Medicare Advantage: Lessons for the Future
Alliance for Health Reform and The Kaiser Family Foundation
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ED HOWARD, J.D.: Good afternoon. My name is Ed Howard. I am with the Alliance for Health Reform. I want to welcome you on behalf of Senator Rockefeller and Senator Collins and our Board of Directors to this program on the basics of the Medicare Advantage program. There has been an awful lot of talk about Medicare Advantage plans in recent months. For one thing, they have been growing almost doubly, as Tricia pointed out in her note to me, in the last five years.

For another, a lot of analysts have concluded that Medicare pays Medicare Advantage plans more than it would for covering the same beneficiaries in the standard fee-for-service Medicare. And that attracts a lot of attention at a time when there are concerns about the trust fund balances and the search is on for pay fors in this era of reform.

So today we're going to take a close look at Medicare Advantage, how it came to be, how it functions today, what some of the proposals are for making changes in it. Our partner and co-sponsor in this briefing, the Kaiser Family Foundation, has been helping policy makers and their staffs understand Medicare and Medicare Advantage, among other things, as much as anybody. It is needed now more than ever, of course. Just look at your kits on the table outside for some of the clear and concise analysis and description, the clearest that you're going to find on this topic.

And that is a nice segue if I can take advantage of it, to call on Tricia Neuman, who is the Vice President of Kaiser and Director of its Medicare Policy Project. Tricia spent the better part of a decade on the hill in both the House and the Senate side and committee professional staffs. She will be co-moderating with me today. Take it away Tricia.

TRICIA NEUMAN, Sc.D.: Thank you, Ed. And on behalf of the Kaiser Family Foundation, I want to thank all of you for coming. I want to thank the Alliance staff for putting together a great briefing and thank in advance the panelists who are terrific.

We wanted to join Alliance in putting together this event because we know you're hearing a lot about the Medicare Advantage program and you'll probably be hearing more about it in the months to come. In a nutshell, for those of you who don't live and breathe Medicare Advantage, these are private plans, mainly but not exclusively HMOs that the government pays to provide Medicare covered benefits to people on Medicare who are covered by the program.

So we think it's important to understand what's going on with the role of private plans in Medicare for a number of reasons. One is as Ed mentioned, although most people on Medicare and the fee-for-service traditional program—about 25-percent—are now enrolled in Medicare Advantage plans. That's about 10 million people. So it's important to understand the

benefits and services provided to a fairly significant chunk of the Medicare population.

Second is that in recent years, the number and types of plans have proliferated. So you may be hearing about that from constituents who are getting lots of plan choices out there and are trying to differentiate one from the other. So as Ed said, there is a growing body of evidence that I think Mark will be speaking mostly about. It looks at payment issues and evidence about how the government is paying plans and how that is increasing costs to the Medicare program contributing to some of the financing issues that are challenging Medicare.

And fourth, we wanted to have this briefing because key Congressional leaders and the Obama administration have talked about making changes to the Medicare Advantage Program and we thought this would be a good forum for understand what are those changes and what are the implications for program spending and for people who are covered by Medicare.

So with that, I know we have a great set of panelists and we are looking forward to the discussion and I'm going to turn it back to Ed.

ED HOWARD, J.D.: Thank you Tricia. The standing logistical disclaimers are that you have a lot of information in your packets, including biographical information about our speakers, to whom I apologize in advance for not giving an adequate introduction. All of the materials in your packets are

also available electronically at www.allhealth.org. Tomorrow at some point, you will be able to view a webcast of this briefing at www.kaisernetwork.org. And there will be a transcript available on our website, www.allhealth.org in a few days. I'll point out to you that in your packets, you have a green question card that you can use to submit a question to the speakers after the presentations.

There are microphones on the floor so that you can ask your questions verbally as well. And I commend that option to you because we often run out of time to get to the questions that get submitted on the cards. There is also a blue evaluation form that I hope you will take the time to fill out to help make these briefings better for you.

So let's get to the program. Tricia was right. We have an incredible group of experts today. They are going to give you some brief presentations and answer your questions. It is kind of a basics briefing. So do not be afraid of asking question that are too simplistic or if you do not understand an acronym, ask for an explanation. Do not hold back because we want you to come out of here more knowledgeable about this topic that you are going to hear a lot more about in the next couple of months than you are today.

And we're going to start with Marsha Gold on my far left. She is a Senior Fellow at Mathematica here in D.C. Marsha is one of the few people in America with an encyclopedic

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knowledge of Medicare Advantage. She is currently taking a look at the Medicare Advantage monitoring program which tracks the use of private plans in Medicare. She has not only been published in journals like Health Affairs and Health Services Research, she is on the editorial boards of journals like Health Affairs and Health Services Research. So she looks at the expert's work and decides whether it's expert enough.

Marsha, thank you for being with us and we are looking forward to you presentation.

MARSHA GOLD: Thank you, Ed. I'll try this. There are a lot of material and a lot of ways of talking about the program. I'll try and be as over-view as possible. My job is to sort of talk you through the basics and the understanding so that when Mark and John talk about more detailed issues of where we're going that you have some basis here.

So, I wanted to give you some background on the origins of Medicare Advantage. It didn't just emerge a few years ago, although the program itself called that it did. Medicare has always adapted and tried to fit things in that otherwise are in the market, even though Medicare was in a lot of ways a single payer program when it started up. That was how the market was, but there were always work arounds. There were things like the Kaiser work around HIP, things that existed and Medicare tried to make sure beneficiaries could get access to.

But the first real formal programmatic private plan in Medicare came through Tefra in 1982. It was effective in 1985. It was the Medicare Risk Contracting Program and it gave people access to HMOs. That proved reasonably popular. It started to grow, and so Congress in 1997 revamped the program and called it Medicare Plus Choice. It tried to do a lot of things in that bill, some of which conflicted with one another and cause us issues today.

But it opened it up to additional coordinated care options like PPOs. You had your first private fee-for-service plan, which was actually envisioned totally differently from the way it's evolved today. It was a right-to-life, don't tell me how to practice medicine type plan that people thought would actually have a lot of cost to the beneficiaries, and for the first time, on an issue that Mark will really be talking about and focusing on, established some rate floors with the idea of how do we get some of these managed care plans into some of the rural areas of the country where they hadn't been. There were subsequent refinements of all the rest as you went along because the big issue with the plans is that the BBA thought in Medicare Plus Choice, you'd have more plans, and in fact you had fewer. And there were a lot of issues.

So the MMA tried in 2003 to automatically reverse that. It increased the amount of money available to HMOs and other plans in Medicare Advantage and set up the name Medicare

Advantage immediately in 2004 with the idea that in 2006 when the new drug benefit came in, it would be a stronger set of plans that would allow more private competition both for the Part D benefit as well as in rural areas with regional plans and a lot of other things.

As Tricia mentioned, enrollment has grown a lot. It's about a quarter or 24-percent of all beneficiaries, but equally relevant are the people choosing the Part D plan, the drug benefit. It is over a third of people. So one-in-three people who choose the Part D separately choose that. A lot of the growth has not been in HMOs. And when it's been in HMOs, it's been in something called the Special Needs Plans that we're not going to focus on here. A lot of it's been in the private fee-for-service plan. Five-percent of Medicare beneficiaries today are in private fee-for-service plans. There has been some recent growth in PPOs, but that's relatively slow and it's only recently picked up.

I don't know that you can see that. Hopefully you can see the overheads better. The most important thing about this chart is just to recognize that even though Congress paid a lot more money to get HMOs and coordinate care in rural areas, it just didn't work. And the main reason we have a lot more in Medicare Advantage today in rural areas is the private fee-for-service option. There are some regional PPOs, although those haven't been very attractive for various reasons.

So in the rural areas, there has been a growth in HMO/PPO options, but if you really break that down, it's often at the parts of rural areas that are nearest to metropolitan areas. So there are some real issues there that have to do with doctors who don't want to contract, low population density, and a lot of reasons that just make it hard.

The main thing to take away from this slide is that there are a lot of companies now that participate in Medicare Advantage. They offer various products. There are fewer of them who go to the trouble of setting up networks to get HMOs and PPOs. More of them were brought in by the private service plans. But beneficiaries have a lot of choice of products from various plans.

On the other hand, while you have that, a small number of companies really dominate the market, not quite as much before the MMA, but still quite substantial. One-in-three beneficiaries or more than that is in Humana/United HealthCare and Kaiser, although a lot of Kaisers are agents from working. And half of all beneficiaries or more are in Banmore Blues Plans [misspelled?]. And if you count 10 firms that we couldn't show up here,10 firms in Blue Cross Blue Shield count for three-quarters of the plan. So it is a fairly concentrated industry even in local markets.

The growth and enrollment—I think this slide shows you why—there were low premiums. People who had trouble with

Medigap premiums who wanted something went there. They could get relatively low premiums per month. A lot of them had zero premium plans. Those are still offered a lot in HMOs. The private fee-for-service plans tended to offer them.

This year for the first time, we're seeing fewer of them offering them. And some of that's deliberate as plans try to get people to shift to PPOs because next year, according to MIPPA, there's going to be a requirement that private fee-for-service plans have networks unless they're in areas of the country where there aren't other plans. Part of it is they have had a hard time making a go and the costs are higher. So they go up.

We did a paper recently for AARP that compared the benefits that you get from Medicare Advantage to what you get from Medigap and traditional Medicare. It's important to recognize that traditional Medicare leaves beneficiaries with an awful lot of liability for out-of-pocket costs. Because of that, they have gone to Medigap plans. They've liked having no out-of-pocket costs. Those have been the most popular plans by and large. Everyone's in plans that absorb that cost. But the premiums are high and some people can't afford it or feel they can't afford it. So the Medicare Advantage plans have been somewhat attractive. The premium is lower.

My personal fear is that not enough people who are making these choices understand the financial choices they make

because we actually know from the Medigap choices they make that they like to not have risks for having a lot of out-of-pocket costs.

But I don't think they know how much things cost. And if you look here, you can see that there's quite a bit of financial out-of-pocket liability. If you're sick or you become sick, your chances of having high out-of-pocket costs are quite high. Now, the premiums are low, so I don't know that you can always blame this on the plans for not doing anything. But the question is what are some of the tradeoffs for different benefits and how much financial protection for Medicare as a whole provides for people. But that's some of the tradeoffs you see in this. There are more reports with detail elsewhere.

People have an awful lot of choices. We recently just did an issue brief that said if we lived in President Obama's zip code in High Park, what would it look like to us if I was looking for a plan? They were better off than some others. They had around 30 plans to choose from. Mostly across the country, over half of people have over 40 plans they can choose from, leaving out special needs plans. Virtually all of them have 16 or more. So that's a lot of distinctions to make when you have people who aren't that good at making distinctions. Even we would have trouble with that.

So where are we now? I think, as I said, Medicare enrollment is high and for reasons Mark will explain, it adds

to Medicare costs. So whether you are neutral about whether that's a good thing or bad thing, there is a financial impact. Private fee-for-service has disproportionately accounted for the growth and contributes to availability in rural areas.

Some of the urban areas may decrease in the future because of the requirements under MIPA. There are many firms competing in the market, but most enrollment's concentrated in a few. The premiums are attractive. That's what makes people go to those plans. But they face a lot of financial risk even if they do. And you have beneficiaries asked to distinguish numerous and diverse choices.

So, legislative sausage creates some complexity when you're trying to offer health insurance to beneficiaries. And that is sort of what Congress is trying to deal with now.

ED HOWARD, J.D.: Great, thank you, Marsha, for getting us off to a fast start and leading very nicely into the presentation by Mark Miller. Mark is the Executive Director of the Medicare Payment Advisory Commission, which is the non-partisan agency that advises Congress on Medicare payment, quality, and access issues. He has been a top official at CMS, OMB, and CBO. By the way, I commend to you the chapter in your kits on Medicare Advantage payment policy from the MedPAC March report to Congress. And we're very pleased to have Mark with us today to talk a little bit about the principles of how Medicare pays Medicare Advantage Plans. Mark?

MARK MILLER: Thank you and I just want to underscore that we are a congressional support agency. We try to balance payment, quality, and access. And while we're talking about managed care today, we also do these kinds of analyses and make recommendations for fee-for-service, which sometimes gets forgotten in these discussions. I also want to acknowledge both Scott Harrison and Karla Sariboza [misspelled?] who are sitting right up here for a lot of the work that I am going to present here today.

There are certain principles to keep in mind when you think about MA payments. The fee-for-service delivery system is very fragmented. It emphasizes volume over coordination and quality. And many years ago, the thought was that if managed care could be brought into Medicare, it would have the flexibility to improve some of the problems with fee-for-service, focus on coordinated care, quality, negotiating rate, controlling volume, that type of thing.

The underlying principle was that if the managed care plans could do better than this fee-for-service sector, then they would have savings relative to fee-for-service which they could keep or use to offer extra benefits to beneficiaries and attract beneficiaries to the MA program. So back in the day before there was a drug benefit, they might offer a drug benefit, or they might offer, as Marsha has been suggesting, lower cost sharing.

So the notion is doing better than fee-for-service and using those savings in order to attract people to managed care. In fact, the notion was that they could do so well, originally, they were going to be paid 95-percent of fee-for-service, and they thought was that the plans would even do better than that. So that's way back in the day.

And again, this is fairly complex, so I need to move quickly. To now talk about the situation here, what you need to keep in mind are bids and benchmarks. So in each county in the country, there is a benchmark which the government has set which is based on fee-for-service. And if the plans bid in order to offer the Part A, the traditional Medicare benefits, exceeds that benchmark, then the program is paid the benchmark and the enrollee has to pay the additional premium.

However, if the bid is below that benchmark, then part of that difference goes back to the plan and part of that difference goes back to the program. Seventy-five-percent of the difference goes to the plan and 25-percent of the difference goes to the program. And with that 75-percent, the plan is to offer extra benefits.

I'm going to show you the same idea, except now I'm going to do it with numbers. I'm telling you the same thing, but we're going to just walk through this so that we understand it. So think of two counties. Let's say that there's a benchmarking in this county that's $800. The Medicare program

says this is the benchmark. The plan bids $700. So that's one Plan A that bids $700. That's $100 below the benchmark. Seventy-five of those dollars stay with the plan. Twenty-five of those dollars go back to the program. Medicare pays 775, the original bid plus 75-percent of the difference. I made this very simple by having $100 difference. The plan gets paid and $75 is supposed to go to the beneficiary in extra benefits.

Now Plan B, I'm going to do very quickly. They bid above the benchmark. The $40 above the benchmark, the beneficiary has to pay that difference. So the notion is that the competitive structure here would drive the beneficiary towards the less costly plan, which can offer extra benefits. So you might look at this and say what's the problem?

The things to keep your eye on are the benchmarks because where the benchmarks set will determine whether you're actually walking away with savings or not. The benchmarks are set administratively through legislation over the last several years, which Marsha has walked through. Part of what's going on is that the benchmarks for counties with very high fee-for-services were able to extract efficiencies and offer extra benefits.

In counties with very low fee-for-service, two issues arose. Managed care plans in a sense, couldn't compete against traditional fee-for-service. The costs of running a managed care plan meant that they couldn't do better than fee-for-

service in those areas which means that they were unlikely to go to those areas.

And two is that if they were in those areas, they could offer skinnier benefits than the high fee-for-service areas. And so this led to some sense of inequity across the country in the availability of extra benefits, which led to legislative actions which Marsha has detailed here and I, in a very broad brush way, said started to set floors.

So they would go into fee for service and say fee-for-service is too low here. So we will administratively set a floor. And there are a couple of different floors, but I'm not going to go into it in detail. In a sense, from a treasury budget point-of-view, the problem is that the payments in those areas can exceed fee-for-service. And that's what leads to additional costs and leads to the question of the paying for those additional benefits in certain areas or in areas that have higher benchmarks.

I'm going to show you this one other way because I like to show everything twice because I assume people just don't understand me at all. So I'm trying to get it across to you. For some reason, internally, we think this is a good way to show it. Think of this graph as displaying high to low cost counties across the country. High-cost counties are in the upper right. And then in a stylized way, the benchmarks are above fee for service in those areas. Even though you could pay

below the floor, if you are above fee-for-service on that line, you're paying more than fee-for-service. So for those of you who are inclined to graphics, that's a different way to think of it.

We're going down to the end here. This is a fairly complicated chart, but I tried to circle some numbers here to draw your attention to a few things. The first thing I would ask you to focus on is the top row of the chart.

So benchmarks, on average, across the country, through this legislative action, as well as some technical issues, which we could take on questions, have ended up being 18-percent above fee-for-service. And that's 118-percent in that first row. The last number in that first row is through the bidding process and getting the plans part of the difference between the benchmark and their bid, on average, we pay 14-percent above fee-for-service.

So now, I want to focus you on just a couple of other things. I want to focus you on the middle column. What that number 102 shows is what managed care plans bid on average across the country to provide the traditional fee-for-service benefit.

So in other words, managed care plans are saying it costs more to offer the traditional fee-for-service benefit than traditional fee-for-service. I also want you to look below

that as you scan down by plan type and see that there are certain plans that are more efficient than others.

So just to pick on private fee-for-service plans for a second, the row that says 113, they bid 113-percent of traditional fee-for-service to offer the traditional fee-for-service benefit. Note that HMOs actually bid 98-percent of fee-for-service. In other words, they do have the capability of providing traditional fee-for-service more efficiently than the traditional fee-for-service program.

Just to draw your attention to the last column, however, for those two examples, even though HMOs are more efficient on the traditional fee-for-service benefit, we pay them 13-percent above the average through the bidding process and the benchmarks. And for private fee-for-service plans, we actually pay them 18-percent above traditional fee-for-service.

I hope everybody is still with me, and if not, I guess that's the way it's going to be. You did get a lunch, okay [laughter]. The thing I want to get across to you is on the bids. To focus on this, the managed care plans, on average, are bidding above the cost of traditional fee-for-service to provide traditional fee for service and over time, that bid has been going up.

What disturbs us is that we have a payment system, and actually this last slide kind of summarizes some of the implications and issues. So when you put all this together on

net, we pay 14-percent above fee-for-service, which means our managed care enrollment as it currently stands, we're about $10 to 12 billion more than we would pay if we were on fee-for-service. Each time someone enrolls in a managed care plan, it is scored by CBO as a cost because of the payment structure.

We are subsidizing extra benefits. The original notion was that the efficiency of the play would pay for the extra benefit. Now, the taxpayer and the beneficiary are subsidizing the extra benefits. And in some cases for private fee-for-service plans, those subsidies can be quite high. We think that this is drawing inefficient plans into the program.

I know I'm out of time. I'm down to my last two points and you did get a lunch. Just let me be clear on this. The concern is that we're drawing plans into the program that are not designed to coordinate care and not designed to be more efficient than fee-for-service. As Marsha pointed out, some of the highest growth was in the private fee-for-service plans who bid well above traditional fee-for-service and are paid well above traditional fee-for-service. My last point, which I believe I've already said is this results in subsidies coming from the Medicare program, taxpayers, and beneficiaries. And I'll stop there.

ED HOWARD, J.D.: Before we go to John, Mark let me just clarify one thing. You talked a little about the variation in your chart that shows the floor payments, the linear chart

of benchmarks from county to county. It implies a variation in the underlying cost of fee-for-service Medicare. Just say a couple of words about how important that is and how prevalent it is and how disparate it is.

MARK MILLER: Well, if any of you have actually run across some of the Dartmouth Atlas material, and other people have done this work as well, it turns out—and I want to be very clear here—in terms of expenditures per person across the country, there is significant variations. The two poster children that are talked about are Miami and Minnesota. When you look at Miami, you see significantly higher utilization rates, particularly for services that are discretionary such as visits, imaging, certain non-invasive procedures, relative to a place like Minnesota which has sort of a history and a tradition of much more conservative care.

So the frustrating thing about this finding is that when you look at differences in quality, you don't particularly see any differences in the populations and sometimes higher quality in the low-utilization areas. Now, just to Ed's point, the concern is this. Even though fee-for-service varies dramatically across the country, the benchmarks are tied to fee-for-service. And that leads to some of the arguments to say that it isn't fair that underlying fee-for-service has these kinds of variations, which should managed care payments also

have the same variations, and that leads to some of the back and forth on this issue.

ED HOWARD, J.D.: Thank you, that was very helpful. I think so. And once again, it's a very nice segue to our final speaker Jonathan Blum from the Centers for Medicare and Medicaid services where he directs both the center for Medicare Management and the Center for Drug and Health Plan Choice. Those two divisions are responsible for paying Medicare providers, particularly prescription drug plans and the Medicare Advantage plans. He advised Senator Baucus and some of the other finance committee members during the MMA legislation Marsha was talking about. He served a stint at OMB. He was the Vice President of Avalere Health just prior to joining CMS this year. And we're very pleased to have you with us John.

JONATHAN BLUM: Thank you very much Ed and Tricia for having me speak today. These events are always the best on Capitol Hill. So it's a real honor to be on the table here, not sitting and having lunch. So, thank you very much for the opportunity. Yes, that's right. It was a great lunch.

I also want to thank all the CMS staff who are here today to help me prepare these remarks. I want to acknowledge Amy Hall [misspelled?] that joined CMS recently to head our legislative affairs shop. And all the CMS staff who are here in the room, can you raise your hand. Don't be shy. If you have any really hard questions, talk to them. They can surely help.

I want to spend some time. I have10 minutes on the clock here. I want to talk about three policy documents that CMS has either put out or helped contribute to. One is the 2010 call letter that sets the contracting framework for the 2010 plan year both for the Part C plans and A plans and also the Part D plans. I want to talk about the 2010 rate notice that came out in early April that has proven very controversial. I want to just talk about the constraints we had when developing the 2010 rate notice.

I also want to talk about the president's budget. The president, during the campaign and the last several months has made cost-savings for both the Medicare and the Medicaid programs a very high priority. He has talked out loud about how we should think about the MA program payment changes and how to set the benchmarks. And I want to spend some time talking about how the White House, the president, the new Secretary for Health and Human Services sees a path forward to better improve how we think about payment rates for the MA program.

The first think I want to talk about is the 2010 call letter. This is the contracting document that sets the contracting rules for the upcoming plan year. So on June 1st, CMS will start to receive plan bids for the 2010 call year. And then CMS will start to negotiate with health plans to determine payment rates, to determine benefit packages, and all that information will get fed into the various communication tools

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that CMS produces to help beneficiaries choose the best possible plan, either the MA plan or a Part D plan for the upcoming calendar 2010 year.

We made some very important changes to next year's contracting process that's going to start very soon. We really wanted to think about a different kind of management philosophy to the Part C program and the Part D program. We had a number of concerns going into the call letter development. First, going back to Marsha's slides about plan choices, we felt very strongly that the plan selection process has to be more simple for beneficiaries. We felt that there are a lot of plans that are offered by the same plan sponsors that don't have a lot of beneficiary participation and also are very similar to other plan offerings offered by the same plan.

Here are some statistics. Roughly 43-percent of all plans today in the MA program have fewer than 100 beneficiaries signed up. Twenty-seven-percent have fewer than 10 beneficiaries signed up. There are some very legitimate reasons why a plan might have very low enrollment. It might be brand new. It might be a special needs plan catering to a very specialized population. It might be offered by an employer to its population.

But in general, we felt that there are too many plans offered by the same plan sponsor that could confuse beneficiary choice. And if the goal is to have beneficiaries choose the

best possible plan for his or her needs, we wanted to make sure that plan choice was meaningful and understandable. So we started a process starting this year to help narrow down the plan selection process so we can have plans that are offered by plan sponsors that have meaningful differences, that aren't redundant with other plan offerings offered by the same sponsor. We plan to work very closely this year with the health plan sponsors to achieve that policy goal.

Secondly, we had some concerns about high beneficiary cost-sharing offered by health plans. Health plans under the law have the opportunity to charge different cost-sharing than offered by the fee-for-service program. And that's an appropriate response by a health plan. You want to design a health plan package that's more responsive to beneficiary needs. You want to fill in some of the cost-sharing gaps that are offered by the traditional fee-for-service program. But at the same time, we have to be very careful that cost-sharing doesn't cause discrimination or cause beneficiaries to have high-cost healthcare needs to avoid the MA program.

So we set out some new parameters this year to have CMS work with health plans to ensure that cost-sharing for certain high-cost services like skilled nursing care, home healthcare, high-cost drugs don't unintentionally discriminate against beneficiaries who have high-cost needs.

Thirdly, some of the marketing materials that plans use can cause confusion to beneficiaries to what is the best possible plan. For example, if a beneficiary wants to choose an MA plan or a Part D plan that offers coverage in the donor hold, what's the best way to describe that coverage? Some plans that offer gap-filling drug coverage tend to provide only generics in the coverage gap.

And that's very much appropriate, but we want to make sure that when beneficiaries choose plans that have different cost-sharing charges, that have different gap-filling policies, that they have consistent use of marketing terms that beneficiaries can evaluate Plan to Plan B to Plan C to truly understand which kinds of plans either in the Part C context or in the Part D context to choose.

So we set out the new call letter. We will start working with health plans. We will start issuing more guidance to help fulfill these overall goals to the Part C and Part D programs. But again, the goal really is to make sure that beneficiaries have choices, those choices have meaning, and those choices are understandable to both the beneficiary's or caregiver's providers and also the tax-payers that currently fund this program.

The second policy document that I want to talk about, and I think you have a summary in your packets, is the 2010 rate notice that CMS put our on April 6th. This sets the overall

payment rates and also the Part D benefit parameters for the 2010 plan year. There were two provisions in the rate notice that I wanted to talk about. One is the overall update factor that CMS will pay Part C plans for 2010 and also the coding intensity adjustment that CMS finalized this year in 2010.

This year's update factor is very, very small relative to prior years. As Mark talked about the benchmarks, those benchmarks get updated each year to account for overall growth in the fee for service program. And this year's update factor was roughly 0.5-percent, a much smaller number than past history and that is primarily due to the fact that our actuaries must assume current law for the physician payment rate under the SGR.

And as you know the actuaries currently project a minus 21.5-percent update for the SGR. And so current law requires our actuaries to take that into accounts and if the physician fee rates were on a much more level scale, the update factor would be much greater. But again, we have to current law and current law is the minus 21.5-percent update under the current law SGR.

The second change that we made to the rate notice was the so called coding intensity adjustment factor. I'm happy to answer any questions about this but basically, CMS collects risk scores for every beneficiary that goes into the MA program and every beneficiary who's in the fee for service program.

And we can carefully track over time how the risk scores change both for the MA beneficiaries and for the fee for service beneficiaries.

This is important because not only does CMS pay a capitated payment to every MA – for every beneficiary going into a MA plan but that payment gets adjusted for the relative risk of beneficiaries. Beneficiaries are who at higher risk, at a higher payment of the plan, lower risk at a lower payment to the plan. Long story short the Congress requires CMS to adjust plan payments if it has evidenced that the coding intensity or the risk scores are growing faster for the MA plan than the fee for service program.

And CMS has conclusive evidence that health plan scores have grown faster in the MA side than the fee for service side without any measurable changes in the actual health status of those beneficiaries. We took a negative 3.4 coding adjustment change this year that'll also have the impact to reduce the plan update for 2010. Happy to answer any questions during the Q&A period.

The last thing I want to talk about in my last 60 seconds here is the overall framework to the President's budget for the MA program. And the President very strongly believes that we need to change how we calculate the benchmarks for the MA program. And as Mark talked about the MA benchmarks under current law produce a 14-percent overpayment on average. We

need to think about a different way to move to a more sustainable level.

The President's proposal is to change the way that CMS calculates the benchmarks moving from the current statutory context to a overall competitive calculation where plans actual bids, the average of plans actual bids, would go to set those benchmarks. We think this produces a system that produces savings. We think it's a system that helps respond to the differences in local healthcare costs in those parts of the country like Minnesota that have historically low fee for service costs.

Plans could set their own benchmarks based upon their overall bids. Happy again to talk about any questions but the overall goal to the President's budget is to think about a brand new way to think about calculating the benchmarks moving from the statutory construct that creates distortions, moving to a competitive set calculation that lets plans control how they could paid under the Medicare program. And I'll stop there. I'd be happy to answer any questions.

ED HOWARD, J.D.: And let me just take the prerogative of the chair if I – the co-chair to clarify Jon, what you just describe as the President's proposal for a new way of determining payments. Sounds a lot like at least one of the options that I saw in the Senate Finance Committee walk through

document that got circulated late last week. Is that a fair judgment?

JONATHAN BLUM: That's fair. The CBO their December budget options book also described an option. I believe the current chapter that you talked about for the MEDPAC report also talks about a concept. But the concept basically is to require CMS not to use the statutory benchmark construct but to set the benchmarks, local areas based upon on the actual plan bids.

In producing the cost estimates that were in the President's budget blue print that came out I guess in March, we used the actual bids that plans submit to CMS to help determine the budget estimates. And we have the actual plan data and the actual bid date or the actuaries have it and that's the basis for the cost estimates in the President's blueprint.

ED HOWARD, J.D.: Great. All right, thank you. Now, excuse me, as I said you have a chance to ask questions and get the most out of this panel. There are microphones right here. There are also the green question cards that you can fill out and hold up and someone will pluck it from your hand and bring it forward.

Let me just take advantage of this interim unless we actually have someone moving to a microphone. George, you're walking past one. But the question involves basically a

request for a little more full some information about the relationships between Medicare Advantage plans and prescription drug plans. In fact, I had to lean over to Tricia and ask what MAPD really stood for; Medicare Advantage prescription drug, right, Marsha?

MARSHA GOLD: Yes.

ED HOWARD, J.D.: Could you explain for us a little about how those two relate, the Part D plans and the MA plans?

MARSHA GOLD: Before the Part D was passed the regular Medicare Part A and D benefits doctors, physicians, services et cetera who got it all through Medicare and then joined a private plan [inaudible]. When part D was case, congress said [inaudible] private plans. So they set up pre-scanning proven drug plans so then in this year [inaudible] benefits that way [inaudible] drug plans.

One thing [inaudible] otherwise is the same concept if you want [inaudible] part A and D through a private plan, those plans combine in most cases, Part D [inaudible]. And so, what we do is we get all of the benefits together in one place. There are some exceptions that private people service plans take advantage of some other things. But mostly, what it means is to get [inaudible] together.

It’s meant because of the opening payments to Medicare Advantage plans that what they can do is use some of the savings from those payments to make them more generous Part D

benefit than a free standing private prescription drug plan can. Because even they'll both get paid the same for Part D, free standing ones don't have any access to other kinds of savings.

And I think that's probably one of the reasons why people have been gravitating towards those plans. It's one choice and you get it all. And you also get some extra advantages, although most beneficiaries still are in Part D free standing today. And some of the same companies offer this.

ED HOWARD, J.D.: Great, thank you. And just to clarify, Jon mentioned Part C. And Part C is Medicare Advantage, right? Okay.

FEED HOWARD, J.D.: A plus B.

ED HOWARD, J.D.: A plus B equals C. Remember that. Yes, go right ahead. You want to identify yourself.

CAROLYN ATHEN: Hi, Carolyn Athen [misspelled?] Health Quality Institute. I wanted to clarify what Jonathan said when you said that there was choice in Part D in the independent plans. And he implied that there is a choice that some plans tended to offer generally coverage in the donut hole. In fact, there are no plans as of 2008 that offer anything but generic coverage in the donut hole.

As of 2008 which changed from previous years there was no available plans that offer prescription drug coverage for

the independent plans in the donut hole. And actually I think plans are encouraged to doing that at CMS to save money.

JONATHAN BLUM: I mean I can't speak to prior CMS policy decisions. And I think you're right, that today in today's world that most believe our Part D plans offer gap coverage only offer generic only coverage. Tricia's nodding yes. So pardon me?

TRICIA NEUMAN, Sc.D.: Very few cover that.

JONATHAN BLUM: But I think going to the broader point is that we have to make sure that when plans are offering different benefit levels they are using consistent terminology. That they're using consistent, you know kind of communication language; the broader point that CMS will be asking plans when marketing their plan benefits this year to help beneficiaries understand what they're purchasing and not use different terms but one plan sponsored versus another plan sponsor if the beneficiaries can better make true apples to apples comparison.

ED HOWARD, J.D.: Yes, go ahead.

MELINDA BEEUWKES BUNTIN: Hi, I'm Melinda Beeuwkes Buntin from RAND. If I'm understanding this correctly, the reason why we're overpaying the MA plans is because we have these floor setup. So the plans are paid more than fee for service spent, true fee for service costs in certain counties.

The rationale for that was that those areas were areas that were traditionally low cost and that it was just therefore

unfair in a certain sense to pay them as little as the fee for service cost in that area. And I'm just wondering if whether there's any data about the result.

So is the result in terms of the bids that in fact that was the case? That plans in those areas had to bid above what fee for service costs were? Or another way you could look at the result is did it have the intended affect that there's some equalization of extra benefits across high and low costs area in terms of fee for service?

MARK MILLER: A couple of things. I think the – if you look at bids in the low cost fee for service areas, the bids tend to track above fee for service which I think was part of your question.

MELINDA BEEUWKES BUNTIN: That was part A of my question, yes.

MARK MILLER: Yes. And so the answer to that is yes and to the extent that you get bids that are below fee for service they tend to be in the higher cost areas. So while I was showing that line which was very stylized and I know that you understand that there's variation in that line. What you see are bids that are kind of like this.

MELINDA BEEUWKES BUNTIN: Okay.

MARK MILLER: What was the second part of your question?

MELINDA BEEUWKES BUNTIN: The second part of the question was is at least the result of having those floors, that there's an equalization of extra benefits –

MARK MILLER: There is certainly benefits being offered in areas of the country that are above what obviously if they could or what would happen in the past in the low cost areas. But you still have large differences in the plan offerings across the country and you know, certainly in high cost areas the ability to offer benefits of peers, I think by and large to be better than some of these other areas. Thank you.

JONATHAN BLUM: Yes. Just to follow up Mark's point. CMS has consistent data results that there is tremendous variation in the number of extra benefits that are offered by MA plans across the country. Those parts of the country that are in the higher costs areas like Miami tend to have a much more generate – more generous benefit package than the low cost areas. And it's a policy call.

Do we want benefits to be consistent across the country? Do we want to have these wide variation? But under current law, even if we were to pay at the benchmark in some parts of the area, there'd be tremendous extra benefits being offered due to the inefficiencies of fee for service in certain parts of the country.

ED HOWARD, J.D.: And I also – I want to just go on a little bit from that and from what you're saying. So I mean a

question, the way you cast it is a sort of what was in this unfair is one point.

MELINDA BEEUWKES BUNTIN: Well, I was saying that was the rationale.

MARK MILLER: And I got it and I know it's not you. Okay? But I just want to use it to say something. And then, you know Jon's point on a policy call. I mean another way to think of the problem is what do you want from the program? So I mean one tactic is, is to say now it's all about being more efficient than fee for service. And I just want to toss off as I drive by, you know, seeing qualities constant can you be more efficient or less costly than fee for service? That's one objective.

And that might drive you in the direction – a very different policy direction where it would say, well the subsidy is to promote plans in other areas. Maybe they shouldn't be so high or nonexistent.

Another objective is no, I want choice all over the country. I want extra benefits all over the country. And then that drives the question of all right, well then how much – how as a taxpayer and as a Medicare beneficiary, how much are you're willing to pay in order to get those things? And I think implied by your questions that's what you were saying.

MELINDA BEEUWKES BUNTIN: Yep.

MARK MILLER: Right.

TRICIA NEUMAN, Sc.D.: And just to put one more quick thing, I know Vicky's waiting. But right now, if you think about that, the traditional program's view as its structured is that all Medicare beneficiaries across the country get the same benefits for the same premium with some income adjustment.

Regardless of where they live Medicare ends up paying different amounts in different parts of the country. And so, as you think of these add on benefits it's important I think to think of it to in relationship to what the policy assumptions have been behind the Medicare program.

VICKI GOTTLICH: Vicki Gottlich, Center for Medicare Advocacy. I have questions about competitive bidding. If is as Marsha says, a limited number of companies enroll the predominant number of beneficiaries. How are we going to have competition?

And then the next question is I'm wondering whether anybody has looked to see what happens in the different markets? In terms of the high, the low – who are going to be the winners and losers, urban versus rural? What kind of analysis have you done? Thanks.

JONATHAN BLUM: I mean I think a couple of things. We have, you know, as producing the estimates in the President's budget there was a very rigorous estimate that was produced by our actuaries and also I think that tracks very closely to what CBO put out in December. But the looks of the actual plan bids

and make some assumptions regarding how plans may participate going forward.

I mean I think different areas of the country will be differently affected. In some parts of the country we have10 plan sponsors and others we have more. We have to think very carefully in constructing competitive bidding to ensure there's not, you know, kind of one plan kind of grabbing everything and being able to dominate the market.

So how this gets implemented by Congress – has to be carefully constructed. But when looking at the actual plan bids as Mark talked about, they are lower than what the program actually pays which produces opportunities for cost savings. And I will say that if we do just, you know, move down to a lower benchmark place, a level across the country, we're still going to have wide variation in benefits, plan participation, and so it's a policy call.

So, do we want to have a plan environment where we are setting prices or payment levels based upon plan's actual costs and trying to get some more parity in plan benefits? Do we want the payment level to be more reflective of the different costs dynamics across the country? In weighing those different tradeoffs, we felt the best possible policy is a competitive bidding framework relative to a straight benchmark cut.

ED HOWARD, J.D.: Okay. I just hope it's – this is just a clarification. So the difference in a competitive

bidding approach is that instead of the benchmarks being set administratively in law, you would gather up all the bids and then say, okay I'm going to set a benchmark based on those bids.

And so to Jon's point, what you're implicitly doing is having the plans declare how much it costs to provide the service and then trying to construct a benchmark on that basis. Just in case anybody's not –

JONATHAN BLUM: Oh thank you, that's helpful.

TRISH SENA: Trish Sena [misspelled?] from the Center for Medicare Advocacy. We have 75-percent of Medicare beneficiaries in traditional Medicare and it's astonishing to me that we have these discussions of policy options about creating some possibility for extra benefits in normal parts of the country.

Why aren't we using the money we have to create extra benefits for the entire Medicare beneficiary population including the 75-percent still in traditional Medicare rather than creating these artificial ways to possibly make the private market? Maybe offer something that might be of added value to a certain number of people. It seems the real policy question is how do we make Medicare better for all beneficiaries.

JONATHAN BLUM: I think that's an excellent question. And I think, you know, based upon the data we've seen by Med

Pack and others for every extra dollar in benefits that are delivered to the MA population that it costs more to taxpayers and beneficiaries that one dollar.

And so I think that there are more amicable ways to distribute those extra benefits across all Medicare beneficiaries not just those who are fortunate to live in certain parts of the country or that have lots of plan choices. That's part of the kind of the rationale behind the President's proposal is to ensure that we are distributing benefits and providing Medicare benefits to the entire Medicare population not only those that are enrolled in the MA plans.

The other issue that I'll talk about is we don't really know exactly for sure what extra benefits, what extra value the MA plans provide their beneficiaries. We – CMS right now does not collect what's called encounter data from the MA plans to actually measure and actually collect data for what services are being provided to their enrollees.

We plan to start this collection this year. We want to collect more information to truly be able to evaluate how do benefits, you know, fair? How are they delivered? How is quality of outcomes achieved for folks that are in the fee for service program versus those that are in the MA population? So that's another thing that we plan to move forward on this year to ensure we can answer that question better than our current data systems provide.

ED HOWARD, J.D.: Anybody else? The only thing I would add is that, you know, impliciting I completely understand the point of – a way to make your point is that this is a targeting issue. Why if we're in the business of offering extra benefits would you target it in this way?

And you know, pay the administrative costs, the marketing costs, that go into the existence of a plan and have the extra benefits distributed based on who actually enrolls into your plans. That's sort of a targeting cost or a targeting issue.

But the other side of it, the question is well why not just expand benefits to everybody and I think, you know, it'd still be up here saying okay, is this the next best spend for the federal dollar? I mean what we're talking about if this goes from, you know, 25-percent of the population at $10 and $12 billion to go to the entire population, you're up to $50 billion per year on top of what Medicare's spending on a program that people are asking questions about.

How about is it going to be there for future generations? So I'm not disputing your point but I do want to make people understand that by simply saying, well let's just give the extra benefits to everybody, that's a $50 billion proposition in year one.

MARSHA GOLD: There also is – and I do think that's a good question but I – there's a sense of history. Originally

when the Medicare HMO program and others were up, the concept wasn't that you'd pay more money for more benefits. The concept was actually you pay less.

You'd pay 95-percent of fee for service and if the plans could do it cheaper, they'd get better benefits. There was a big study of that which CMS finally did and my colleague, Grandy Brown [misspelled?] did. And in fact, it found that those plans were able to deliver – were things more cheaply but they also were overpaid because risk adjustment wasn't good.

And so CMS didn't get the savings it did but that was what was behind it. And in some ways, even though some people who were enacting the MMA knew exactly what they were doing in terms of the payments. Other changes were sort of – they aggregated. You know, the rural people wanted the floor. So you aggregate that.

And then someone else wanted something else. And you put it all together and no one voted that there should be a 118-percent more than fee for service in this program. So to some extent, this thing has morphed. And I think the key question facing Congress now is what do we do with it?

I think what you hear from Mark and Jon are two – Med Pack has sort of talked about changing administrative pricing. They've been consistent and correct me if I'm wrong, but consistent on saying that this unlevel playing field doesn't make sense. And there are various ways you can fix it.

The administration has said let's use a competitive feature to reduce those payments. There seems to be a consensus that reducing those payments makes some sense. And the question is how do we do it? And I think one of the questions for people here is how do you do that while being fair to people and being as little disruptive of beneficiaries as you can.

ED HOWARD, J.D.: Along that line, I just want to recall for some of the folks that were around here five or six years ago even. That lots of members of Congress got lots of mail about the plans that entered Medicare Advantage and then withdrew when the payments went down too far for their comfort level. Maybe 118-percent is a pretty good comfort level for everybody. Go ahead, if you would.

TRICIA NEUMAN, Sc.D.: There a lot of questions here about competitive bidding but I think that Jon and Mark have talked as much about it as they may want to but – so I'm going to talk about another question that somebody had. Which is another question of extra benefits again and you know, it's confusing. I think with the so called over payments and plans are providing extra benefits; yet, Jon talked about plans are charging more than traditional Medicare.

So this person wants to know is that going to be possible even with the call letter that tries to put a lid on

that? Will it be possible for plans to still have higher cost sharing under their plans than traditional Medicare charges?

JONATHAN BLUM: Yes, that's a good question. There are some that have commented to CMS and that have made very strong recommendations that a beneficiary that's enrolled in the MA plan should pay no more than the cost sharing for those that are in the traditional fee for service program.

So if you pay a $20 co-payment for a sniff visit or a physician service making this up, that the MA plan can charge no more than $20. They have the right to lower it but not to increase. The law is quite clear. And so when Congress created the MA program, they let plans have flexibility in how their cost sharing is structured.

If plans want to have lower cost sharing for certain services but higher cost sharing for others, so as long as their actuarial equivalent to the overall cost sharing benefit to fee for service that that is permissible. But CMS does have authority to make sure that cost sharing benefits that are offered by MA plans don't discriminate beneficiaries.

Meaning that they don't set a cost sharing value that would cause a beneficiary who has diabetes or congestive heart failure not to want to sign up to a plan. So CMS staff through really rigorous reviews of cost sharing benefits to make sure that they don't discriminate against certain beneficiaries. We plan to have those reviews become stronger for 2010 plan year.

We want to make sure for certain services that cost sharing isn't too high for a Part B, for example, for a very high, you know, cancer drug for example. For cost sharing for home health services, for skilled nursing facilities; we want to make that a plan's cost sharing requirement, you know, doesn't produce undue burden to plan.

So under current law, CMS cannot require a set cost sharing package requires – offered by a plan but we can do very tough reviews to ensure that plans don't discriminate. And that's going to be authority that we plan to use for the 2010 plan year.

ED HOWARD, J.D.: And the tough reviews amount to what we used to call jawboning? Is that fair characterization?

JONATHAN BLUM: I think it's fair. I think CMS also has the authority to reject plan bids. So we're hopeful that plans will work with us. We're hopeful that plans will have to share the same shared goals as we do. But we plan to use the authorities that Congress provides in us to ensure that benefits don't discriminate.

ED HOWARD, J.D.: Yes, go ahead.

PAUL PRECHT: Hi, I'm Paul Precht with the Medicare Right Center. And I'd like to ask Tricia's question in – Chris Neumodos [misspelled?] question in a different budget neutral way.

That is right now we counsel people with Medicare which basically they can join a MA plan and we have to look at the potential cost sharing that they face there and whether the plan has an out of pocket limited, for example. And the alternative to that is Medicare plus a supplement because right now, you can't, in good conscience, say you know go with Medicare alone because there is no annual out of pocket limit and if you were to get very sick, you could face tens of thousands of dollars in costs.

So is there any thought to looking at the Medicare benefit and structuring – restructuring it in a way and I know there's not a lot of appetite to spend more money on Medicare beneficiaries when we're trying to cover 46 million uninsured. But restructuring it in a way so that people could take the Medicare benefit and have that assurance which is what you want from insurance that if you were to get very sick with cancer or something, that you don't have essentially an unlimited liability.

JONATHAN BLUM: I think there is a lot of interest by the administration to look at ways to improve Medicare, to improve its cost sharing structures. I mean there's different concerns that you hear about that all have to balanced. Currently a fee for service program doesn't offer catastrophic coverage.

Another concern that you hear about is that cost sharing services aren't, you know, kind of distributed evenly across all benefits. Some benefits don't have cost sharing requirements. Others have quite substantial cost sharing benefits.

The other concern that you hear about is that beneficiaries who are in the fee for service program that purchase supplemental coverage, Medigap coverage often purchase first dollar coverage that tends to skew some of their cost sharing incentives that Congress has created.

The other thing that you hear about often is that for beneficiaries that qualify for low income assistance don't apply for benefits or states set up the different screens that could be changed to ensure more low income beneficiaries do qualify for cost sharing assistance. But as Mark, you know these – that it isn't free to expand or to change the cost sharing benefits.

They have to be weighed very carefully. That you hear very conflicting recommendations by folks about the best way to do it. But I can say there is, you know, a very active interest and you know, to ensure that we both improve that the fee for service program while also considering changes to other parts of Medicare.

MARK MILLER: The only thing that I'll add because Jon covered kind of back and forth in this. But you were very

careful in setting up the question in saying budget neutral. And the first thing I'll say is we have a chapter coming out in June report where we're discussing a lot of the sets of issues that Jon just went through.

And two, if it is in fact budget neutral, then what's happening, you know, Jon's detailed it but what's happening at a conceptual sense is you're lowering the costs for people who are very sick because they're hitting, you know, very high, you know, deductibles, out of pockets, that type of thing. And raising it for people who have – who are more healthy.

And if you stay budget neutral, that's what you're always doing when you're kind of balancing off of the different benefits. And I'll just leave it to you and to anyone else in the room to discuss how that actually plays out but that's fundamentally what you're doing.

SUSAN JAFFE: Hi, Susan Jaffe, with Health Affairs Journal. The Obama administration estimates that the savings from going to competitive bidding is something like a $177 billion over 10 years but Med Pack has said the savings would be about $157 billion over 10 years. Are you anticipating that competitive bidding will result in payment – in clearing payments that will be less than the costs of traditional Medicare?

JONATHAN BLUM: I mean I can't – I mean different groups use different baseline assumptions. So I'm not sure you

can compare the CMS actuaries estimates to Med Pack to CBO. They use different baselines, different assumptions but I think, in general, both CBO and the CMS actuaries have, I think, very similar cost estimates for the competitive bidding.

I mean the whole notion and the whole, I think – one of the primary policy arguments behind competitive bidding is that we need a much more flexible payment system that can respond to local dynamics relative than a pro-rata reduction to the plan benchmarks. In certain parts of the country, plans costs are much below fee for service. If you think about south Florida and that's an area of the country where we think that plan benefits can be delivered much more cost effectively than the fee for service program.

In other parts of the country and in the so called low cost areas, you know, plans will have different cost structures, different bidding structures. And so the President has put forth a competitive bidding to create a much more flexible payment system that produces the cost saving goals but at the same time is better able to respond to local healthcare cost dynamics.

TRICIA NEUMAN, Sc.D.: This just in. This is a question about how Medicare benefits can be improved for members who have third party insurance and how care can be better coordinated? And one of the subgroups of the population that we haven't talked much about are dual eligibles who go –

who can go into Medicare Advantage plans and be in the special needs plans.

So a question for the panelists may be, what do we know about how well Medicare Advantage plans are coordinating benefits for dual eligibles? And what do we know about the quality of care and how well they're coordinating care for this population? Do we have any information?

ED HOWARD, J.D.: Marsha?

MARSHA GOLD: Yes, it's a complex topic. The sort of quick answer is that they're not doing it as well as they could but it's complicated to do it. I think you have to keep in mind that if someone is dual eligible there's sort of two things that's coordinating if it's Medicare and Medicaid.

One is the acute care benefits and really Medicare's paying most of that. There's just a little bit of money on the side for the state's cost sharing. And so whether or not states want to get involved in that is difficult.

The other thing that is long-term care and there, there could be lots because Medicaid's paying a lot and that whole acute care long-term care sector could really be coordinated. When our special needs plans were set up, there were no requirements on them to do almost anything different than what Medicare Advantage would otherwise do.

That was, in some ways, deliberate. Now, Congress has backed off. And the administration has come forward and there

are some more quality requirements that are being placed on them on a – on each type of plan so there's the dual eligibles, the institutional, the other. I'm not 100-percent up-to-date on how things are going and whether it's improving.

There may be people here who can answer it but these are high cost people by and large. And there probably is a lot of room to improve it but one of the questions is states differ and this a great segue to how health reform could differ. Some want to coordinate. Some don't. Some feel there's more interest in coordinating. Some don't.

And we've talked to firms, some of them want to coordinate. Some of them don't want to have to do anything with plans, they'd rather even pay a lot of money not to charge the co-payments just not to have to talk to the state. So it's different types of ways of doing it.

MARK MILLER: And we do some work on this either one or two years ago and we ended up making an array of recommendations on this special needs plans. And it goes right to the points that Marsha is making that this was an option. And we didn't see a lot of, kind of, rigorous adherence to what the principle of the special needs plans were which was to focus on either certain chronic condition populations or in this – peculiar to this question, truly coordinating the care between Medicare and Medicaid populations.

I won't go through them. On the website there is a chapter that goes through this but on the duals, we have specific recommendations to require that there actually is coordination between the Medicaid and the Medicare programs because we were getting dual eligible snip plans that had no relationship whatsoever with the state. And we were thinking that was kind of missing the point.

JONATHAN BLUM: Part of our call letter revision for 2010 also helps to implement that recommendation but also that Congress adopted. And so we do think it's important that those special needs plans that are providing services to those dual eligible populations actually have some agreement in place.

So there is coordination that is real and not just in that name only. I do agree with Marsha that most of the plans that are providing coordinated services to the dual eligible primarily out on the cost sharing side and not so much on the real hard knock, long-term care benefits. So we are really interested to look at ways to help promote this concept where you can really start to integrate the long-term care benefit with the acute care benefit.

That's probably the best opportunity for cost savings, for quality improvement but I think to date the special needs plan programs only taken very, very small steps towards that coordinated integration role and I think we have a lot more work to do in that regard.

DAVID GREGAN: David Gregan [misspelled?], Georgetown. Historically, there's been consistent indication that private plans actually enroll less sick beneficiaries. And I wonder what we know now or what we think now in terms of the actual percentage difference if you took into account the sickness levels of the beneficiaries in traditional compared to MA plans, one.

And two, what can be done in the future to make risk adjustment better so that these variations -

[END RECORDING]