's not such a bad deal.

For Supplement carriers, it's, "What? Did something happen? Should I have been paying attention to this?" We were talking at breakfast this morning. Some Supplement carriers—I'm sure none represented in this room—still don't understand that pre-standard products with a pharmacy benefit can't continue with the pharmacy benefit. Pharmacy's out. Pharmacy's taken over by D. If you have a pre-standard product out there with an embedded pharmacy benefit, that baby's gone, at least as it exists now. There are a few things that are happening in the world.

What about the states? Don't even go there. The states are very upset about this whole thing, particularly the departments of insurance that have these PDPs they don't know what to do with. We split the baby, so we're going to go 7.5 percent risk-based capital, which is an interesting compromise between 3 and 15 percent. The pharmaceuticals actually stepped up to the plate. Amazing! The levels of rebates, discounts and other goodies that the pharmas threw at the PBMs and PDPs is unprecedented, better in some cases than commercial. It's unbelievable pricing on the part of pharmas. I was stunned. We all thought pharmas would just take the money and run. They realize if this doesn't work, you know what the next game is. We're talking national. We're talking resource-based relative value schedule (RBRVS) for pharma, for drugs. So, they're betting the farm that this has to work out.

And for PBMs, as I mentioned, it's be there or be talked about. They are very much in the game, and some are taking risks. Others are partnering. Even more interesting to me is the transparency or the seeming transparency the PBMs have been willing to engage in during this rate-setting process. Let's face it. PBM pricing is like, "What am I buying here?" But in fact, the PBMs have come clean. At least we think so. If they try to hide the rebate, somebody's going to jail. So, there are certain governors on this process that certainly allow that.

For those of you who are interested in Part D pricing, we probably won't get a chance to go through it, but one thing to take away is there's a big difference between bidding and what you actually get because Part D retail pharmacy payments from the feds are risk-adjusted. Of course, since nobody's provided this benefit before to anybody to date, who knows if the risk adjusters actually will be correct or not? We've done a lot of work as a firm, and I'm sure your firms have as well, on modeling what the pharmacy costs are and trying to apply the risk-adjusted payment to those drugs spent, and they seem to work reasonably well. But the fact of the matter is, we don't know. The revenue stream that you get out of your Part D benefit, though, is dependent on who enrolls, what their risk score is, if there's any adverse selection going on, what your admin and overhead is, luck and your out-of-pocket premium. That's just the back end. If you're interested,

take a look at the slides in the back end of this presentation because they step you through the process.

So let's look at the market segments in bidding for a second. On the process of setting a bid for the benefit design, remember there are 40 million Medicare beneficiaries out there. The duals, which comprise about 10 percent, or about 4 million, maybe about 6 million folks, are true full-benefit duals, and they are auto enrolled. They're in January 1, like it or not. There's another—we really don't know how many—5 million to 7 million folks in low income. Whether or not you think Part D will work or you think that individuals will or will not enroll in Part D, 10 million people will be getting their retail pharmacy benefits through a PDP come the first quarter of 2006. That's a lot of people. How many are getting them through PDPs now? Zero. PDPs didn't even exist. In fact, arguably they still don't exist yet. They're coming together. This is a huge deal. These are untested organizations to a population that we largely haven't had a lot of experience on, and they're the early adopters.

What are the other segments? Medigap. Between 25 and 30 percent of the eligible population are in Medicare Supplement products. Managed care is about 15 percent, or the MA plans. We're all hot and bothered about managed care plans and MA. That affects 5 million people out of 40 million. Just keep those numbers in mind. There are 35 million people who don't enroll and haven't enrolled in Medicare HMOs. Now, Medicare HMOs could double, up to 10 million, and almost be as big as Medicare Supplement, and that's not going to happen. We might see managed care roam up to 6 million or 7 million, but we're not talking about massive wholesale enrollment. Part D is now. With PDPs, everybody's in the game. We have 10 million out of the box, plus all the MA plans, plus the employers and the other organizations. So, you have a lot of potential in the marketplace. On the payment side for the Part D carriers, we have an 8 percent bump for duals and 21 percent for institutionalized, plus they are risk-adjusted.

How does the bidding process work? What's different between Part D and MA A/B is that for A/B, the feds set the benchmark. For PDPs, the benchmark is a function of the bids. That's why a lot of people are sweating right now. We don't have any clue what the national benchmark will be. The national average is a combination of the plan bids and what the plan estimated the catastrophic coverage would cost. The CMS brings these all together and then calculates what the national reinsurance estimate is and what the bid amount is. Then below that, it calculates the regional averages based on a couple of other factors. So, the national average going into the bidding process was thought to be probably 110 for Part D only, not including the catastrophic. It may be south of that by now. We don't know, and we can't violate antitrust by sharing our bid results yet.

Wood Slide 7 works through an example. When you hear about the $35 premium—and this example worked out to $34.43—this is by statute. The 25.5 percent is what Congress set as the amount of the out-of-pocket for the individual to buy a

standardized pharmacy benefit. Let's say that the national average bid was $25, the national average bid was 110, and the catastrophic estimate was 25. You take 25.5 percent of that, and you come out to $34.43. If the average was 100, it'd be 25.5 percent of 125, not 135. When you calculate all these averages, and you can work through these slides yourself, what you're trying to do is compare what you bid versus what the national average is. So, if the national average turns out to be 110, and you bid 95, then your premium will not be $34.43. It will be something substantially less than $34.43. It won't be the full $15 less because of the calculations, but it will be substantially less. Ideally I want to price point my product. I want it to be $29.95. I can't do that. We don't know what the averages are. So we'll end up with these products in the marketplace at price points that we didn't anticipate. It's an interesting process.

If the plan bid, for instance, were 105 in this case and the national average is 110, then that $5 will translate into a member premium of $30.29. If the national benchmark were 10 percent higher, you can see that, in fact, your out-of-pocket premium would be even lower. But because you don't know whether it's 110, 121, 100 or 95, you're sort of stuck, at least in year one. Hopefully by year two and year three we'll have some experience, but in year one we're throwing darts. By the way, nobody knows really how to price this product anyway because the only data sets we have for people who've had pharmacy coverage for seniors are groups. No individual has pharmacy. They have some crummy HIJ product with $1,500 of reimbursement for $3,000 in spend. That's not a pharmacy coverage. Even at Reden & Anders, we basically have about 500,000 lives with people who have full benefit, almost nominal out of pocket, unlimited pharmacy coverage primarily through groups, and that's the database that you're using to calculate the bids. Do group retirees represent well the rest of the Medicare population? It's as good as we can do. So year one pricing is kind of interesting. Year two, we'll get better at it, but year one is an interesting situation.

In terms of sources of revenue, you have member premium and your out-of-pocket premium. You have your federal Part D subsidy, which is the low-income subsidy. You have your reinsurance estimate. The other portion of the subsidy is the 74.5 percent, which is the amount that the feds have dedicated to the program.

Wood Slide 12 shows risk-adjusted payments for an entire state's dual population. Remember that we were talking about risk adjusters before and whether they work. We're talking about 400,000 duals here. The pink line is the risk-adjusted payment based on the HIJ scores of that population because we had the medical side as well. The blue dots are the actual spend. Look how nicely that tracked. The only problem is if you get all those people out on the tail, you have a problem. Then adverse selection sets in. This slide shows you that while risk adjusters for a population work, for any individual, the risk adjusters don't work, understandably.

The people in the left side of the page don't spend money on drugs. You'll always be overpaid for somebody who doesn't spend anything. You'll never have a risk

adjuster of zero. It will be 0.8 or something. It won't be zero. You're being overpaid for people who have no drug spend. For folks who are on the right side, no matter how much you get paid—if somebody's on a drug that costs $20,000 a dose, for example—you won't get paid enough. Your job, as plans, is to get a balanced selection of folks in the program because adverse selection doesn't go away with risk adjusters.

What are Medicare Supplement plans faced with? For one, they may or may not want to be a PDP. In fact, PDP's a different game. There's lots of risk. Medicare Supplement carriers tend not to take on a lot of risk because they're filling in the gaps in Medicare, and Medicare's the primary adjudicator. But what do Medicare Supplement carriers have that PDPs and PBMs and even MA plans don't have? They have agents, boots on the ground. And those agents are hungry. They are all over it. They want to sell Part D in a big way, and they're not looking for the commission. They're looking for the contact with the individual. It gives them an excuse to call the subscriber and chat with them about the Part D benefit. Then, they can add, "By the way, how's your life insurance doing?" It gets them in and makes sure they don't wander off to somebody else, and it allows them to sell them something else.

So, agents are absolutely the key, and now we're seeing PDPs begin to wake up and smell the coffee. CMS is helping the Supplement carriers out in a big way because CMS has told many PDPs recently—in the last two weeks—that you can't do telephonic enrollment. You have to have a signed application. You can do it through the mail, but our preference is face to face. The only way that PDPs will get face to face in 34 regions across millions of square miles is with Supplement agents, people on the corner.

MR. JACK STEVEN KECK: Those of us who work with Medicare Supplement are somewhat accustomed to the changes that occur in this product due to changes in Medicare. After all, we're working with a government program. It's always changing. The changes generally are around benefits that are not quantified within the policy forms. A good example of this is the Part B deductible, which is now being indexed to the changes in the payments for Part B services. The changes now being brought about by the MMA are quite substantial compared to the past. The changes not only affect pricing of new products, but also will have some effect on existing policyholders, which may or may not affect their premiums. As we've heard in many sessions so far, the creation of the Part D program and many of the changes brought about by the MMA are some of the most substantial changes in Medicare since its inception. I believe much of this is to reflect how people are receiving their health care today and to recognize the importance of prescription drugs in the health care for the aged beneficiaries.

Today I'll talk about the major provisions of the act that are impacting Medicare Supplement policies, policy form and design changes that have been brought about by this, as well as the rating implications. I'll also discuss some of the marketing

issues that are involved and a few other points that I believe are worth noting in this.

As a result of the MMA, there's been quite a bit of clarification in the definitions and policy provisions in the forms, as well as in explaining where Part C and D interact with Medicare Supplement policies. The definition of Medicare-eligible expenses has been changed to reflect the fact that Part C and D are not totally excluded from Medicare Supplement policies. Currently, the definition just says that Medicare-eligible expenses are those that are covered by Medicare and that are reasonable and medically necessary, as defined by Medicare. Now the definition says those expenses have to be incurred under Parts A or B. There'll be no cost-sharing for Part C and D under a Medicare supplement policy. Not only that, but the Part D expenses that you incur will not be counted as continuous loss for an extension of benefits.

The reinstatement provision also has been changed. It's now clarifying that for those people who should decide to have their coverage reinstated after being eligible for Medicaid, a new plan can be reinstated as substantially equivalent to the plan they had prior to the suspension. In the past it just said they could have any plan reinstated. But now, if they enroll in Part D during their suspension, they have to have their outpatient prescription drug benefits removed, and their premiums are adjusted accordingly. The additional 365 days coverage wording for Medicare Supplement policies has been strengthened as well for new issues. Currently it covers 90 percent of the benefit, and for new issues after the regulation's been adopted, it will cover 100 percent of the benefits. The payment will be at the rate that Medicare would have paid had they covered this benefit. This means that the payment the issuer makes will be counted as payment in full, and the provider is not able to bill the insured for the remaining balance.

The preventive medical care benefit also has been changed. Historically it listed some of the tests that are allowed, their frequency, and the normal caveat of "any other tests that are deemed necessary by the physician." Now it just states that the frequency and the selection of tests are up to the attending physician, but they must be medically necessary.

There are a few other changes that are going on to Plans H, I and J specifically. As we've noted, the outpatient prescription drug benefits must be removed for new issues, and the disclosure notices must be sent to these policyholders. This disclosure notice will explain some of the options these people have available to them should they have this plan. It will also list what the revised premium will be should they have their outpatient prescription drug benefits carved out. As of this time, as far as I know, the CMS and NAIC have not finalized how the disclosure notice should be sent, but we do know that this notice must be sent during the 60 days prior to the initial enrollment period for Medicare Part D, which is November 15, 2005, through May 15, 2006. This means that starting September 14, people can begin receiving these disclosure notices.

As has been noted several times, after December 31 of this year, outpatient drug benefits will no longer be available in any Medicare Supplement policy form. At this time we have many very fine named Medicare Supplement plans, A through J. This Modernization Act came out with two new plans, Plans K and L. Plan K will provide coverage of 100 percent of the Part A coinsurance for Day 61 through 90 in a Medicare benefit period. It'll also provide coverage of 100 percent of Part A coinsurance for each inpatient reserve day used from Day 91 through 150 in the Medicare benefit period. Upon exhaustion of the inpatient hospitalization, including reserve days, it will cover 100 percent of the Part A-eligible expenses for hospitalization for up to 365 days. Again, this benefit will be paid at the rate Medicare would have paid, and it'll be considered payment in full. It will also cover 50 percent of the Part A inpatient deductible per benefit period, up to the out-of-pocket maximum. It will cover 50 percent of the coinsurance amount for each day used from Day 21 through 100 in a benefit period for skilled nursing facility care eligible under Part A until the out-of-pocket maximum is met. It will cover 50 percent of cost-sharing for Part A-eligible expenses in respite care until the out-of-pocket maximum is met.

It'll cover 50 percent under Parts A or B for reasonable cost of the first three pints of blood until the out-of-pocket maximum is met. It covers 100 percent of the cost-sharing for Part B preventive services after the Part B deductible has been paid by the insured. It covers 50 percent of the cost sharing otherwise applicable under Part B after the Part B deductible has been paid until the out-of-pocket maximum is met. It covers 100 percent of all cost-sharing under Parts A or B for the balance of the calendar year after the outpatient maximum has been met. For 2006, this out-of-pocket maximum is $4,000. It will be indexed to inflation as determined by the Secretary of the Department of Health and Human Services each year.

Plan L, as noted, is identical to Plan K, as far as what benefits are covered, but the coinsurance percentages are changed from 50 percent to 75 percent, and the out-of-pocket maximum is changed to $2,000. I'm not sure how beneficial these plans will be or how popular they will be, as they don't provide first-dollar coverage. For these people, there's an ever-changing out-of-pocket maximum that adds an extra level of complexity, although it does cover 100 percent once this out-of-pocket maximum has been met.

As a result of these changes, companies will need to file new forms or amendments with the departments of insurance of the issuing states of these policies. I believe that companies most likely will use amendatory riders in the case where a state or plan is not active and is not intended to be so. They will be able to file this and use it for any of the occasional new sale that may come about. To the extent a state or plan is intended to be active, and they wish to use them, they will file new forms and use these for both new policyholders and their existing policyholders. Many of these changes affect all plans the same, so it should be relatively easy for companies to get these done and filed with the states on time. These timelines are fast approaching. The plans that provide prescription drug benefits have additional

problems in meeting the deadlines, as they have to provide the amount of premium change that will occur as a result of removing the outpatient prescription drug benefits.

One thing that companies will need to remember when they file their new forms or amendments is that they have to include the Plans K and L in their outline of coverage. Along with changes in forms, the applications, replacement form and guarantee issue guidelines also have been changed. The application will now include references to the reinstatement provision for Medicaid or enrollment due to disability and then subsequently getting an employer or a union-based group health plan. If someone should have those coverages and wish to reinstate, as we said, they have 90 days after they lose this eligibility to reinstate what is a substantially equivalent coverage to prior to their suspension. The replacement forms will now include reference to MA plans and their disenrollment. It'll also include reference to whether their current plan contains outpatient prescription drug benefits. It should be noted by people that if someone has a MA plan, they're not able to apply for Medicare Supplement coverage unless the effective date of their Medicare Supplement policy is after the termination date of their MA coverage.

The guarantee issue wording has been changed as well. This wording is now incorporating reference to those policyholders who do have outpatient prescription drug coverage. If these people have coverage, they can either keep their current plan or be guarantee issued in any other plan from their current carrier. The current carrier can offer any plan or a guarantee issue, except they must offer Plans A, B, C, F and K and L, should they be available by them.

These plans that provide prescription drug benefits will also require rate action. You will have to file new rate pages with the departments of insurance indicating what the rates will be, excluding the outpatient prescription drug benefits, and these rate pages will be in addition to those that are already on file for coverage with patient prescription drug benefits. Currently the NAIC working group is trying to determine a method by which to determine what the rate reduction is, although I believe no matter what we do, we'll have to justify these to the regulators, probably by using a company's own experience as best as possible.

After the companies go through all this work, we also have to give policyholders some options, especially those who have outpatient prescription drug benefits. As Steve and Pat have talked about, they have many choices available to them now outside of Medicare Supplement. But those who do have it, if they should decide to stay within it, can decide to enroll in Part D during the initial enrollment period. If they should do that, they can keep their current plan with the outpatient prescription drug benefit removed and the premiums appropriately adjusted, or they can purchase any of the guarantee issue plans that are available by their current carrier. If they should decide not to enroll in Part D during the initial enrollment period, they can keep their current plan as is, with no change necessary, but they need to consider that if they even think they might enroll and

enroll after the initial enrollment period, there are a few key points they should know.

The enrollment period after the initial one will generally be November 15 to December 31 of each year. Unless they have creditable coverage from their current drug plans, their premiums for the new Part D plan will be higher than if they had enrolled during the initial enrollment period. For creditable coverage, they have to have coverage now that is greater than or equal to what Part D provides, and it's not expected that any of the current standardized Medicare Supplement plans will provide creditable coverage. If they should enroll after the initial enrollment period, the only choice they have as far as their current coverage is to keep it with the outpatient prescription drug benefit removed. I do believe these issues will drive more people with Medicare Supplement policies to enroll for their prescription drug coverage in the initial enrollment period. The guarantee issue period, as well though, for those who do enroll during the initial enrollment period, begins when they receive their disclosure notice and ends 63 days after they enroll in a Part D plan. There are timelines that all of us will have to abide by.

With the changes coming about as they have, there are some marketing issues that companies need to consider. They could enter the Plan K and L market, but as I said before, it doesn't provide first-dollar coverage, and there are out-of-pocket maximums that have to be explained to policyholders. I'm not sure how popular this will be with all carriers, but I have a feeling there'll be quite a few market makers who will enter this market, and the rest of us will watch and see how their experience emerges and listen to what the consumers are saying to our field forces.

Another choice is that they could enter into the Part D program. There seems to be a lot of people doing it, but I think one reason some might do this is to recoup the premiums that they're losing for the carveout of the outpatient drug benefits from their existing plans. But as Steve indicated, it's also a good chance to have a face to face with these policyholders to try to offer them either their own coverage or some other benefits that their company may provide. In doing all these changes, a company will have to educate its field force. They'll have to talk to them about the changes that are occurring and how this affects the policies that they're selling and the policies that are currently on the books. They'll have to know the changes and options the policyholders have as well, so that when they're sitting there talking to them they can explain to them what they have to do and what they can do.

I do have a few other issues that I believe are worth noting at this time. The refund calculations are changed as well as a result of the MMA. Historically, the refund calculations are based on the most recent 15 years prior to the current year to calculate the benchmark loss ratio. Now the calculation includes all experience on the block. The 15th year will now be 15th year and beyond. So all the experience is used in the calculation of the benchmark loss ratio. I also believe from what I'm reading that you'll have to keep pooled together the plans with outpatient drug benefits whether or not the person has opted to have the benefit carved out.

As we've indicated before, pre-standardized plans aren't free of the change either. To the extent they have drug benefits, they also will have to change and have these benefits removed. I believe they, too, will have the same options that standardized policyholders have to at least keep their plan with the outpatient drug benefit removed. I'm not sure about the guarantee issue of existing standardized plans for these policyholders. Everybody will have to adopt some version of this regulation, and so the drug benefits will affect the waiver states of Massachusetts, Minnesota and Wisconsin as well.

The dates I feel that we really need to keep in mind include September 8, 2005. This is the date by which all states have to adopt the NAIC regulation in some form. September 14, 2005 is the date the policyholders can begin receiving their disclosure notices. They must receive them by November 14, I believe, since November 15, 2005, through May 15, 2006, is the initial enrollment period for the Part D program. As of January 1, 2006, no Medicare Supplement policy can contain outpatient prescription drug benefits on a new sale.

At this time, I base most of my comments on readings of the current NAIC regulation. Several states have adopted this regulation as it stands. You will need to review the states prior to filing to see what they've adopted. A few adopted it unchanged. A couple adopted it with minor changes. There are several states in which the regulation is either imminent or pending. Unfortunately, about 15 states indicate they're doing nothing at this time, although all wording is that they plan to finish prior to the end of June to assist everybody to get all their filings into the state regulators.

These dates are approaching very quickly, and I believe the departments of insurance are about to be inundated with companies with these filings as well. They've been filing all the stuff for Part D in the MA until now. They'll just get dumped on even more with all the new form filings and amendments for the existing standardized Medicare Supplement policies. I have a feeling this also will either slow down or halt all filings that are in the departments, unless they have their own area that's just dealing with that and other people to handle other areas.

I don't think any of us want to be the last to this dance. It will be a long ride to get through this, and I'm afraid there might even be some that just don't spend much time reviewing what has been filed with them. I do feel some will review them thoroughly. Others, I have a feeling, will just take these and stamp them "approved" because they look close enough to what needs to be done. They have too big a pile to get through in the short timeframe they have. We don't have much time to get these done before the initial enrollment period. These have to be done by then because the policyholders have to get their notices prior to the initial enrollment period.

As you can see, we have a lot of changes going on. It will take a lot of work to get these companies into compliance, and I think we need to do our best to try to get them through as quickly as possible.

MR. CHARLES E. MERZ: I'm with Neighborhood Health. What has been the response to the demonstration projects that are available in Part D?

MR. WOOD: The reinsurance?

FROM THE FLOOR: Yes. I'm not sure if there's another one in addition to that.

MR. WOOD: There's no other Part D demonstration. What you're referring to is the ability to take a capitated amount for the reinsurance estimate if you'll be filling the coverage gap. It hasn't been tremendous. I'd say there's been a modest uptick on taking a capitated amount for reinsurance. I think it's mostly because people just don't understand things in this first year, and reinsurance looks awfully nice. What we're talking about is the 80 percent coverage on the back end once an individual hits $5,100 or $3,600 out of pocket. That's a nice thing, and people are, I think, a little risk averse. We didn't see a huge uptick. I don't know if you folks did either. There were a couple, but not wholesale. Maybe that will change next year.

MR. DUNKS: I would say we saw it largely on folks that had significant enhancements. A lot of people looked at it. If they had enhanced benefits above the standard, probably just a little, then they did this risk tradeoff, and they said, "It's not worth it in terms of the member benefit." Those that did, I think, almost all went for the one that reduced the member premium.

MR. WOOD: It was the same with us.

MS. LINDA P. ZIEGLER: I'm with the Florida Office of Insurance Regulation. I guess I'd like to add a plea to Steve's last comments. Please file soon. Don't put it off. Please make my life easier by not giving me a whole pile in early September or something like that. So file early. Thanks.

MR. WOOD: That would be applicable to every state. They're sort of on the tail end of this. CMS has been working an unbelievable amount of hours. I mean it's just unprecedented. But now it's the states' turn, and it will get worse before it gets better.

MR. GEOFFREY C. SANDLER: I'm with Empire Blue Cross/Blue Shield in New York. This session is labeled as a session on health plan issues, and most of the discussion here has been on the product side. I wanted to ask a question about what some people might consider an employer issue that has big implications on the health plan side. That's around certifications of actuarial equivalents and attestation of creditable coverage because from an administrative point of view,

that creates a lot of issues internally within a health plan. I was wondering what you're seeing in terms of how health plans are responding to those issues.

MR. DUNKS: All health plans are dealing with certification of creditable coverage and attestations, should the employer decide to go with the 28 percent subsidy. I'm seeing health plans really basically undecided at this point, trying to decide among doing it themselves, referring it through some special arrangement, facilitating it or just being hands off completely with employers. There are some actuaries at health plans who won't sign things because of coverage issues, and in that case they're pretty much looking for somebody to refer that work to.

MR. WOOD: We're seeing, in fact, the benefits consulting firms—Hewitt, Towers, Mercer, Wyatt, and those firms—taking a much more proactive role. Now, of course, that's only with the clients that they work with, and there are a lot of other groups out there. Health plans themselves have been very reluctant to sign those creditable coverage certificates because of the coverage liabilities and the like. They are referring things on to the likes of actuarial consultancies. So it's not common yet, but it could be. The rush again will come.

MR. SANDLER: What you just described probably is reasonable in the middle and larger group markets, where the client companies maybe actually know what a consulting actuary is. At the smaller end of the market, in the community rated market and the under-10 life groups, under-25 life groups, where it's typically a broker-driven market, they probably have never seen or heard of an actuary. The idea of now getting involved with one over issues like this and the fees involved in it and so on creates a lot of practical issues, just in terms of sorting out who's going to do what.

MR. WOOD: Right, and CMS isn't making it easy, either. They just mentioned the other day on the phone that they'll actually go into the Academy Web site to make sure that the actuary who certifies the creditable coverage actually is an FSA or an MMA. This is serious stuff. I have seen both PBMs and health plans—I don't know if you've seen this—that have come to us and said, "Give us a package deal. Name a number. For $1,000 a cert or something, for a very simple certification, we'll have you do it so it's on your liability coverage as a consulting actuary. We'll sort of put you on retainer for it." It gets them out of it. Now the question is, for a very small group, for an employer with only about 50 retirees, will they want to pop $1,000 for a creditable coverage certificate?

MS. KATHLEEN A. TOTTLE: I'm from Amerigroup Corporation. We're a Medicaid-only plan, so it was very interesting hearing about a lot of the dual eligibles and the SNF projects that you were talking about. It sounds like you did a lot of bids, 1,500 to 1,600.

MR. WOOD: It was about that.

MS. TOTTLE: I'm not sure about the rest of you. I'm sure it's very large. Is that because people didn't have actuaries inside to certify or that there was just the lack of knowledge internally in these companies, and they wanted to share the risk with you all instead of them doing it?

MR. WOOD: This is the first round of bidding, and I think most firms—Medicare HMOs, MA plans and clearly PDPs—really turned to the consulting actuarial community for leadership. It's not because we're any smarter than the rest of the world, but if we're doing several hundred of them, presumably we've gotten good at it, or at least we have a better understanding. Keeping up with the moving target of those bid tools and the bid rules was day by day, hour by hour, and most plans' actuaries or staff just simply didn't have that kind of time to spend on it.

It was the classic situation where hiring a consultant made sense in the first year. I suspect that in the subsequent years, more plans will again take it back in. But in the first year the bidding process was almost—I don't know what your perspective is—like make it up as you go along. I mean the rules were changing up to the last day for the bid forms. It was crazy. There's a lot of risk involved, too, a huge amount of risk, so I think that most firms retained actuaries to file the bids.

MS. TOTTLE: My follow-up was: Do you expect some of that to change going forward? And it sounds like that will change slightly. Will it keep changing year after year, where it's still a great idea to use the consultants, or do you think this is something that the internal actuaries can absorb themselves and keep up with the day-to-day changes that happen? That's probably a hard question.

MR. DUNKS: There'll be some in-house actuaries—for instance, on Part D—who will say after they have real experience, they can do this. It doesn't appear that difficult to them. What remains to be seen is how many changes in Part D occur and what the cost of keeping up with all the details entails. It was an enormous cost this year. I agree with Steve's comments. I think the other thing I'd add to his comments is some people just didn't have data to develop estimates or, if they did, it was really weak, and maybe they were looking outside of their data sets. So, besides time and skills and being current with the regs, there was a data issue.

MR. WOOD: I would reinforce the data issue as well, and I think that will carry going forward, too. First of all, the rate filings are in June, right? So when you're filing for 2007, you'll have all of five months of experience. I don't think that's enough. So 2007 will look a lot like 2006 in terms of the bidding because, for better or worse, consulting actuaries have huge data sets because they work with lots of clients. But at some point, you have to internalize it. You have to take it on, particularly if you're like Amerigroup and do five, six or seven SNPs. This is your core competency.

We work with even the largest and most sophisticated firms that have 10, 15 or 20 years of MA experience, and they still use outside actuaries because they want that

outside perspective. You get caught up in your own thought processes and management, I think. Sometimes we look over their shoulders, and sometimes we'll do the numbers.