RECORD Volume 30, No. 3*

Annual Meeting and Exhibit
New York, NY
October 24–27, 2004

Session 127 PD
Reactions to Medicare Reform Legislation

Track: Health

Moderator: JOHN S. CATHCART

Panelists: DAWN E. HELWIG
MICHAEL JAMES THOMPSON
DALE H. YAMAMOTO

Summary: The panel offers a summary of the Medicare reform legislation signed into law in 2003, which implemented sweeping changes to the Medicare program. The panel discusses the potential impact(s) of this legislation on the insurance industry as a whole, including issues and concerns of particular interest to actuaries.

MR. JOHN S. CATHCART: Last year the Medicare Modernization Act (MMA) was passed, providing the most significant changes to the Medicare program since its inception in 1965. As I'm sure we are all well aware, it does a number of things. It provides outpatient prescription drugs; it provides enhanced payments for Medicare Advantage. I think that there's still a lot of implementation going on, and there are likely to be some additional adjustments and further changes to the program in the coming year before we know exactly what's going to happen. I think that there's a lot to be played out after the election regardless of who gets elected.

In today's session we're going to be looking at Medicare reform and its impact on three groups of Medicare beneficiaries. Michael Thompson will be talking about Medicare Advantage plans (formerly known as Medicare+Choice and Medicare HMOs). Following that, Dawn Helwig is going to talk about the impact on Medicare Supplement plans. Finally, Dale Yamamoto is going to talk about the impact on retiree health plans.

Note: All handout materials are available through the link on the table of contents.

Let me give you some background on each of our panelists. Michael Thompson is the principal in the New York health-care practice of PricewaterhouseCoopers. He has over 20 years of experience in health care and employee benefits strategy development and implementation, design, financing, pricing, operations and analysis. He serves as PricewaterhouseCoopers' national leader for health and performance health-care strategies and is a frequent speaker on next-generation health-care strategies. He is a Fellow of the Society of Actuaries and a member of the Medicare Reform Committee of the American Academy of Actuaries.

Dawn is a principal in the Chicago office of Milliman, where she has been since 1986. She specializes in health product development analysis with a focus on long-term care and Medicare Supplement. Prior to joining Milliman, Dawn worked for 10 years for an insurance company, primarily in health-care pricing and analysis. She is a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries.

Dale is an actuary in the national practice of Hewitt Associates in Lincolnshire, Ill. He has been there since 1991, and his work emphasizes all phases of actuarial services and employee benefits. He recently chaired the 2000 Technical Review Panel of three actuaries and three economists appointed by the Medicare Board of Trustees to review financial methods and assumptions of the Medicare program. He has testified before Congress, and he is an ongoing resource for the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary and the Congressional Budget Office. He also serves on the Board of Governors of the Society of Actuaries and the Board of Governors of the Conference of Consulting Actuaries. He is a Fellow of the Society of Actuaries, a Fellow of the Conference of Consulting Actuaries, a member of the American Academy of Actuaries, a member of the National Academy of Social Insurance and an enrolled actuary under ERISA.

MR. MICHAEL JAMES THOMPSON: I'm going to focus at a high level on the changes to Medicare Advantage. This is the biggest change in Medicare that we've had, certainly as long as I've been practicing. The changes were implemented to overcome a lack of coverage for prescription drugs in the Medicare program as well as to transition away from the fee-for-service Medicare program that often gets overlaid with a Medicare Supplement program that fills in all the cost-sharing. The second point is central to the changes implemented to the Medicare Advantage program.

Medicare Advantage is not a new program. Previously, we had Medicare Risk, then we had Medicare+Choice, and now it's called Medicare Advantage. It's the same program. So that's the first change—the name. The second change is payment reforms around the Medicare Advantage program, and then some new Medicare Advantage plans. The basic concept of Medicare Advantage is to offer different forms of senior coverage through private health plans and insurers as an alternative to Medicare. These plans can be HMOs, PPOs, point-of-service or provider-sponsor organization plans. Typically, though, the dominant plans have historically been

HMOs in this base. These plans are subsidized by the federal government on a basis that is comparable to what would have been paid under the Medicare fee-for-service program.

Prior to the Medicare reform legislation, the previous program (then called Medicare+Choice) was suffering from increasingly insufficient financing from the federal government. This resulted in a major decrease in the number of Medicare+Choice plans, from 345 plans in 1999 to 145 in 2004. The number of enrollees didn't decline nearly as much, from 6.3 million to 4.6 million. At the same time, and not unrelated, the average out-of-pocket expenses, both premium and cost–sharing, increased from $429 to $1,260. So as Medicare squeezed its reimbursement, health plans had to react and either get out, raise the premiums and/or cut back the benefits.

Another one of the key concerns in the Medicare+Choice program has been the lack of access across the system to such plans. Due to the reimbursement structure that varies by geography, the plans are very prevalent in certain parts of the country, while in other parts of the country the federal subsidy didn't support development of these plans.

The key features of the Medicare Advantage reform are that there are two sets of plans now—local plans and regional plans. The local plans can be any of the forms of coverage of HMO, PPO, fee-for-service or medical savings account (MSA), and they have a service area of one or more counties. There is enhanced funding of those programs to make up very low increases in the past few years. For example, many plans have been capped at 2-percent-type increases under the previous formula.

In addition, there is a new regional structure that hasn't been fully defined yet. These regional plans are meant to enhance participation and access to these programs in rural areas. The government has been trying to even out the compensation to attract more plans into rural areas.

Here are the highlights of the payment changes. The 2 percent annual cap on Medicare+Choice payment was removed. On average, there was a 10.6 percent increase in the CMS rates, which doesn't sound like a lot for those of us seeing health-care trends at double digits, but compared to 2 percent increases historically, it's a substantial increase. In general, the industry in fact has reacted positively to this.

Let me trace how the Medicare+Choice/Medicare Advantage subsidies have changed over time. There was a new payment structure introduced in 2004, which was intended to even out the compensation structure across the country. It paid the greater of the fee-for-service costs, current payment increased by the greater of the national average increase or 2 percent, or the minimum floor payment. That's important because what actually got established as the payment rate in that

2004 structure will be the starting point for the increases in 2005. In 2005, the 2004 payment increases by the greater of the national average increase or 2 percent.

In 2006 we're going to move to a competitive bidding process. The goal is to actually get into more of a "managed competition" mindset. What's different is that there will be a benchmark established within each area. If your costs are greater than the benchmark, then you will be compensated at the benchmark and would be expected to charge a premium to make up the difference. But if your bid is less than that benchmark, the government will actually share in the savings, and the balance of it will go back to the beneficiaries in some sort of extra benefits or rebates.

What has been the impact of the increase in federal funding of the Medicare Advantage program? The average Medicare Advantage premiums dropped from $42 to $31. CMS estimates that the money has gone in a few different ways. Some of it has gone to decrease enrollee premiums; some of it has gone to decrease cost-sharing. Some has gone to increase benefits, but a significant part has actually gone to expand access for the program.

What's the impact for health plans? Clearly the changes in the financing have to be viewed positively overall. Plans will want to re-evaluate whether they want to either re-enter or expand within a service area. The dynamics of risk selection are going to change dramatically as well, because within these Medicare Advantage plans, at least one of the plans that you offer in a service area has to include Part D-type coverage.

The regional PPO plans scheduled for 2006 are going to be offered across broader geographic areas. With the Medicare Advantage or Medicare+Choice-type plans, you could define your service areas. You look at the payment rates, you look at your networks and you define what you think you can make work profitably. With the regional PPO plans, CMS defines the service area and you elect to enroll in it. Again, the reason CMS is promoting these plans is encourage the expansion of Medicare-Advantage-type programs into rural areas that historically have not had access to such programs.

It still has not been decided exactly how those regions will be defined. Frankly, that will be a huge impact in terms of how this will evolve. The narrowest geographic territories are probably by state, but they've talked about covering the country with as few as 10 regions. At this time, it not clear where this will end up.

There's no limit on the number of PPOs in a region. To support adoption, there are some transitional provisions. There is a risk-sharing arrangement, which will cap the amount of risk that regional plans will take on. If you recall how we first got into risk-sharing arrangements with administrative services only (ASO) for managed care, it's very similar in that there is a risk corridor where the plan takes

all of the risk and then the government takes 80 percent of the losses or the gains after that. Since this is an untested product and a very large market, plans can cushion the blow a little if they make a mistake when they go in. It will limit the amount of upside as well, obviously.

With the PPO plan design, whether you're in- or out-of-network, you provide coverage for Part A and Part B services. Since the PPO competes with the Medicare Supplement plans, the in-network benefit might actually be targeted to compete effectively with those of the Medicare Supplement plans. The out-of-network is essentially equivalent to Medicare.

One of the concerns with the existing Medicare Supplement plans is that there is no cost-sharing. It's essentially fee-for-service with 100 percent coverage and no management. The opportunity here is actually to apply more discipline around potentially the same level of benefits and to price more favorably to attract market share. Again, among the plans that you offer, at least one of those plans has to offer a Part D benefit.

In 2006 there will be competitive bidding pricing. There will be a benchmark established. The benchmark is established on a local area for those local Medicare Advantage Plans. There is some sort of weighted average for the regional PPOs that might be offered. If the bid is within 3 percent of the benchmark, you receive the benchmark amount as a subsidy. If you get above the benchmark, you charge the beneficiary premium. If you charge below the benchmark, the savings are shared with CMS.

There are some incentives in the program. Clearly, access is a core objective for CMS in this regard. Again, they are looking to transition from the system that they have in place. There's no easy way to take away Medicare. There's no easy way to take away Medicare Supplement, but they are hoping that they can build a market and that they can migrate people to a system that has more modern features to it. They've actually established a bonus for one of the national systems if you were to step up and cover every market. I'm not sure that will happen.

If there's no regional Medicare Advantage program in a region, the Secretary is authorized to increase payments to attract somebody. In addition, if the formula turns out to be too punitive with the health plans, where they potentially could start leaving a region, it gives some flexibility for some negotiation as it relates to the fee. It's an interesting dynamic. I think they are trying to build something that has a little flexibility in it to try to sustain the market over time.

There's still a belief that risk adjustment plays a major role in the compensation system. Over time, 100 percent of the payments will in fact be risk-adjusted.

The takeaway here is that clearly the government is seeking to change the underlying structure of Medicare, a huge part of our health-care sector. Medicare

Advantage is at the core of that strategy. To do that, they've increased payments to Medicare-Advantage-type programs. There are new opportunities to evaluate, whether you're in the business today or you're re-looking at the business today. The nature of the risk and financing dynamics have changed dramatically and will have to be re-examined.

MS. DAWN E. HELWIG: I'm going to talk about the impact the MMA has had or is expected to have on Medicare Supplement plans. In order to do that, I'm going to digress a little, because while this legislation has probably been the biggest legislation in terms of affecting where the government wants to go and trying to move people into managed care plans, it hasn't had a lot of direct impact on Medicare Supplement plans. There are a number of things that are going to happen, but it has not been a complete overhaul of the Medicare Supplement system.

However, I do want to point out (this is where I'm going to digress a little) that regulations that have been passed historically, including some of them that really have just had the most direct impact on Medicare Advantage plans, have also had residual impacts on Medicare Supplement plans. I'm going to start out with a little bit of history and a little bit of the state of the Medicare Supplement market today, and then I'll try to spend the majority of my time talking about the direct impacts from the MMA on Medicare Supplement.

In terms of talking about the Medicare Supplement background, I'm going to talk about regulations, as I said, but I also want to talk about recent trends in the market, in terms of the number of companies that are in the market. If you can keep in mind what has happened with the regulation as I talk about the number of companies in the market, there are some correlations there—the number of policies that are being sold, the distribution of the sales by plan and what has happened with loss ratios. I'll end up with talking about the direct effects of the MMA, as well as what some potential indirect effects could be.

Historically, we have had five major pieces of legislation that have affected the Medicare Supplement market. The very first one was the Baucus legislation in 1980, and then there was the Omnibus Budget Reconciliation Act (OBRA) legislation in 1989 and 1990. We'll talk about each one in a little more detail. There were the Technical Corrections to those in 1994, the Balanced Budget Act (BBA) of 1997 and then the MMA.

The Baucus amendments in 1980 were the first major regulation of Medicare Supplement policies. They came about as a result of some serious Congressional investigations that were done at the time. They were very public, where senior citizens were brought before Congress to talk about the abuses in terms of products that had been sold to them. As a result, there was some legislation enacted as far as minimum benefit requirements for Medicare Supplement. A mandated loss ratio was established of 60 percent. There were certain benefits that the policies had to

cover in terms of providing Part A co-payments, Part B co-payments, etc. There were some serious marketing standards that were put in place to address the abuses.

The policies that were sold from 1980 through 1991 are what have become known today as the "pre-standardized policies." They had a variety of different benefit coverages. Other than these minimum benefits, there were not specific standards or benefits that had to be covered. Probably the most all-encompassing regulation to affect Medicare Supplement was the OBRA regulations in 1989 and 1990. These did some major things in terms of the Medicare side in general by putting in place some physician payment reform. They established the Resource-Based Relative Value Schedule (RBRVS) and put some caps on excess charges that a physician could levy. From a Medicare Supplement standpoint, this is the regulation that established standardization of Medicare Supplement policies. This dramatically changed the Medicare Supplement market, because now we had 10 standardized policies for which a person could compare the premium, company to company, for a Plan C, or a Plan F and so on. Medicare Supplement became much more of a commodity after this regulation passed.

This regulation also increased the loss ratio standard, effective November 5, 1991. It was increased from 60 to 65 percent for individual policies and to 75 percent for group policies. The Medicare Select program was established, which was basically a Medicare PPO, although there's not a whole lot that you can do on the Medicare side in terms of providing incentives for a person to use a particular network. About all you can do is agree to waive the Part A deductible and work out something with a particular hospital network to do that. Medicare Select policies in effect are quasi-PPOs policies with basically Medicare Part A deductibles being waived.

There were some corrections in 1994 to this OBRA legislation, where some of the requirements of the legislation were extended to the old pre-standardized policies. In particular, the 65 percent loss ratio requirement was made effective for pre-standardized policies from that date forward. I didn't mention it earlier, but there had also been a rate refund provision that was put in place with the OBRA legislation, where a company needed to monitor its loss ratio standards, and if they weren't coming up to the required 65 percent rate, refunds needed to be given. Also, some pieces of these technical corrections required significant duplication notices to be given on all health insurance.

This brings us up to the BBA of 1997, which had some very significant impacts on Medicare risk plans. This is the point in the Medicare risk market where much of the payment that was being given to the Medicare+Choice plans at the time was cut back and, as Michael alluded to, the benefits were either dramatically cut or premiums were increased or both, with the result that Medicare Advantage plans were put at a little bit of a disadvantage to where they had been before this legislation.

On the Medicare Supplement side, there were a few changes as a result of this legislation. Primarily there were two new plans that were introduced. They were high-deductible versions of two other plans—a $1,500 deductible in that year, and it has been indexed every year since. It introduced MSAs for seniors and introduced a couple of other options outside of Medicare Supplement, like the fee-for-service option. Probably one of the things that impacted Medicare Supplement plans most was that there were some additional requirements put on insurers to accept people on guaranteed-issue basis. With the OBRA legislation, it had been required that anybody buying a Medicare Supplement policy for the first time within the six-month period of enrolling in Medicare needed to be guaranteed issue. This was extended in 1997 so that the companies had to guarantee issue somebody who was rolling over from a Medicare+Choice plan. There needed to be some existing pre-existing condition waivers.

The 10 standardized plans that were put in place as a result of the OBRA legislation are shown in Helwig slide 2, page 4. As you can see, they're a building-block approach. The basic plan, Plan A, has to be offered to everyone. In a couple of other states you might also have to offer another plan, but Plan A has to be offered everywhere. It basically just pays the Part A co-payments and the Part B co-insurance. On any of these other plans, you add some of the other benefits in by building blocks. As you can see, there are three plans right now (H, I and J) that have some prescription drug coverage in there. The prescription drug benefits that are in plans H, I and J are relatively minimal compared to what is going to be in Part D of Medicare. That becomes an issue now as we move into the effects of the MMA.

That's a little of the historical background. I want to now briefly talk about some of the things that have happened in the market in terms of trends. Keep the legislation and what has happened there in mind as you listen. The number of companies selling Medicare Supplement has declined over the past decade. In particular, there has been a recent decline in the number selling group policies. But in general, the effect of the standardization of the policies, as I said, made Medicare Supplement a commodity product. Companies found that it's not as easy to compete in that market as it used to be. There were also some commission restrictions that were put in place; the first-year commission can't be any more than twice the renewal commission. So in some cases it became a little less favorable for the agents to be selling the product. A number of companies have just gotten out of the market.

Interestingly, we've seen a little turnaround of that just in the last year or so. Maybe some of that is driven by the attention that Medicare Supplement plans are getting or Medicare is getting in general with the MMA. But there are a number of companies that have been talking lately about getting in, and there are going to be some entrants in this market in the next year or so, which is probably the first time we've seen that for a while.

Helwig slide 2, page 5 shows some dramatic shifts in the companies who are the top 10 leaders in selling Medicare Supplement. Some of the ones that were in that top 10 list in 1993 aren't even in there in 2003. Some of the top leaders in those early years have actually gotten out of the market or are just not very active in it anymore.

In terms of the number of people covered by Medicare Supplement, that also has declined. Thirty-seven percent of the eligible population had a Medicare Supplement policy in 1996. It's now down to closer to 30 percent. This is interesting to me, because this happened at the same period of time when the cutbacks in the Medicare Advantage plan took place. If anything, I might have thought that the cutbacks in the Medicare Advantage plan would spur the Medicare Supplement market and we'd see this percentage going up. One of the implications of this is that we have, I think, a lot more uninsured over-65 out there, because I don't believe that the Medicare risk numbers have changed that much in terms of higher penetration percentages. I'm pretty sure the employer numbers have not changed a whole lot, which leaves the fact that the uninsured has really grown in this time period.

Helwig slide 2, page 6 shows what the most popular plans are right now. Plan C and Plan F tend to dominate the market. A slight exception of that is on the Medicare Select plan, but that's more a function of the companies that have been selling Medicare Select. Plans H, I and J, as you can see, only constitute 12.8 percent of the Medicare Supplement market. But I would note that there are not very many companies selling Plans H, I and J. Keep in mind that everybody has to offer Plan A, but beyond that you're not required to offer all 10 plans. You can offer just two of them if you want; you can just offer Plan A if you want. There are a fairly limited number of companies that are offering Plans H, I and J. For those companies, obviously, in order for the total population of Medicare Supplement to be 12.8 percent for Plans H, I and J, the companies that are selling it have it as a high percentage of their business. If people want a Medicare Supplement plan with prescription drugs, they have to seek out the few companies that are selling it.

Helwig slide 1, page 7 shows the distribution by state. There are probably not any big surprises here, although there may be some in terms of where the distribution of Medicare Supplement is by state. You would expect Florida to be up there, as well as Pennsylvania and Texas; they are some of the more heavily populated states for the over-65 population.

The Medicare Select numbers are a little interesting, but that is more driven by the fact that the Medicare Select program was experimental for a number of years. It was only offered in a limited number of states, and then it was expanded with the technical corrections. So there were a few companies and, in particular, a couple of Blues plans in some of these states that offered the Medicare Select, and that's why the distributions are so high there.

What has happened with loss ratios? As you recall, the loss ratio standard for Medicare Supplement was increased with the OBRA legislation from 60 to 65. You get a different result on loss ratios depending on whether you look at the individual or the group experience. Generally speaking, the individual experience has come down slightly over time. There have been a few bumps here and there, but for the most part, there has been somewhat of a decline. You get a different answer on this if you take the individual experience and break it out by the Blues plans versus the commercial carriers—the Blues plans tend to have much higher individual Medicare Supplement loss ratios than the commercial carriers. But the commercial carriers are probably close on average to about a 70 percent loss ratio.

What are some of the direct effects as well as the indirect effects of the MMA? First I want to discuss the direct effects. The MMA says clearly that you cannot sell any Medigap policies with prescription drug coverage after January 1, 2006 (after Medicare Part D kicks in). That means Plans H, I and J, which are the three standardized plans that have prescription drug coverage, have to have that benefit stripped out of them. If you continue to sell Plan H, I or J with the prescription drug benefit in it after January 1, 2006, there are going to be some significant criminal and civil penalties to the company for doing so. It doesn't say that Plans H, I and J go away. In fact, the regulation allows for new Plans H, I and J to be sold. They are equal to the old Plans H, I and J, but with the prescription drug benefit removed. The resulting plans actually are unique from any of the other seven plans. It's not like you take Plan H and you pull out the prescription drug benefit and you have something identical to another plan. That doesn't happen. It's going to be pretty darn close, though. With Plan H, if you take out the prescription drug benefit, it's identical to Plan C, but without the Part B deductible coverage. Plan I is very close to Plan G. Helwig slide 2, page 8 shows that if you take those three plans and pull out the prescription drug benefits, Plans H and I are very close to two of the other plans, C and G. Plan J stays somewhat unique because it's the only plan of the 10 that covers every single possible building block benefit here.

One way to look at this is that you're going to call them "new" H, I and J. They are going to be allowed to be sold, but that prescription drug benefit has to be out of them. As far as the effect on existing policyholders, the Medicare regulation and actually the federal regulation, as well as the NAIC model, which has been drafted in terms of the effects on Medicare Supplement plans, clearly state that any standardized or pre-standardized plans that have drug coverage cannot be renewed after January 1, 2006 if the policyholder enrolls in Part D (the prescription drug benefit piece of it cannot be continued). If a policyholder opts out of Part D for some reason (I don't personally think that there's a lot of logic that somebody with the Plan H, I or J should opt out of Part D, because Part D is much better in terms of benefits and will cost less than what they are paying for the prescription drug benefit with H, I and J), because it is possible that there are some old standard, pre-standardized policies that have some pretty generous prescription drug benefits, that person may decide it's to his advantage to stick with that. Although again, keep in mind that Part D is being heavily subsidized by the federal

government, and most likely the premium on that is going to be a lot lower than what the policyholder is paying.

If people do decide for some reason to opt out of Part D, then they can continue their existing coverage with the prescription drug benefit in it. But if they decide to enroll in Part D, the insurance company needs to give them two choices. The first choice is that they can continue with their Medicare Supplement plan, but with the prescription drug benefit pulled out and with the premium reduced to reflect that. I'll come back to that in a minute.

The second option is only available for policyholders who enroll in Part D within the first 63 days of being eligible. Those policyholders are allowed to take their plan H, I or J or their old pre-standardized policy and roll it over on a guaranteed-issue basis to a Plan A, Plan B, Plan C, a high-deductible version of F or one of the new Plans K and L, which we'll get to in a second. If the person does not enroll in Part D during that initial enrollment period, the person loses the right for that guaranteed renewable rollover. The only option that remains to that person then is to continue with his or her existing plan with the prescription drug benefit pulled out and the lower premium.

The insurer does have an obligation to notify insureds. This obviously is going to happen sometime next year, because the first people are enrolling in Part D on January 1, 2006. Before that period in time, insurance companies are going to need to have filed and approved the revisions to their rates that are going to pull out the prescription drug benefit. They need to notify insureds that this is their option during the 60 days prior to that time that person is going to be eligible to enroll in Part D. They can either do a guaranteed rollover to one of the other plans, or they can take this and continue with their coverage with this lower premium.

There are some pricing complications that occur because of what insurance companies are being asked to do here. First of all, just look at the premiums on standardized Plans H, I and J, and look at the actuarial value of the prescription drug benefits in there. Take Plan H, for example. Look at the actuarial value of the prescription drug benefit and compare that to a Plan C, for example, which is the closest plan. Plan H is generally going to cost maybe 30 percent more than Plan C, plus the cost of the prescription drug benefits. The reason for that is that the less healthy Medicare Supplement insureds are the ones who go into Plans H, I and J with the full prescription drug coverage. If you go in and strip out the actuarial value of the prescription drug benefit of Plan H, you are most likely going to be at a premium significantly higher than the Plan C premium. If a person is presented with the option of accepting a lower premium versus rolling over on a guaranteed-issue basis to Plan C, you can pretty much guess what he or she is going to choose. I think that leaves insurers with a difficult choice to make. They may need to make a decision on their Plan H to reduce that premium all the way down to something close to Plan C, realizing they're going to have some pretty high losses because they still have the worst morbidity risk on H; they are probably going to have either

some high loss ratios or an increase in loss ratios on Plan H. Or they may need to take into consideration that there will be a fair amount of rollover into Plan C, and take a higher rate increase on all of those plans that have guaranteed rollover for 2006. In other words, spread out that extra morbidity that they've had on Plans H, I and J among the plans that are going to get the guaranteed renewability.

This creates some issues for companies that are in H, I and J right now and perhaps want to continue selling the new H, I and J after 2005. There's a great opportunity for a company that's not in H, I and J right now to come in with new H, I and J starting in 2006. They don't have to build in the anti-selection, because the prescription drug benefit is gone now and you're not going to get any more anti-selection in those plans. You can come in with some low, competitive premiums on those compared to the company that has Plan H, I or J and has to pull out the prescription drug benefit. There are a lot of anti-selective issues that companies are going to need to think through, probably sometime next spring or summer as they are starting to think about what their premiums for 2006 need to be.

The other impact of the MMA is that two new plans are being introduced: Plans K and L. The purpose of these plans was to create a couple of options that would provide for more cost-sharing. The way that they've done it is by having some plans here where there's a pretty high out-of-pocket deductible and significant cost-sharing on the main benefits that they feel are maybe a little more under the insured's control. You still have to pay 100 percent of all of the Part A core benefits, which basically are the hospital co-pays and the hospital excess days. In other words, if somebody gets to the point where he or she is hospitalized for a significant period of time, they didn't want to penalize that person with making him or her pay any co-insurance on that. The Medicare Supplement policy will still pay for all of those benefits.

But beyond that, Plan K basically is going to require the insured to participate in the co-insurance. There's a co-insurance on the co-insurance, effectively. Where the co-insurance on Plan K is 50 percent, the insured would be responsible for 50 percent of the Part A deductible. That, by the way, was a very standard product feature on the old pre-standardized policies, and it just went away with the standardization. It's being brought back in here. You just pay 50 percent of the Part A deductible. You are required to pay 100 percent of any Part B preventive care services, but beyond that for non-preventive care services (there's a list of those), you pay 50 percent of the Part B co-insurance. Given the co-insurance is 20 percent, basically you're splitting that with the insured—the insured is going to pay 10 and you're going to pay 10. There's a $4,000 out-of-pocket maximum in 2006; it's indexed thereafter. After that out-of-pocket deductible is reached, 100 percent of these co-pays is paid.

Plan L is identical to this, except that all of the 50 percent co-insurances are increased. Actually, the policy is going to pay 75 percent of each of these things instead of 50 percent, and the out-of-pocket deductible is decreased to $2,000.

There are other direct effects that are happening as a result of MMA. The Part B deductible is increasing effective 2005 to $110, and it's going to be indexed thereafter. A number of these plans do cover the Part B deductible, so that's going to have a direct impact on the premiums that companies are selling starting in 2005.

There are a number of indirect effects. Also starting in 2005, there are going to be some additional benefits covered under Part B. There's going to be a "Welcome to Medicare" physical that somebody gets once they enroll. There's some additional cardiovascular screening and diabetes screening. Those might have some small impacts on Medicare Supplement trends because you're going to be paying again the co-insurance piece of that. One of the more dramatic after-the-fact changes that we've seen is that there was scheduled to be a 4.5 percent physician fee cut this year. It was replaced by a 1.5 percent increase in physician schedules. If any company projected their trends for 2004 assuming that there was going to be that fee cut, you might be seeing some higher loss ratios than you expected this year.

As we get back into how the Medicare Supplement sales and how the Medicare Supplement experience relates to what's going on in the Medicare Advantage side, all of the things that Mike talked about in terms of the effects of MMA on Medicare Advantage will have some effects on Medicare Supplement. There's going to be greater emphasis on Medicare Advantage sales; the benefits will probably improve or the premiums will reduce again as a result of the added incentives and the better payments on Medicare Advantage. Will that affect Medigap sales? Will it affect Medigap persistency? Will you have more people leaving Medigap and going to Medicare Advantage products?

As a company looks through this regulation, some of the things that need to be thought about are: How does this product fit in with the company's goals in general? If you're also in the Medicare Advantage market, how do you see the subsidy as taking place or what kind of risk profile are you going to get under the two different plans? Is this the core product for the market that you're in? How does your competitive position affect whether you're going to sell this product or not?

There are some major issues to consider on the mix of plans that a company might want to offer. That competitive position might be affected by whether or not you've been in H, I and J in the past. I'm hearing a lot of talk about getting into K and L, but nobody is making a lot of decisions yet. Companies have had limited success with the high-deductible F and J plans. There is definitely a mentality among the senior citizen population that they don't want to be paying anything out-of-pocket when they buy a Medicare Supplement plan. The new plans K and L, as well the high-deductible plans F and J, require a fair out-of-pocket payment. That's their intent. The high-deductible plans have not met with a lot of success, so there is some question as to whether there's going to be a lot of interest in K and L.

We have heard a lot of companies talking at least about the possibility of doing some affiliations with some pharmacy benefit managers (PBMs) or some other companies that are going to be the ones offering a Part D benefit, to see if they can maybe hook up with them and be the marketing arm for them in a sense to have their Medicare Supplement agent sell both the Medicare Supplement plan and Part D enrollment, so that they can just be one-stop shopping for them.

MR. DALE H. YAMAMOTO: What I found interesting in what Dawn was saying is that carriers haven't had an interest in providing the high-deductible plans. This is a future business tip—there are a lot of employers who are considering dropping out of retiree health care altogether, depending potentially on the Medicare Supplement market. Programs that look like a high-deductible program that provides a catastrophic kind of offering are going to be appealing to employers dropping out of the coverage if all they want to do is get out of the business and maybe provide some kind of financial supplement for the program. I think that's a business to come, but that's not what I'm going to talk about.

I'll give you an overview of what the Medicare drug benefit looks like and some of the prescription drug plans, what the employer choices are and some of the responses we've seen from employers to date, as far as what the potential effect is going to be on their programs.

What I want to talk a little about and focus on in this presentation, too, is a set of proposed regulations that came out on August 3. It had two different sections to it. One focused on the Part D benefit itself; the other focused on Medicare Advantage. The comments had to be submitted by October 4, so everyone got their comments in. We'll talk a little about what some of the business organizations and consulting firms have commented on. They anticipate the finalization of these proposed regulations in early 2005. I've heard comments anywhere from by Christmas to inauguration. I think 2005 is a pretty ambitious schedule to get everything done. When you look at what has to be put together by 2006, the government has a lot of work to do.

The proposed regulations are somewhat unusual when you take a look at them. If you look at any of the regulations that did come out, the preamble is longer than the actual proposed regulations. In fact, the preamble is about 80 percent of the total pages. It contains a lot of different information because they punted on a lot of different things and asked for a lot of discussion. That's why the comments that they receive are going to be very important to form the final regulations that come out in January.

The benefit has a $250 deductible, 75 percent for the next $2,000, and what they call a "doughnut hole," where the beneficiary pays 100 percent between $2,250 and $5,100, if they have no other outside coverage or payment toward this. It has to be truly an out-of-pocket amount. I've heard a lot of people say, "Where did they come up with this? There is not a creature like this that exists in today's medical

world." Have any of you gone to any of the consumer-driven health plan/catastrophic plus health reimbursement arrangement (HRA) program design sessions? When you look at the graphs they put up on catastrophic HRA programs, they look just the same, because you have an HRA account that kind of fills the bottom part of the grid, you have what they call a "bridge" to go between the HRA to the high-deductible plan, then they have a high-deductible plan later. It does exist. I don't think anyone ever put those two pieces together.

Enrollment periods are going to start November 15, 2005, for that initial enrollment period and then end on May 15, 2006. After that, starting in the 2007 enrollment, it's going to be three months before and three months after the beginning of the calendar year. The enrollment is going to be limited to any resident of that particular prescription drug service area that is going to be identical to those 10 to 50 service areas that Mike alluded to for the Medicare Advantage programs. I think they are going to be the same regions and the same service areas. There is a late enrollment if somebody enrolls late. It's akin to the Part B late enrollment fee for the Part D program.

The way the 100 percent no coverage between the $2,250 and $5,100 is actually written in the MMA is that an individual has to have $3,600 of true out-of-pocket expenditures before that 95 percent benefit kicks in. If you have any kind of coverage before then that pays any of what the intended beneficiary co-insurance is, it really increases where the 95 percent benefit kicks in. So if you have an employer program that supplements the Medicare Part D program, the only thing that's doing is extending the point in time where Medicare takes over and provides a catastrophic 95 percent benefit.

One of the things that CMS does recognize is: How do you keep track of this stuff? You have an employer program that's going to be providing a benefit. You have a prescription drug plan that's also going to provide a benefit. How are you going to coordinate the two so that you understand when someone hits that $3,600 maximum? The regulation talked about the data sharing and some kind of massive data accumulator that would keep track of this. They have said it's the responsibility of the prescription drug plan to keep track of this. Good luck.

What the true out-of-pocket really means is that 100 percent, like I said, goes up to whatever that extended number is. Sometimes for a lot of the plans that we've been working with that have very rich programs, effectively you never hit that 95 percent limit because the program is rich enough that retirees, unless they are on some very expensive maintenance drugs, some of the biotech types of drugs, will never hit $3,600 of out-of-pocket cost.

What kind of employer options do we have? Congress and CMS want to encourage employers to continue coverage. That was one of the biggest things that Congress had in mind when they implemented some of the incentives they have in the MMA. The preamble talks about several different employer options. One that the MMA

focused on is if you continue the employer plan, we'll give you a 28 percent subsidy. I'll talk about that a little later.

Other alternatives that the preamble talks about include wrapping around or supplementing the Part D program. Just subsidize the Part D premium, so you may pay part or all of the premiums that the retirees have to pay. Or you can directly contract with the prescription drug plan, even be a sponsor or be your own prescription drug program just for your own retirees. Employers are going to have the option to eliminate coverage and potentially just subsidize the Part D program. That's something Congress does not want to see happen.

Congress had four specific goals that they adopted when they said that they're willing to provide this federal drug subsidy to employers. They wanted to maximize the retirees retaining employer coverage, because they saw historically a declining prevalence of employers offering coverage in the first place. They wanted to avoid any kind of employer windfalls. One of the first things that came out of *The Wall Street Journal* when the MMA was passed was that there was the potential, based on how the MMA was written, that employers could be receiving this federal subsidy even though the only thing they provided was a retiree-pay-all plan. That's not Congressional intent, even though I think the reporters were correct. When you read the MMA, it looks like you could do that. The final regulations will attempt to avoid that.

They want to minimize the administrative burden. That's something, coming from the government, that they want to minimize the administrative burden. But I think they do want to try to do that. In all of the discussions CMS has had with employer groups, they stress that point. They don't want this to be too burdensome. Lastly, they want to minimize government cost. The ongoing employer involvement in all this pushes back some of the government costs for the catastrophic coverage. It does make it attractive to pass on a lot of this burden to the government in the first place.

What is the drug subsidy? In order for employers to be eligible for this drug subsidy in the first place, they have to have a plan that's at least actuarially equivalent to the standard drug benefit. That's something we had hoped this preliminary regulation would have addressed so that we can understand what to do in all the work that we do. They didn't. I'm going to talk about that a little later, too.

The subsidy that you get essentially is going to be 28 percent of the allowable retiree costs between $250 and $5,000 (all of these dollar amounts are indexed). What they really mean is that they're trying to get at what the costs are for the actual cost of the drugs, including the co-payments. If you walked into a drug store, what are you going to pay after you've paid for all the discounts and the dispensing fee? They also want to include in this calculation the value of the rebate, which is something that is going to be difficult to do, because the way rebates work today is that usually you don't get that for another three to six months after the

drug spending has happened. But that needs to be accounted for in the calculations of that 28 percent.

There was a nice thing that was thrown in at the last minute, and the interesting thing about this is that the employer groups did not demand this. This is something that Congress just gave to employers. The reimbursement is not taxable. If you're spending $2,000 in 2006 for your drug program, you can still deduct the full $2,000, so you don't have to reduce it for the effect of the drug subsidy. You can still deduct the full amount. It truly is a tax-effective means of providing drug benefits. CMS has estimated the average subsidy to be about $611; Congressional Budget Office (CBO) estimates are closer to $700. I've had estimates anywhere from $575 to $700, so they are in the right ballpark of the estimate of this drug subsidy.

Like I said, the proposed regulations don't directly address the definition of actuarial equivalency. They give three different choices. There are actually four or five different choices. The first choice is what they call a "one-prong" choice. Just compare the actuarial value of the total value of the employer plan to the Medicare program. It's kind of a simple test of a plan value kind of concept. The second one is one of the things this did is (this is probably the most straightforward and the one that's directly addressed in the MMA; this is almost when you read the MMA how you should do it), but that doesn't avoid the windfall effect of an employer offering a retiree-pay-all program. To take care of that they said, "Let's limit the subsidies to what the employer pays under its own program." So if they would have normally calculated the $611 as a 28 percent subsidy, but they only subsidize $500 of the employer plan, they only get a subsidy of $500. The problem with both of those is that the first one doesn't avoid the windfalls, and the second one CMS admits is not provided for in the Act. Maybe there's going to have to be some technical correction to make this choice a viable option.

The second one is a two-prong test. It's probably the closest to meeting the spirit of the MMA. It's two-prong from the perspective that one test is that you test the total value, so it's like the one-prong test. It's a total value test to make sure that the value of the benefit is at least equivalent to the Medicare program. The next one is looking at the net value of the employer-provided benefit compared to the government-provided benefit. The trick is that they are not sure what the "net value" means. They have a range of choices. One is that they feel that the floor has to be whatever they provide in the form of the direct subsidy, something comparable to that $611 and 28 percent benefit calculation. The other one is to just calculate the value of the Medicare benefit and subtract out the Medicare Part D premium. That gets to the concept of that's what the government provides in the form of the Medicare program. That's part of the highest bar that they can set with this two-prong test, the value of the Medicare benefit less the premium. CMS and a lot of the Congressional staff are concerned that if they set the bar that high, more employers would drop out of providing coverage because it's too high of a bar to set. So they are trying to rationalize: How can we set that bar a little bit lower?

A lot of the analysis that we have done is with the two-prong test. We've usually done the test with the Medicare value of the benefit less the Part D program, so we've set the bar a little bit higher for our clients. But mostly it's because we want to set a relatively conservative expectation of whether or not one of our clients is equivalent to the Medicare program and eligible to accept the subsidy. Otherwise, they are going to get back to us and say, "You said."

One of the things that the proposed regulation did do is make the statement that the way you apply this test is that you look at the average beneficiary in your programs. One of the concerns that we had is, what happens if you had a plan that had some varying contribution requirements for different classes of retirees? For example, if someone retired with 10 years of service, maybe they have to pay the full cost; for someone with 30 years of service, the employer paid the full cost and the retiree paid nothing. What do you do with that situation? Do you have to separate out or divide up your program to be the "haves" and "haves not" of whether or not you can accept the subsidy? The regulations did say to focus on the average benefit provided to the average participant in that group, so you can take the average of that 10-year service and 30-year service retiree put together if on average you're providing a benefit that's actuarially equivalent. You're okay and you can accept the subsidy for the whole group.

One of the things that is in the MMA is that the certification has to be done by a qualified actuary. A qualified actuary is someone who is a member of the American Academy of Actuaries and qualified to do this kind of work. The Academy is trying to figure out what that means for the Academy as far as other qualification requirements. In the end, you are subject to the qualification standards of the Academy. If you're not qualified to do the work, you shouldn't be doing this work.

The definition of a "plan" that's included in the regulations is a pretty broad definition. It's taking a look at whatever you have set up as a written contract for the program. It does create some confusion because most employers have a lot of different plan designs covered under one ERISA plan. We need some clarification of exactly what that means to the programs that have a lot of different definitions within the program.

There is a process that they've laid out in the regulations about the timing of when the proposal has to be made. The bottom line is that an employer has to apply for this every year. The way the regulations are written out right now, there has to be an actuarial certification every year that the plan is actuarially equivalent. We'll see what happens with that with the final regulations. They received a lot of comments on that from employers.

There are some other options that employers can do if they do not feel the direct subsidy is a good option to go into. There has been a question of whether or not this federal subsidy is going to last beyond 2006, 2007 and 2008. What's the long-term viability of that subsidy? They think it's going to go away. Rather than go

through the trouble of creating the administrative systems to capture everything that they need to capture and report, they said, "Let's not do that. Let's think of some other options." Other options are addressed in the regulations, but they may not be attractive. These options include supplementing Part D and coordinating the program, just like you might do with the current Medicare program.

Another idea is that you might directly contract with the prescription drug plan to provide benefits only to your retirees. So it could be a plan that supplements the standard Medicare options, but it's only a plan that is offered to your retirees. If you neglect the tax advantages of the 28 percent subsidy, these kinds of options have often produced some savings that are close to the value of the federal subsidy. That's not taking into account the tax advantages. So for a tax-exempt organization, companies that technically are for-profit but haven't made a profit for a while so they don't expect to pay taxes in the future, the alternative options may be a good viable option and financially equivalent.

All the other options do rely on the retiree participating in Part D in some fashion, though. So that's kind of a trick that we have to get around. Something to keep in mind is that the Part D programs that are going to be offered are not like Part B; it's not a federally run program. There are going to be private programs with individual companies bidding for the right to provide the prescription drug benefits to retirees. Every one of these prescription drug plans is going to have its own unique negotiated discounts with drug stores and with the pharmaceuticals. They are going to have their own formularies (lists of preferred drugs) that are going to be offered. It's not going to be a pleasant thing with which to be coordinating.

CMS had a conference call yesterday that covered a lot of these issues. They spent a lot of time on what kinds of waivers they would be allowed to permit during this whole process, because the MMA allows for it. They are expecting to be very flexible and working with employers on all sorts of waivers. The waivers include whether or not the employer provides its own prescription drug plan, so it needs a waiver to get away from the state licensures. That's a requirement right now under the MMA for prescription drug plan. They'd also need a waiver so that they can provide the benefits directly to only their retirees. There are other waivers that could be potentially offered, too. It could be a prescription drug plan working with the employer program and being able to offer a program that's just for that group of retirees, although the prescription drug plan may be offering coverages for other individuals.

With Medicare Advantage plans, employers are starting to take a look at whether or not they want to engage with Medicare Advantage plans anymore, given that a lot of them have pulled out of the Medicare+Choice program because of the service area reductions and the decline in the number of Medicare+Choice plans that are offered out there. Most clients that I've talked to are taking a wait-and-see position. They understand that the MMA has tried to re-emphasize the Medicare Advantage program and the HMO contracts, but most of the ones that I'm talking to are not

betting the ranch on a big expansion of the Medicare Advantage programs; they are mostly taking a wait-and-see approach to it.

In the end, for any employers that think that they may take the 28 percent subsidy, the key question that they have is: What is going to be the definition of "actuarial equivalence" for them to qualify for the subsidy? They need to understand what the definition of "plan" is going to be so that they know how it applies to their programs. They have to wrestle with the issue of whether they can set up their administrative systems to comply with everything they have to comply with to be able to accept the subsidy on an ongoing basis. Are the subsidy and the tax advantage enough to offset the extra cost they are going to have in their administration? For employers that aren't going to look for taking the direct subsidy, the key issue that they have is to try to figure how they are going to coordinate with the prescription drug plans in the first place. How flexible are the group waivers going to be that CMS offers to them? Can they get around the whole administrative issue of tracking the true out-of-pocket maximum? How do they work around that? Because they're going to have to take some responsibility, how much reporting are they going to have to do? What is going to be the structure and viability of the prescription drug plan market? We haven't seen a lot of health plans jumping on the opportunity of providing prescription drugs for retirees. We hear a lot of talk, but we haven't seen any direct comments that they are going to be in the market.

Who has commented and who has provided comments to CMS? All of the employer industry groups have commented. Several major companies—for example, the auto workers and other major employers—have made comments. All of the major employee-benefit consulting firms have provided comments to CMS, so they have a ton of paperwork to get through.

MR. GREGORY G. FANN: I have three questions. The first two are for Dawn. You mentioned that about 63 percent of members are in Plans C and F. This seems to be consistent across the country. The real differentiating benefit on these is the Part B deductible, which is really dollar trade in this market—it's about $100, $110. I've seen illogical situations where premiums really exceed that benefit, and there seems to be a herding mentality to these plans. It seems to be encouraged with the government offering guaranteed issue into C and F, but not Plans D and E. I don't understand the rationale behind that. Could you speak to why that may be occurring?

The second question deals with the refund calculations. How is that going to be diced out when Plans H, I and J kind of divide into two different benefits, one with drugs and one without drugs, looking at the history, comparing it from a lifetime standpoint?

The third question is to the whole panel. Nobody talked about Medicare MSAs. Is there now a market for that with this new legislation?

MS. HELWIG: In response to the first two questions, Plans C and F are the most popular. I agree that it's a herding mentality. More of the Plan F-type of plan structure, or something similar to that, was the most popular plan before standardization. Most companies were selling something similar to a Plan F, and that was what most Medicare Supplement policyholders were buying. With standardization, that plan structure just kind of continued.

With the implementation of the excess coverage limitations, the difference between Plans C and F went away to a large degree. There are actually companies in the market that have higher Plan C premiums than Plan F. It really just is what the agents have been comfortable in selling, I think. There have been a few companies recently that have done some things with commissions to try to encourage agents selling some of the other plans a little more, but I'm not sure that there has been any real reason for it. As you said, I think some of the guaranteed issue aspects in terms of the rollovers from the Medicare+Choice plan, or now the rollovers from H, I and J, always keep C and F out there. But I think that that is more because those are the most popular plans, too. I think the federal government is more reacting to the popularity of those plans and making them the rollover options. But I don't think there's a good reason.

The refund calculations is an interesting question. There have not been any changes in the Medicare Supplement regulation on how the refunds are going to work as a result of the removal of the prescription drug benefits on H, I and J. Right now the refunds operate on a plan-by-plan, state-by-state basis. As a company is starting to think about some of the anti-selective effects when they eliminate the prescription drug benefit and what they're going to do to their premium on H, I and J, thinking through the rate refund calculations and what that could do should come into that consideration. If you have a lot of people from H, I and J that roll over on a guaranteed issue to C and F, you're probably not going to have much rate refund issues on those plans. It's probably more of a rate increase issue. I'm not sure H, I and J and taking people out of prescription drugs there is going to put any companies into a situation where they are now going to have to give rate refunds and they didn't before. There isn't anything in the regulation that would say new H, I and J are monitored on a different basis for rate refunds than the old H, I and J. H is H, and it's not separated out between old H and new H, so it will create some interesting issues that have to be thought through.

As far as the MSA, I don't have a whole lot to comment. We have seen a lot of interest in it on companies wanting to get into it more.

MR. THOMPSON: On MSAs, on the one hand, if you look at general trends obviously in the active employee market, that's a general movement. My personal belief is that seniors aren't quite ready for that yet. They weren't ready for managed care until they got used to it in their active population and they kind of grew into it. I'm not sure that it will automatically be a winner in terms of selling. The competition that you have is the more standard Medicare Advantage plans and

the Medicare Supplement plans. I think there's room for disagreement there, but I'm not sure that that's going to be a dominant plan any time soon.

More likely I think is that plans are going to change in the active population and then plans will gradually evolve in the senior population where people will be used to them and migrate into them over time.

MR. EDWARD M. MAILANDER: I'd be interested in anybody's comments about how the MMA will affect the commercial market, the provider behavior, either with respect to utilization or cost of services.

MR. THOMPSON: Boy, that's a loaded question. I don't know that it got to fundamental root cause issues as it related to the supply side of the equation. It's geared to more of two different elements. One element, I think, is the irrationality of having a medical program without a drug program. That's not really a sustainable strategy to manage a population, particularly one that is rife with chronic care conditions. Two, I think it's the basic overutilization problem associated with no cost-sharing. I don't think that we've gotten to root cause in terms of changing the provider behaviors on that, per se.

On the Medicare Advantage side, I think there's probably some opportunity for health plans to step in and be a little creative in terms of where they might take compensation structures to build incentives for quality, efficiency and things of that ilk.

MS. HELWIG: I have just one other comment from the fee-for-service side. This is not a new phenomenon, but I think Medicare Supplement carriers have traditionally seen, number one, their trends be somewhat higher than the general over-65 population because of the type of people who buy Medicare Supplement plans. But number two, and maybe more interesting, some of the experience that we've looked at recently from at least one large carrier has indicated that they have seen an uptick in frequency even though the average charge is down. In other words, it seems like there has been more unbundling going on lately by the physicians. It has actually caused an increase in their trend above and beyond what they had expected it to be. You kind of wonder what's going on at the physician level that's causing some of that.

MR. MAILANDER: I apologize for the obscurity of my question. My question was about the commercial side, not the Medicare side.

MR. THOMPSON: I assume you're dealing with a cost-shift element. Medicare Advantage is still a relatively small part of the program. The cost shift is going to be driven more by Medicare reimbursements. Frankly, I'm not sure I know if the pattern on that has changed dramatically. I don't think that the Medicare Advantage in the short term is going to make a big difference in terms of the level of cost shift to the commercial side.

MR. YAMAMOTO: The only comment I could make is that the prescription drug plans are private programs that are bidding for the right to provide the coverage. At the moment, there is not any government control over the prices of the drugs being provided. Theoretically, there shouldn't be any effect on the commercial side of the business. As far as the cost-shifting of the drug cost onto the commercial side, the pharmaceuticals, and I think everyone else, is concerned about how long that is going to last. But as far as the way the MMA is written now, they really can't do that.

MR. THOMPSON: I'll just add that I think you're in California. So my comment notwithstanding, obviously California is a different situation. There is a much more predominant Medicare Advantage market in that state. In this case I would say that if Medicare has enhanced reimbursement to plans, more money in the system is only going to help the commercial side, not hurt it.