Medicare Advantage:
Early Views and Trendspotting
Alliance for Health Reform and Commonwealth Fund
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ED HOWARD: I'm Ed Howard with the Alliance for Health Reform. Thank you for coming. I want to welcome you on behalf of Jay Rockefeller, our chairman, and Bill Frist, our vice-chairman, to this briefing on the Medicare Advantage program, one that was reshaped and expanded in 2003 as part of the Medicare Modernization Act. Our partner in today's program is the Commonwealth Fund. We're happy to have Stuart Guterman of the Fund here today, along with Anne Gauthier and a couple of other folks.

Medicare Advantage is the current incarnation of private health plan involvement in Medicare, involvement that began in the early '80s. As I understand it, although the numbers change hour to hour, something like 7 million beneficiaries are enrolled in Medicare Advantage plans of various kinds, so it is a big factor in the scene. It's been the frequent center of fairly spirited discussion as well, and today I suspect will be no exception.

Just a couple of logistical items; you've probably heard them before if you've come to these briefings before, so bear with me. An awful lot of background information in your packets; our slide presentations, some got into your packets, some were lying there to be picked up, some you may find only on our website, but they're all there. And I commend them to you; there's lots of valuable information. You'll also find

biographies of the speakers that are a lot more extensive than the introductions they'll get from me. There will be a webcast available tomorrow morning of this event on KaiserNetwork.org and a transcript within a few days, there and on our website at AllHealth.org.

The ubiquitous blue evaluation form is in your kits, and we'd very much appreciate it if you'd take the time at the appropriate interval to fill that out and give it back to us and give us some feedback. And there are, on the other side, I guess, some green question cards that you can use to ask questions of the panel. We reserve a fair amount of time for Q&A, and we want to get your questions answered. There are also microphones available where you can speak your question if you so choose.

As I noted, we have with us Stu Guterman of the Commonwealth Foundation, where he is the head of the program on Medicare's future that the fund has run for a number of years. He's also a veteran of Medicare from the inside, as director of CMS's Office of Research, Development and Information. It's nice to share moderator duties with someone who actually knows something about the issue that we're talking about. Stu, thanks for coming, and we look forward to your remarks.

STUART GUTERMAN: Thanks, Ed. I won't take long, because I don't want to take any time away from this terrific panel we've assembled.

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When we were thinking about this session, we figured that May 19th was a good date, because after May 15th we figured that there wouldn't be any controversial issues remaining in Part D, and so what would people talk about? So we thought that we would put together a panel that I think is going to provide a very lively discussion, raise some issues, and hopefully give you some points to take away with arguments on both sides of those issues and ideas about how we can continue to work on the Medicare Advantage program to improve it for the beneficiaries that it's supposed to serve.

And we do have a terrific panel, and I want to thank, on behalf of the Commonwealth Fund, thank the Alliance for setting this up, thank all of you for coming, and thank this panel for agreeing to participate. We're going to start with Marsha Gold of Mathematica Policy Research, who's going to give an overview of the issues and raise a couple of issues that come out of her extensive work on the Medicare Advantage program and its predecessors.

Then we're going to go with Brian Biles, professor of health policy at George Washington University, who's going to present some results from a paper that it coming out today on the Medicare Advantage program and the range of implications for beneficiaries in different groups by health status. Then we'll have Karen Ignagni, who's the head of America's Health Insurance Plans talk about her response to the issues that have

been raised and make a few points of her own on her perceptions of the program is operating. And then we'll finish with Abby Block. We figured we'd give CMS the last word for a change, and Abby will represent the perspective from the group that runs the Medicare Advantage program from inside CMS.

So, unless there's any other issue that needs to come up, I'll just hand it over to Marsha.

MARSHA GOLD: Hi. I'll be reviewing what I think the central things are that we do know now about 206 from the available public data. And I'll leave 2006 enrollment to Abby Block or others, to the extent there's more discussion on it, because that isn't really public.

So, first, as widely reported, almost all Medicare beneficiaries have at least one MA choice in 2006. Whether they know it or not, we don't know, but they do. And you can see from the table that the growth has been mainly in the rural areas, which is where they didn't have a lot before. And the only exceptions to choice are really in Alaska, which really has much less choice, both of MA and PDPs than most any other place, and a few parts of New England; New Hampshire, Maine and New Jersey.

This has more detailings on the types of offerings that exist in rural areas in different parts of the country. And I'll draw your attention first to the first set of three columns. Those are the local HMOs and PPOs. That's

historically, especially the HMOs, been the backbone of the program. It's where most enrollment is in. And what you can see is that that's still pretty much an urban phenomenon. There are more of those options, especially PPOs, in urban areas. But while there's been some growth in rural areas, it's still a minority of beneficiaries in rural areas who have them. So the expansion of availability, especially in areas that didn't have much before, is really due to the expansion of the private fee-for-service plan and, to a lesser though still significant extent, to the regional PPOs.

One of the things I've heard people say is that they've discounted—they say, "Well, Medicare Advantage plans enrollees already had drug coverage, so this isn't really much." And I think it's important to recognize that while we've been tracking this for a long time, and while MA beneficiaries tended to have drug coverage in the plans, the benefits really come down in recent years. And Part D really was an improvement for them. In 2005 of the basic plans, only a little more than a third had brand name coverage at all, and over 50-percent of them limited it to $1,000 a year or less. So they have been helped by Part D, and I think it's important to recognize that.

These are all unweighted numbers, because CMS hasn't released the enrollment data at the county level so we can weight them up. But basically, what you see here is that in

general, for MA premiums average—this is just the prescription drug part—they average about $18 per month across all of them, compared to $37 for the prescription drug plans. And even by type, while there's variation, the MAs on average are a better deal. Now, this shouldn't be a surprise. In a lot of ways, that's what Congress paid people to do in the MMA. They're allowed to apply AB savings to offset the cost of the drug benefit, and so that makes it less expensive. PDPs don't have access to that. And also, they're paid more than Medicare pays in the traditional program, so that gives them more flexibility.

If you look here, what you can see is that there's some variation across the plans. You have to realize that about two thirds of the plans that are offered are HMOs, and that's where the current enrollment really is. This only comes out partly in this table, but I think HMOs still are the best deal in terms of just the benefits. There are still many zero premium products and some other features that make them attractive in terms of the benefits. The private fee-for-service plans—and these are total premiums; these aren't just prescription drug premiums—they have lower premiums than I might have thought, because they're not set up to be managing care. We're still looking at these data, but the preliminary stuff that I've looked at says that when you start looking at the cost sharing on AB, the regional PPOs and the private fee-for-service plans

will be less generous than the HMOs in that area. So that's still to be looked at and to be known.

The most criticized part of the drug benefit as I see it reading the papers is the coverage gap, which no one proposed as a matter of policy; it just was a better alternative than the other things that were left over. And MA doesn't solve this problem. Most plans still have maintained the coverage gap. There are important structural reasons they would do that, aside from finances. There are some plans that cover generics, but typically not brand name drugs and you have the data here.

Now, when you look at the trends in enrollment in 2006, it's important to recognize that really—some of the press that's been coming out about the role of certain firms in the market doesn't surprise me, because a small number of firms have historically dominated MA enrollment. And they're some of the same firms that are offering national PDPs, and so they dominate that, too, especially if they're below the benchmark and they get all that automatic enrollment. It doesn't mean they may not be attractive to beneficiaries, but you have to realize that there's a base of enrollment there that's going to make some firms dominate.

This is as of September 2005. And so what you can see is that Kaiser is 15-percent of MA enrollment. They're one of the only firms that really was pretty steady all through the

period when things were unstable. They've been growing enrollment. They have a lot of agents. They have a unique system. Then United and PacifiCare were each major player before, and they're now 19-percent of the market. And their products compliment one another, so when you put them together, there's not as much overlap as you thought and a lot more diversity, so it will be interesting to see how that looks in 2007. Blue Cross Blue Shield affiliates are diverse. They're usually local plans, although now with Well Point as a national one, but they make up—if you can count them right, and I thank Blue Cross Blue Shield for helping us count them by the reports they've done—they make up 17-percent of the MA enrollment in September 2005. And then Humana's only 8-percent, but that's much up from what it was earlier in the year, and they're private fee-for-service enrollment's been growing heavily.

So then what you can see is that, with the exception of Kaiser, which has pretty much stayed with the same products it's been offering all the way through, all the other major firms have expanded in 2006 and have some product that's available to at least 69-percent, or over two thirds, of beneficiaries. In Humana's case, it's almost all because of private fee for service and the regional PPOs. In the others, it's a more diversified or mixed set of products that they're offering, although they may only offer one in a particular market. It varies a lot.

We put here the enrollment trends from the regularly reported monthly CMS data through December of 2005, as we were going in. Now, you should realize that some of the new plans in MA came on board in the fall, so some of this enrollment may already reflect the influence of the upcoming year. But essentially, enrollment went from 5.5 million in January 2005 to 6.1 million in December 2005. That's an 11-percent growth, though it's still only 14-percent of the market. We don't have public data on drug coverage before then, so I can't segment that 6.1 million into the number that had drug coverage. But if you look at the coverage of drugs in the basic plans, it's at least 75-percent should have some drug coverage. So at least 4.6 of the 6.1 had some form of drug coverage, and it's probably somewhat higher than that. So you can think of that when comparing it to the number for 206.

So, where does that leave us in terms of what we know? First, I think it's unclear, to me at least, right now whether beneficiaries are even focusing on Medicare Advantage. It's been so complicated for them to sort of think through the PDP options that whether or not they're thinking about whether MA might be better, I don't know if that's going to happen this year or it would happen next year. We'll know when we see the enrollment data, probably, at least some of that. If all else, one of the questions, obviously, is how well beneficiaries will understand the options and how much they affect choice. It's a

much more complicated set of options. Before, it was mainly you join and HMO or you stay with your traditional Medicare, and now there are a whole lot of different options that they need to understand.

Second, a lot of the increase in availability, especially in areas that didn't have private plans before, really is due to the regional PPOs and the private fee-for-service plans. And I think it remains to be seen how those products will translate over time. I'm not sure yet how competitive the regional PPOs will be and for who. The availability of that product is heavily driven by Humana. It was called for in the Act, and it was a major interest, but I can't tell if the benefit packages are going to be competitive and what the enrollment levels will be vis-à-vis the others and what that will mean for who is in them and where. And policy-wise, that's important, because that was a major part of the MA expansion.

I think the private fee-for-service expansion—I'm not sure anyone ever anticipated; it just sort of was in there from the old BBA, and it was expanding before 2006, and it's really expanding now. The question I have on that is how viable a product it is and will it really improve on traditional Medicare. Essentially, it's a free rider. It's taking advantage of Medicare's negotiated rates right now. Medicare will have a harder time negotiating rates if it gets a lot of

enrollment. They have varied limits on what they can do to manage care. They can do some through the patients, but not too much through the doctors. So whether you think of this as an improvement for beneficiaries over traditional Medicare is a question, I think, for policymakers to understand. It's not an empirical fact. It's something to consider.

There are two more things. One is, right now a lot of these patterns are highly dependent on payments. So Medicare now gets more than it costs Medicare to deliver traditional fee for service. So my big concern is what happens to beneficiaries over time. I don't know if those rates will be maintained. Even if the excess is maintained, will they jump up and down? If they jump up and down, the benefits are going to change, and then people are going to be very upset because they just made the choice. And I think most people remember the late 1990s early 2000s, and few would want to go back there. So that's a really unsteady time.

And finally, this may sound like a geeky concern, but it's probably one of the most policy-relevant things I'm going to say, which is: you can't understand this stuff unless you build it up from the microdata and figure out what beneficiaries are doing. You need data at the county level for each contract, and this year, and in the future especially, also at the plan level, because without the plan level, you don't know who's getting enhanced benefits or others; you don't

know who's in an SNP and who's not in an SNP. So I'm really hoping that CMS will not only start releasing the data that they historically have over time but that they'll add a plan identifier to it, and do it consistently over time, because I think a lot of us are going crazy trying to figure out what's going on, because it's hard to work from the aggregate numbers. You really have to build this up. It's very difficult.

Thank you.

ED HOWARD: Before we go to Brian, could I just ask you what an SNP is?

MARSHA GOLD: Special Needs Plans. Now, all the MA plans are available to any Medicare beneficiary, essentially, who wants to. SNPs are specialized plans. Most of them now target dual eligibles with Medicare and Medicaid. Some of them deal with institutionalized people. And there are a small number, but I expect it to grow over time, that are targeted at certain people with complex conditions and frailties.

ED HOWARD: Okay. Good. Thank you very much. Brian?

BRIAN BILES, M.D., M.P.H.: Thank you very much, Ed.

First of all, I would agree with Marsha's point on data. I think that's very important. And then I think I'd also recognize the work that she and her colleagues have done over the years to track out-of-pocket costs by plan enrollees. The study that we've done really does address the question of whether beneficiaries understand the options, and particularly

out-of-pocket costs, and the fact that it's really very important.

The general—and I would even say conventional—wisdom, but certainly the message, is that Medicare Advantage plans will save seniors money. There have been a number of statements from HHS that indicates that it's $100 a month less than Medicare and Medigap. And then beyond that, more recently there have been comments about the largest savings are for enrollees with chronic illnesses. And so the conventional wisdom, the real implication is, that Medicare Advantage plans really save all seniors out-of-pocket costs. So that's the point of this study. Is that, in fact, an accurate characterization?

If we look, we really find there are three important background points. First of all, health care costs vary greatly among the elderly. The sickest 5-percent have 43-percent of total cost at an average of $63,000 a year. They healthiest 50-percent, on the other hand, altogether have only 4-percent of cost at an average of only $550. And this is from a study recently released by CBO. The second point, Medicare risk adjustment payment to plans, is not ideal. And again, MedPAC has indicated Medicare overpays for healthy enrollees by $180 a year, which is not terribly significant. But most important, Medicare—and this is the new risk adjustment system that's just now being phased in—underpays for the sickest

enrollees by more than $4,000 a year. So plans have real incentives to marginally enroll healthy. But they really have incentives to stay away from individuals who are very sick and use a lot of services.

The third point is that Medicare Advantage plans are not required to offer from a set of defined benefit packages like Medigap. And if you're familiar with Medigap, you know that they provide one of a set of generally ten benefit packages with defined benefits. For example, Medigap Plan F covers all Part A hospital deductible and Part B deductible and coinsurance. The background for this study really comes from years of site visits and reviewing health plan benefit packages, discussions with plan members or plan managers very concerned, sometimes even obsessed, with risk selection and being left with the sickest individuals in their market area. And then again review of benefit packages indicated that plans were surprisingly now charging $100, $200 and some even $300 a day for hospital care. So that was really the genesis of the study.

The analysis includes plans in all cities with significant Medicare Advantage enrollment and available data. And that actually is described in some more detail in the issue brief which is in your package. The study compares out-of-pocket costs between Medicare Advantage plans and AARP Medigap Plan F, which is available, open enrollment, with generally

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community rating. And so it's 88 plans in 44 cities all across the country and characterized for individuals in good, fair and poor health. Here are the cities. You can see they're all across the country, not located particularly in one geographic area or another. Again, these are cities where MA enrollment was greater than 10-percent last year, in 2005.

The real finding, probably the most important findings, is the great range if out-of-pocket costs for individuals in poor health. And it's from a high of over $7,500 a year to a low of less than $1,500. And so you'll see there the distribution of the 88 plans.

And so again, to go back to the conventional wisdom that Medicare Advantage plans are always advantageous to the elderly, this distribution indicates that it depends very much on which plan and in which city. You'll see here that for beneficiaries in poor health particularly had higher costs in Medicare Advantage plans than had they joined regular Medicare with Medigap Plan F. This was 16 of 88 plans. On the other hand, in fair health, it was only two of 88 plans were more expensive, and in good health, none at all. We did find that in four of the cities, both of the largest plans had higher costs for individuals in poor health. So again, it's not only a choice of plan, but it also may well be the city in which the senior resides.

The question is: is this important? And the answer is yes and no. On one hand, again, 5-percent of beneficiaries have about 43-percent of expenditures. So on one hand, these are the people who really use care, really participate fully in Medicare and in Medicare Advantage plans. On the other hand, it's a small number. Beneficiaries in poor health are only about 6-percent of the totally number of elderly and disabled. And I think it's clear, then, to indicate that the study does indicate for 95-percent of beneficiaries, Medicare Advantage plan does offer a better benefit package. So in terms of numbers on one hand; on dollars, it's much more questionable.

If we then look at payments to MA plans, we find that Medicare pays MA plans a more than average fee-for-service cost now in every county in the country. So every plan in every county MA plan payments are greater than the average fee-for-service costs. Running the 2005 data, the average was about 11-percent more; in some counties, more than even 15- or 20-percent more than cost in traditional fee for service. Medicare extra payments averaged over $800 per MA enrollee, more than fee for service. And looking to the future, trended forward, preliminary projections would indicate that MA plan rates would exceed fee-for-service costs by more than $25 billion over the next five years.

If we then look at the effect, presuming that the extra payments are assumed to subsidize MA plan benefits and then

could be added to out-of-pocket costs for MA plan enrollees, we find that for enrollees in poor health, just under half of the MA plans would have higher cost than in Medigap Plan F. In fair health, 20-percent of the plans would have higher costs, and even in good health, as much as 14-percent of plans. So if we consider that the extra payments that Medicare makes to plans subsidize benefits, without those subsidies, the picture, again, is considerably different.

Finally, policy implications, and we think there are really four area here that are important. First of all, just individual seniors and their advisors should make decisions to choose a plan very carefully, especially if the senior has chronic illness. And again, we know that for those individuals, out-of-pocket costs can run from as little as $1,500 to as high as $7,500. So the city and the plan make a lot of difference, and people should look carefully about which plan and which city they're choosing a plan in.

Secondly, we know seniors need individual assistance in choosing plans. Currently, Medicare funding for direct assistance to beneficiaries on plan selection by SHIP is very limited. And one thing that might improve the situation would be to set aside a small percentage; a very small percentage, perhaps a quarter of 1-percent of payments to plans, or $125 million per year. This would provide as much as $3 per Medicare beneficiary all across the country so that there are

counselors available to beneficiaries who can then understand the benefits that may or may not be available in specific plans and in specific cities.

Medicare Advantage enrollees should not be locked into Medicare plan enrollment for an entire year. Again, people can make bad decisions and can end up in plans for which, at some point during the year, they might be better off not enrolled.

The fourth point is Medicare should develop a limited defined set of benefit packages for MA plans similar to those used for Medigap, again, not just allow plans on their own to choose their benefit packages, again with hospital cost sharing as much as $200 or even $300 a day, but define benefit packages the way Medigap operates and has operated for almost 15 years.

And then finally, back to the ultimate incentive for all of this, the current and new risk adjustment system now being phased in is certainly better than the previous one, but it's far from ideal. And Medicare, again with billions of dollars a year on the table in payments, should support extensive and continuing research on more accurate risk adjustment system.

So thank you all very much.

ED HOWARD: Thanks, Brian. We'll turn now to Karen Ignani. Here's your pointer.

KAREN IGNANI: Thank you. I was just asking for the time clock. I know nobody asks, but it's very helpful. My

goal is to speak as fast as Marsha [laughter], and to be as incisive as both the two previous speakers have been.

It's a pleasure to be here. I had planned, prior to last night, to do a fairly deep dive on the kinds of benefits that Medicare beneficiaries were receiving and are receiving—were receiving in 2005, are receiving today—to give you some real subtext about what the expectation might be for some of your constituents. I told Brian this, this morning when I came here: I didn't read Brian's paper until last night because I had a number of things that I was doing this week, and it caused me a long night of tossing and turning. But during those tossing and turning hours, I did go on the Health Metrics website, so I got a look at some of the specific plans that were looked at, and thought a great deal about what we know to be the case in terms of methodology.

And frankly, I guess the best way to start is just to take the elephant out of the room and address it directly. The issue of Medicare Advantage has always been quite ideological. The question is: should there be private sector participation in the Medicare program? Is it a value or is it not? In looking at Brian's paper, what I was concerned about, quite frankly, is there may be an impression left with all of you—I apologize if you're getting my back—there may be an impression left with all of you that I'm not sure is the case. And I

wanted just to talk with you about why I don't think this is the case and why there may be another view based on these data.

So I'm going to begin now. First, the question about whether we are a better deal: Brian's study notes 88 plans. Yes for good health, yes for fair health, and yes for poor health, based on this study. If any of you had a 78 popularity opinion with respect to constituents in your area, your bosses would be very happy with that. So I think that's the first window.

The second window is the sample size: 88 plans. I looked this morning. This was out of 1,600, roughly, plans in 2005, so it's a 5-percent sample. That's not to say that we shouldn't consider it. I'm not making that point. But it is important for context.

Comparison of Medicare Advantage versus the Medigap F, the AARP: approximately 10-percent of the Medigap beneficiaries are in AARP. In large measure, AARP plans are the only Medigap plans that community rate. The others do not. So if you take into account the rating factors that would be implied in traditional Medigap if you were looking at 60-percent of the Medigap beneficiaries that are not in the AARP plans, then you would also have a very different picture.

Drugs in 2005 were provided to 80-percent of Medicare Advantage beneficiaries. Marsha made the point that we know that that's the case. But the types of coverage were not

certainly anything near what we see in the Part D plan. I'll come back to that in a moment. And there were significant additional benefits provided in Medicare Advantage again that are not allowed for in the comparison.

The benchmark for analysis in my three o'clock, doing a very quick look at the website, I looked at what constitutes poor health status on this Health Metrics website. Twenty-four doctors' office visits, two emergency room visits, three in-patient admissions, 72 prescriptions and one physical vision hearing exam. I talked to several of our medical directors in the plans that are mentioned in the study—didn't have time to talk to very many more this morning—and all of them told me the following. They said that they pride themselves on the disease management and care coordination types of activities which Medicare Advantage individuals clearly and highly value. So for COPD, for CHF, for diabetes, for cancer, they basically told me, bottom line, Cliff Note version of the conversations, is that they were not doing their jobs if anybody in poor health had these kinds of encounters. But yet we are, I think, unfortunately. And I understand that Brian was limited by the way this particular website grouped this information, but I think it will be very instructive to see some of the CMS data coming out.

The next slide shows you a little bit about the broader specifically benefits that we have. We offer disease

management, as I said; stop loss, 85-percent of enrollees are receiving it; caps on hospital cost sharing; prevention; other benefits and drugs in ’05. One of our medical directors in the Philadelphia market made the point that not including drugs in this analysis means that you are not considering a value of about $400 to $500 per beneficiary in 2005. So that’s not to say that it’s generalizable over the entire markets that were looked at, but I think those are interesting data. JAMA data shows us that we’re doing a better job on five of seven key HETUS quality measures, higher satisfaction, the disenrollment in Medicare Advantage not withstanding, all the problems that all of you are familiar with in terms of funding is a little less than 2-percent. That shows you that when people participate and choose a Medicare Advantage plan, they don’t leave. So something there is valuable for them, and I think it’s useful for us to look at.

Savings for the government: this is also very important, as many of you know and perhaps some of you don’t, but in the new payment scheme that was passed as part of Medicare modernization, we have to contribute 25-percent of savings back to the government. That’s a value of $2.3 billion ’06 to ’09.

The safety net for low income individuals: my colleague Jeff Lemieux is in the room. He’s done the latest look at the distribution of numbers of people who are low income, under

$20,000, non-white. We know a great deal about how the Medicare Advantage plans are serving and acting as a safety net for individuals in our cities and towns across the country, and now increasingly, as I know Abby will report, in suburban, rural and areas that heretofore didn't have Medicare Advantage opportunities.

This is my four o'clock revelation. What should you know about 2005? To not put too fine a point on it, Medicare Advantage was on life support in 2005. This was year one after Medicare Modernization passed in December of 2003. We then were asked to submit bids roughly about six, seven weeks after that to expand benefits. All of the finances and the additional bump up went into additional benefits. CMS has tracked that very specifically. In 2005, what our plans were busy doing was beginning to recontract with providers and beginning to rebuild this program. I've looked at the specific rates of increases in a number of these counties that were looked at. I can share them with you, but a number of the counties that were looked at were new floor counties that were passed as part of the BIPA legislation back in 2000, where there were reasons that members of Congress made a decision to provide additional funding.

There are two categories of counties that members of Congress have strategically decided to provide additional funding to in the Balanced Budget Act of 1997: rural counties,

and in BIPA, they were small floor counties, areas like Portland, Albuquerque, Seattle, Cleveland, Providence was one of them, and a number of counties up in New York. If anybody's interested, we can provide that. The payments, the risk adjustment, 50-percent, 75-percent and 100-percent next year, we know from Brian's study that according to the MedPAC analysis that we are paid more than $4,200 less than the annual cost for enrollees in the high cost quintile and approximately 180 more. We do not know what the distribution of individuals with high health care status, low, et cetera, are in the plans. And so the assumption that because we are not being paid at full 100-percent risk, therefore we must be appealing to individuals in good health, I think we need to examine more specifically.

Three-hundred, Marsha mentioned, new special needs plans; 300 in 2006, very exciting. The focus of those special needs plans are to provide better, more coordinated medical homes to individuals who are dual eligibles. I don't think anyone in this room would suggest that those individuals are not without a number of co-morbidities.

But I want to come back to Brian's recommendations. We agree with his recommendations in a number of areas. First, the repeal of the lock in: this is a program where beneficiaries have voted with their feet. They don't leave. They shouldn't be forced to stay into a delivery system that

may not, for an individual or two—and that's too many, if it's just one or two—may not be appropriate. We agree with that. We also agree that we should continuously assess the predictive power of risk adjustment. We've been very much anxious to do that. We think that a discussion of new benefits should begin on the fee-for-service side. The fee-for-service program is the benchmark program, and we should be thinking about it where there are shortfalls.

Finally, we believe very strongly that we should simplify the information that beneficiaries are received, and we are launching a program at AHIP. We've been reaching out to beneficiary groups to work with them on displays of information. We've conferred with CMS, with physician groups, et cetera. We think we can add something to the thinking about how do you streamline information, give people more clarity, without standardizing benefits.

Two final points: one, 22-percent of the Medigap beneficiaries are in non-standardized plans. They purchased them before the NAIC standardized the plans. They like being there. And what we hear most frequently from the Medigap beneficiaries: Why can't you offer XYZ? So, in that system, a number of our members who are offering Medigap to ten million people would like to offer disease management, would like to offer a number of other kinds of programs that beneficiary services need.

Similarly, on the Medicare Advantage side, I think we can go a great long way toward more information and stopping short of ossifying products in the way that we represent all the Medigap carriers. And they would be the first, if this were a session on Medigap, to tell you why they think, from a beneficiary perspective, there is value in providing innovation, providing opportunities for people to purchase additional services they might need. But at the same time, the point about clarity of information is one we significantly agree with.

Thank you.

ED HOWARD: Thank you, Karen. We will now hear from Abby Block. We also now know why Karen's slides were not in your packets. [Laughter]

KAREN IGNANI: I apologize for that.

ABBY BLOCK: Well, thank you very much for inviting me to participate in this, I think, very useful and interesting discussion.

The first slide really gives you a picture of the scope of MPAD plan options across the country. This is for 2006, and so this tells you, confirms what Marsha has already told you about the availability of MA plans, the growth in availability and how significant that really is in terms of providing beneficiaries with real choice. As Karen pointed out, a considerable amount of this growth has indeed been in areas

where MA plans didn't operate previously, and having seen that movement, particularly into rural areas, is particularly gratifying. It was one of our goals, and I'm pleased to say that we're seeing that happening. And I think that's a good thing in terms of offering beneficiaries greater options.

The next slide actually gives you a breakout of the Medicare Advantage plans by type and tells you how many organizations are participating. As you can see, regional PPOs, there are 11 organizations in 38 states; local PPOs, 131 organizations in 42 states; local HMOs, 259 organizations in 45 states; private fee for service, 25 organizations in 50 states and the District of Columbia and the territories; and others, cost plans, demonstrations and so on, 69 organizations in 30 states.

In terms of benefit types, this graph shows the percentage of enrollment by benefit type. This is the prescription drug benefit type in the MAPD plans. As you can see, 74-percent, the vast majority of enrollees, have chosen a MAPD plan that has enhanced benefits. And typically, that enhanced benefit is no deductible; that is, the plan has eliminated the $250 deductible that appears in the standard benefit. The basic alternative, 17-percent, that's the next highest category. And that category as well tended to eliminate the deductible. So that, I think, was the big

feature that people clearly were looking for and got in the majority of plans.

The next chart shows you what MAPD premiums look like in terms of, again, how beneficiaries made choices. As you can see, while only 36-percent of the plans had a zero premium, 53-percent of beneficiaries chose those plans. And I think that's an important point in terms of, obviously, the fact that people do shop price and price is important. Again, if you look at the second graph going to the right, 37-percent of the plans had a premium between one cent and $32.19, and 23-percent of enrollees chose that. Am I reading that right? Have I got the colors right? So again, zero premium was very important. And overall, two thirds of the MAPD plans had an overall zero premium. That's not just the prescription drug premium, but the overall premium. And that's really quite amazing, I think.

In terms of the bidding process, the only thing I want to point out here, and I think it's already been clear from the other speakers, under the bidding process for 2006, any difference between the benchmark and the plan's bid, if it's lower than the benchmark, the government gets 25-percent of that savings, and the other 75-percent, which goes to the plan in the form of rebates, is used for additional benefits for the beneficiary. And the types of benefits that can be offered vary from premium reductions, premium reductions for the Part B premium, premium reductions for the Part D premium or other

premium enhancements, including benefits that are not covered by traditional Medicare. So clearly that extra money accrues to the beneficiary's benefit.

I just want to talk a little bit about how CMS reviews the benefit proposals that we receive from the plans each year. All required Medicare Part A and Part B benefits have to be included. And there are very definite protections from discriminatory benefit packages. It's one of the things we look at very, very carefully to ensure that nobody is proposing a benefit package that would discourage any category of enrollee to not choose that plan. We also look at trying to maintain a level playing field among plan bidders.

I just want to quickly address some of the other point, since I see that the clock is telling me to sum up. In terms of the study specifically, I think the point has already been made that the vast, vast majority of beneficiaries, even according to this study, are better off in an MA plan financially. But specifically, in terms of the markets that were chosen, there are specific factors that affect each individual market, and I think it's very difficult to make generalizations without being aware of those specific factors. And I'm just going to talk very quickly about the Philadelphia area, for example. Clearly, of the plans in that area, there's one plan which, although it has relatively high cost sharing, appears to have been designed specifically to work with

Medicaid, so that cost sharing would not affect a real beneficiary as it appears to affect a theoretical beneficiary.

The other thing that you should know about the Philadelphia, it being in Pennsylvania, many of the plans in that area specifically had designed their benefit package with the knowledge that many of their potential beneficiaries were covered by the PACE program, the SPAP in Pennsylvania, which provides very generous prescription drug benefits. So those plans would tend to have, perhaps, better medical benefits, but wouldn't have the prescription drug coverage, because that coverage would be made up by the PACE program.

So those are a couple of key things. Particularly in the Portland market, I just want to point out, in terms of the review process, it's interesting that the study looks at Portland. I'm very much aware, having participated, along with others at CMS, in the negotiations process for 2006, that one of the things that we particularly looked at in the Portland area was the benefits for cancer care, particularly chemotherapy. And where we found outliers, we specifically negotiated an out-of-pocket limit for 2006, which made up that gap.

So we're doing that. We do that every year as we scrutinize the proposals. We have new processes in place moving into 2007, again to carefully review the benefit packages to ensure that they're not discriminatory, to look for

outliers and to negotiate with the plans to make sure that, in fact, everyone is treated fairly.

I've run out of time, but I was asked specifically to provide the enrollment numbers, so may I beg your indulgence to—

ED HOWARD: Let the record show that Abby is the winner of the keep within your time limit award for this panel, and—

[Laughter]

ABBY BLOCK: Well, I'm watching this clock carefully. But I would be remiss if I didn't provide the enrollment numbers, since I promised I would do that.

These are the numbers that we released on April 27th of this year. So they are the latest publicly released numbers, and they are for MAPD plans. The top plan at this point—and we've done this at the national level. We've really aggregated up, so the number I'm going to give you, the first one, is for United PacifiCare together, and they now have 1,179,700 enrollees, and that's 20-percent of the total enrollment. And I need to mention, of course, that these numbers, as I said, we effective April 27th, so they don't include any last minute enrollment that came in on May 15th. And we're still calculating those.

The second plan in Kaiser Permanente, and they have 821,500 enrollees, and that's 14-percent. The third is now Humana. Humana has 792,500, which puts them at 13-percent.

Next is High Mark, which is a Blue Cross Blue Shield Plan, and they have 226,400, which puts them at 4-percent. HealthNet, 167,400, at 3-percent; WellPoint, another Blue Cross Blue Shield plan, 133,800, they're at 2-percent; Independence Blue Cross, 212,500, at 2-percent; HIP of New York, 119,800, again, 2-percent; NMM Health Care, 117,900, 2-percent; Aetna, 99,700, 2-percent; NewQual Health Solutions, 97,800, 2-percent; Scan Health Plan, 83,100, they're at 1-percent; Coventry, 78,000, they're at 1-percent; WellCare Health Plans, 70,800, they're at 1-percent; Empire Health Choice, 61,400, they're at 1-percent. That gets you to a total of 1,752,000, and that's 30-percent of the total enrollment. The grand total is higher than that, and the rest of the over 7 million enrollees are in other plans who had less than 1-percent of market share.

STUART GUTERMAN: Now everyone close their books, and we'll be passing out the test papers. [Laughter]

ED HOWARD: We're going to let you ask the questions instead, if you'd like to come to one of the microphones, or fill out a green card. And while you're doing that, can I sort of jump in here and maybe start with a question to Brian that might occur to the simple minded among us? So I'll ask it.

Listening to Karen's presentation, she said in the worst case grouping—that is, those in poor health—78-percent of the people had lower out-of-pocket costs. That sounds like a pretty good record. What's the big deal?

BRIAN BILES, M.D., M.P.H.: Well, I think the first point is, there is this general statement which becomes conventional wisdom, that health plans are always, always more efficient, more effective and have better benefits than Medicare with Medigap. And I think when we started our work in this area we assumed that to be the case. But we found, much to our surprise, plans across the country with $100, $200, $300 a day cost sharing, co-payments, for hospital care. And so when you begin to add that up, you saw that the out-of-pocket cost for individuals who really used hospital care could be quite substantial. And we know, again, that financially, again, 5-percent of the individuals have 43-percent of the cost.

And so it's an issue both for individuals and people advising individuals about specific plans and in a number of specific cities. But beyond that, it's a problem for the program as a whole if, in fact, health plans which are now up to 12-, 13-percent don't include individuals who have almost half the cost of the entire program.

PAUL PRECHT: Hi. I'm Paul Precht with the Medicare Rights Center. I was glad to hear—

ED HOWARD: Can you speak a little more directly into the microphone? I don't think it's—

PAUL PRECHT: Okay.

ED HOWARD: There we go. Thank you.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

PAUL PRECHT: I wanted to ask two questions, if I may, to Karen Ignani. I was glad to hear that you all were opposed to lock in, which starts on July 1st this year for MA plans and has already started for the drug plans. And I'm wondering if you could just outline what your plans are to get legislation, if you think it's needed, before that takes effect on July 1st.

And I also had a question for Abby Block, which is: we hear sometimes from beneficiaries that they signed up for a drug plan, the customer service rep said, "Don't worry. Your drugs are covered." There's a special enrollment period for folks who are victims of deceptive marketing, which that's clearly an example. But there's not a lot of clarity as to how that works. So how would a beneficiary who's in that situation go about switching plans now if they're in a drug plan since lock in has already started?

ED HOWARD: Karen, do you want to start?

KAREN IGNANI: Thank you for the question on lock in. we have been nothing but consistent on our position on lock in from the time that it was originally raised. And I think Brian makes a very good point about why we should, as a matter of policy, reconsider this. Since Abby's here, we hope that there could be some way, somehow, that CMS could interpret this. I understand that that may be difficult, but Abby, you won't mind my saying again.

In terms of what we're going to do legislatively, we're continuing to make the point about why we're excited to show very low disenrollment, that people, when they get into these products, they stay. We have wonderful satisfaction. These are our most highly satisfied beneficiaries bar none. So we can provide all those data. We're going to continue to do that and work very hard to try to achieve this objective. And we'd be happy to work with you guys on that.

ED HOWARD: Brian, do you want to tackle the other one? Abby?

ABBY BLOCK: Well, to answer your second question, we have an active casework process. We do casework every day, a little bit in the central office, primarily in the CMS regional offices. And so the proper approach in that situation that you've described would be for the individual to contact their local CMS regional office, present the situation to the caseworkers there, and they will work with the individual to try to find a satisfactory resolution.

ED HOWARD: Stu, do you want to use a card?

STUART GUTERMAN: This question says: For each panelist, what is the top change needed for Medicare Advantage next year? We can go down the row. Karen, do you want to start?

KAREN IGNANI: Well, I'd like to go back to the lock in point, and the reason for that is it's clear that a number of

individuals have looked at Medicare Advantage and have made a judgment about it based not necessarily on experiential information but it's been more of a political discussion, shall we say. So from our perspective, given the very, very low disenrollment that has been consistent with the beginning of the program, we think beneficiaries should be allowed to vote with their feet. If there's one individual who has chosen a plan who doesn't feel comfortable with that, then I think that's a reasonable condition, then, to allow an individual to move out of that plan. And I know that we don't see that very often, but that would be the one thing that I think would significantly add. We're going to be doing a great deal of work. This is not regulatory or legislative, on the display of information to try to help beneficiaries navigate not only through Medicare Advantage but also Part D. And we'll be talking with a number of you about that.

ABBY BLOCK: I have an area that I think is the biggest one, but I don't have a legislative fix for it, because it's sort of integral to the bill, I think, which is this year, the dual eligibles and the low income subsidy people who went through all the hassle of being found, finding out what they had, getting into a plan, switching plans if they needed to. I'm worried about how they're affected if those plans that they're in, and if they wanted to stay, if they're not under the benchmark, so they're not available for the low income

subsidy, and what happens to them. I don't know how one fixes that, unless you strong arm plans. But it's inherent in competition.

STUART GUTERMAN: Brian? Do you have a fix to suggest?

BRIAN BILES, M.D., M.P.H.: Yes. I think, actually, there are sort of three in different generations. First of all, next year I'd agree with Karen. Lock in would be the most important single thing. But I think, beyond that, we should begin to work to define benefit packages. That will take several years. And beyond that, we should also begin to fund in a much more major way than we are today, the next generation of risk adjustment, because that's going to take more than several years.

MARSHA GOLD: Well, my perspective is really very operational in regard to the experience that we had in the first month or two of the program this year. One of the major problems that we encountered, and of course the provision is statutory, as I'm sure you know, somebody can enroll in an MAPD plan as late as the 30th or 31st of a month, and that coverage becomes effective the first day of the next month. Given that the vast majority of MA plans do have a prescription drug benefit, and prescription drug coverage is a little bit different from medical coverage in that it's really based on real time—that is, when the individual shows up at the pharmacy counter, the pharmacist has to be able to process that claim

immediately—what we're looking at, and we started in working with Karen's organization and others this year, and will continue the effort, I think, moving into 2007, is to really, from an educational and outreach perspective, try to inform enrollees that it's very, very important and very helpful to them if they could enroll in the early part of the month rather than the very last minute, the late part of the month. If they enroll early, that allows time for all of the systems transactions to take place and for all of the information to be at the pharmacy at the first of the next month when that enrollment takes effect. So we will be working on that, certainly, with great emphasis, I think, for the coming enrollment period.

STUART GUTERMAN: We have another question. This one is addressed to Dr. Biles. Your brief recommends that MA plans have a cap on out-of-pocket costs. Would you propose the same cap for fee-for-service Medicare?

BRIAN BILES, M.D., M.P.H.: Well, certainly a cap for fee-for-service Medicare would be a good addition. On the other hand, the point of people choosing private plans is they need security. And so a set of defined benefit packages, which may or may not include a cap—perhaps some would, some wouldn't—most of the Medigap packages, in fact, do not include an overall cap. They simply specify what out-of-pocket costs must be covered. So again, I think the most important thing is to

begin to work with NAIC, presumably the same pattern that was followed in the early ‘90s with Medigap, and begin to design packages and then implement them in the next, say, three or four years.

STUART GUTERMAN: Any other comments on that?

KAREN IGNANI: I think that the person who posed the question asked a very important policy question. And the way we have been approaching the traditional fee-for-service program in Medicare and Medicare Advantage is that the fee-for-service program is the benchmark. We have to provide benefits that are actuarially equivalent to the benchmark. To the extent that we are going to be talking as a matter of policy about requiring certain things to be done on the Medicare Advantage side, then if it’s valuable on one side, it certainly is valuable for all of the individuals who are on the fee-for-service side. So if, as a matter of policy, all of you and your bosses want to go forward with talking about a stop loss in traditional Medicare—which, by the way, was included in the old catastrophic legislation that’s sometimes referred to as repealed, but it was a good idea then; it’s a good idea now—then we will match that. And that’s the way the program ought to work. If you start turning things on their head and start setting up a prescriptive set of benefits on the private side, again, it may respond to more political concerns, but it does relate to do we have a playing field that there is a benchmark

and then we compete with that. So it changes things quite significantly.

I think, if you are contemplating standardized benefits, you ought to talk to individuals who would like to have more choice if they're in standardized benefits. And you will hear that message loud and clear. So there's a great deal of important benefits that are provided to beneficiaries that you don't want to constrain. On the other hand, I think that the requirement for our arena ought to be to work very closely with CMS and beneficiary groups on the display of benefits. And those are two different things.

STUART GUTERMAN: I'd also refer you, on behalf of the Commonwealth Fund, I'd refer you to a paper that was in Health Affairs web exclusive, that was written by Karen Davis, the president of the Fund, Marilyn Moon and Cathy Schoen and Barbara Cooper called Medicare Extra, where they proposed a more comprehensive Medicare benefit package that included an out-of-pocket cap.

ED HOWARD: Before we go on, bear with me. Karen, you had said something, the memory of which was triggered by your answer to this last question. Could you say a few more words about how you would ideally balance what you've wanted to accomplish in the way of getting greater flexibility to plans on benefit design compared to the Medigap A through J on the one hand with what opponents of that idea would probably argue

would be the greater confusion that would result in people's minds if they have less opportunity for apples to apples comparisons?

KAREN IGNANI: I think that this is, again, a very ideological discussion. It's similar to a number of other discussions about—and I know you didn't mean it that way, Ed—Medicare Advantage versus fee for service. It follows that individuals who have concerns about the existence of private sector in the Medicare arena, there's been a focus on a variety of issues, and we see it on the Part D side as well. In this area, standardization is coming forward, both in the area of Part D as well as Medicare Advantage. And what we've seen from the field, when we ask beneficiaries—and I'd be delighted to take any one of you out to any one of our plans, not just one, to talk to seniors when we pose this issue or this question to seniors—they begin to be very opinionated about whether or not they can sort through a variety of choices.

Now, having said that, we really believe that there is a middle ground here with respect to the display of information, and we intend to work very hard on that with beneficiary groups to make sure that—I'll use a Part D example, because it's easier—that, for example, in the area of premiums, to what extent are premiums below the average premium; to if you look at deductibles, to what extent are we providing deductibles that are better than the statutory $250? Co-

insurance: to what extent are we beating the statutory requirements? In the coverage gap, to what extent are plans offering those kinds of alternatives? This is the kind of thing we've been thinking to try to help organize material.

This is not—and I would be very, very careful—this is not to criticize, either implicitly or explicitly, anything that CMS is doing. But this is to try to use the advantage of some of what we've observed and some of the unique capacities we have to come together with a variety of stakeholders to try to provide some suggestions. And that's what drives it, talking with beneficiaries. I've learned a lot from them about what they don't want.

ABBY BLOCK: I'd like to comment on that as well, just really to second everything Karen has just said, because we have been thinking along exactly the same lines, and absolutely plan for 2007 to structure presentation in very much the same way that Karen has outlined. And I think one of the slides that I showed you was the first step in that direction. We looked very carefully at what choices people made and what the driving features seem to be that led them to make those choices. And certainly presenting options based on those characteristics of plans we think would be extremely helpful and plan to work in that direction.

ALLAN GLASS: Allan Glass for Senator Biden. Question for Karen Ignani: it seems to me the issue is not people's

loyalty to the plans; it's the plan's loyalty to the people. In many areas of the country, the Medicare Plus Choice program was beset by huge instability, with companies coming in and moving out every year based on individual business decisions made every year. And panels of providers were constantly changing, again based on individual business decisions of the companies involved. Given that the companies that are offering these new Medicare Advantage plans are some of the same actors that were involved in the previous Medicare Plus Choice program, what kind of assurance are you going to be able to give beneficiaries that if they sign up for a plan that it's going to be there next year and that they're provider is going to be there next year? Because I can tell you that many beneficiaries are very gun shy about MA plans because of a terribly bad experience with volatility and instability in the past.

KAREN IGNANI: I appreciate the frankness of your question, and I know that Delaware has had a particularly tough time. I can also tell you that I know very well what the rate situation was like there. After the passage of the Balanced Budget Act of 1997, we made it very clear to members of Congress we thought there were going to be significant problems. I hate to say that we were right about that. We were right about that. So we worked from 1998 to '99 in the BIPA legislation, in a couple of other pieces of legislation,

to gradually start addressing some of the problems. It wasn't until the passage of Medicare Modernization that we were able to address some of the structural problems in a significant way. And what you saw, starting immediately six to eight weeks later, the additional benefits that were put into the packages in '05, the beginning, only the beginning. This is why I mentioned earlier that in '05, this was a program on life support, because the trajectory was down, as Marsha showed in her enrollment figures, down, down, down because of plans being forced out of the program. Not one of our members wanted to leave the program. These are the most highly satisfied beneficiaries. They were committed to the program. Many were in the program for ten years.

So what we hope to do is to maintain the adjustments that were made in the Medicare Modernization Act so that we can continue to build the program and provide beneficiary choice. At the same time, this is why we feel so strongly about lock in, so that people can vote with their feet, so all of you can be satisfied this is a product that individuals want to be in, it's working for them, and we're delivering the expectations that beneficiaries have as well as all of you. So this is a very serious issue for us.

SABEL BIORKMAN: Hi, Sabel Biorkman [misspelled?] with Ways and Means, Democratic Staff. I have sort of a three-parter now that we've been standing here talking. One is a

direct, I think pretty straight forward question for Abby to answer at the end, which is echoing Marsha's concern about getting more granular data about who's where and what kind of plans. I'd be curious if you know now, or can get back to us, with the specific number of beneficiaries who are in plans, PDPs and MAPDs, that have a coverage gap, because we know about the offerings, and we know loosely what types—actuarially equivalent, enhanced—that they're in. How many are actually in a gap plan? So that's a discreet question.

On catastrophic coverage, Pete Stark has had a bill he continues to reintroduce that would put a catastrophic cap on out-of-pocket costs in the fee-for-service program. We would welcome AHIP's support of that bill.

KAREN IGNANI: You have it.

SABEL BIORKMAN: And anybody else on here, great. We'll follow up with a letter.

But the final thing is really getting to the meat of what we're talking about today, which is Medicare Advantage overpayments and what we're looking at now. And I think I would restate, maybe, your opening point, Karen, which I don't think the ideological discussion is whether there should be plans in Medicare. They've been in the program for decades. Democrats took a role in getting them there and keeping them there. But the question is: how much are we willing to pay, or as under currently, overpay for them, especially in light of

the pressures that the program is facing with an aging population and the other financial pressures? And then plans, when they first came in, said that they could do it cheaper and better, and that's where the 95-percent came from. And Marsha's data and other data showed that with selection they were still making out fairly well under that.

As the dynamic began to change, and we began to tick it up, we're now at a place where, as Brian mentioned, 111-percent. In the past we've been talking about 115-percent. But regardless, I think no one would argue that we are not paying the plans more than fee for service. And CBO has said that reducing the plan payments to fee for service would generate $64 billion over ten years, which far exceeds the 25-percent savings that are coming through the rebate right now. And I just would like a comment maybe from Brian or Marsha about whether and why that shouldn't be one of the first things that we are looking at next year when we are looking at the competing programs. Those plan overpayments, I'd remind everybody, come from both A and B, and so they're contributing to a decreased solvency of the trust fund and they're raising Part B premiums in the march toward the 45-percent trigger.

So it's all interrelated. I think people would like to have plans available if we can do it without losing our shirts. And it gets back to the catastrophic discussion and others, that no doubt the plans offer richer benefits. There are

tradeoffs in that, but why shouldn't every beneficiary have access to those richer benefits? So that's where we—

ED HOWARD: Well, in addition to Brian and Marsha, I suspect that Karen and Abby might have something to—

ABBY BLOCK: Well, I'm going to try to answer the first part of the question, the specific part of the question. The rest of it is a very broad and obviously political and philosophical discussion. But in terms of the first part of your question, yes, I think we will be able to say shortly how many people do not have coverage in the gap. If you read our call letter for 2007, which I'm sure you did, I think you probably noted that coverage in the gap is the key issue for us. And as we negotiate with the plans, we are certainly going to be encouraging more plans to offer coverage in the coverage gap. So we'll see what 2007 looks like as compared with 2006.

In terms of the data—and I just want to take this opportunity to note a difference in terms of the PDP average premium. Marsha's quite correct in terms of a simple average, and with all due respect, I know you don't have the numbers that would have—

MARSHA GOLD: I would have liked to count—

ABBY BLOCK: No, I realize that. And so I know you did right with what you had available. But I think we have announced very broadly that the actual weighted average premium for the stand alone PDPs is actually $25 a month, not $37. And

that represents a substantial reduction in the estimated cost of the prescription drug benefit, for one thing, and clearly indicated that competition did provide really good prices, premiums, for beneficiaries along with really rather good benefits.

MARSHA GOLD: And I'll just say that I'm glad to hear that. I really think that it's critical that we have these data in the public sector so that we can all calculate them, because we are at a disadvantage without that. So hopefully CMS will be able to deal with that shortly. It's a simple adding a plan identifier to the existing state county plan file, and I'm not sure there's any reason not to do it that I know of, because those have been traditional public data on a public program.

Well, I guess I'll wade in a little. I was trying to let Brian do it, so I didn't have to do it, and I still will let you do it. I'm not going to take a position on whether they should be paid more or less. That's a policy decision. I agree with Karen on that one. Congress can decide that. What I do think is important is probably that, from a public policy perspective, that there be a goal that the Medicare Advantage program be stable over time from the point of view of beneficiaries, so that the Congressional policy should drive to a stable program. And this up and down on the rates and on the legislation makes that very hard. So right now they are paid

more. I think it's important to have a discussion as to whether that's what Congress intends or not. I'd hate to see it go down the line very far and then all of a sudden Congress will intend, and we'll have all these people there, because we all went through that. So my point would just be to—it turns out the beneficiaries are punching bags in these ideological debates, and I'm not sure anyone wants that. So that's my comment.

STUART GUTERMAN: If I can jump in here just to ask Abby for clarification, I recall when the unweighted number was $37, CMS was saying that the unweighted number was $32.20, and I presumed that was because they included the NAPDs in that figure. And I thought the $25 number corresponded to the $32.20. So is that $25 really—does that correspond to only the stand alone PDPs?

ABBY BLOCK: My understanding is that that $25 is for the stand alone PDPs; that it does not include the MAPDs in that number.

ED HOWARD: Before I do this, I just want to—

KAREN IGNANI: [Off microphone]

ED HOWARD: Yes. I'm sorry. Go ahead.

KAREN IGNANI: Brian, did you want to start, or—

BRIAN BILES, M.D., M.P.H.: We have done a fair amount of work in this area, and one of our briefing papers is actually in your package, in which we basically ran the amount

of extra payments at the county level multiplied by the enrollment in those counties. And that found that in 2005, again, the total was something on the order of $2.7 billion. It averaged about $550 per individual MA plan enrollee, an average of about 7.8-percent. And we have begun to look at the recently posted on the CMS website payment rates at the county level. Initial analysis there shows extra payments something on the order of 12-percent or more projected in 2007. So I think there's some indication that the extra payments are continuing into the future.

Beyond that, I think there's sort of a background question. One is I don't really think plans are particularly an ideologic issue. I actually worked in this building for Senator Kennedy, and he was the initial sponsor of the HMO act in the Senate, which was the initial legislation that really built the foundation for what we see as managed care in the country today. So I don't think it's particularly one of ideology. It's a much more practical question. Certainly the argument has been that managed care plans actually manage care, and that we have a fee-for-service system that's very inefficient, particularly in terms of quantity and intensity, new technology of care. And managed care plans, with their contractual relationships with physicians and providers can actually provide care more efficiently than the inefficient fee-for-service system. And so that's the basis as was

indicated for the theory that managed care plans should be paid certainly not more and certainly previously at some point less than average costs in the fee-for-service system. And so when, again, the current payment system, based on policies included in the MMA in December of 2003 now pay plans more than the average fee-for-service cost in every county, I think that gets to be a question of: is that an effective way to manage Medicare and health care dollars?

KAREN IGNANI: Sabel, I'm glad you asked the question the way you did. When I mentioned ideological divide, I didn't particularly mean Democrat versus Republican. I meant individuals who feel strongly about Medicare fee for service primarily being the place were beneficiaries receive coverage versus those who believe there ought to be a role for the private sector. And I'm glad you raised it that way, because you gave me an opportunity to clarify it.

Indeed, I believe the reason the Medicare Modernization Act included a number of the specific provisions that as you know well were very modest, to say the least, in terms of cost impact for Medicare Advantage plans because of the work of all the Democrats as well as Republicans whose constituents wanted to preserve these valuable benefits. In 2005, roughly 50-percent of beneficiaries or enrollees were under fee for service because the MedPAC analyses, and I think, Brian, in your analyses, along with MedPAC, don't take account

of the GME factor. We don't have apples to apples. Number one, those that were over were, in virtually all cases at that time, both due to the decision that Congress made to have the rural floors back in 1997 and the small community floors that are districts where a number of you represent.

And the reason for that is very straight forward. In the rural area, there's been a history in Medicare fee for service, I think, as most people know, that there were issues that were accommodated for rural hospitals and fee for service. There was the parallel policy developed because in those particular areas, there was no interest on the part of hospital systems in particular but also physician groups to contract with managed care. They were virtual monopolies. They weren't interested in doing it. They didn't have the infrastructure to accept bricks [misspelled?], et cetera. So there were reasons for that. And I think that it's fair game to talk about the rationale for some of those reasons. It's very exciting now that rural individuals, people living in rural areas, will have the opportunity to choose.

So I think that what we've tried to do is to shine a spotlight on where we agree with analyses, where we disagree with analyses, but the bottom line, try to maintain the steadiness with respect now that we have Medicare Modernization, so people can choose plans that are providing more services. And for people at the lower end of the

spectrum, the economic spectrum in particular, this is serving as an important safety net for them, which is, I think, a very important policy issue.

ED HOWARD: We have people at two of the three microphones. Let me just remind you that as we finish the session up, I'd love to have you fill this blue evaluation form out before you go. Yes, sir, go ahead.

BRETT COUGHLIN: Hi. I'm Brett Coughlin [misspelled?] with Inside CMS, and I had a question about cherry picking, and what prohibitions there are against plans that cherry pick healthier patients, and what penalties there are; and then if there have ever been any instance where a plan has been found to have cherry picked a healthier patient; for anyone on the panel.

ABBY BLOCK: I can hopefully answer that question, since it's really a CMS issue. We have very rigorous marketing guidelines, and we enforce them rigorously. And those guidelines have provisions that would make it very, very difficult for a plan on any broad scale basis to cherry pick. In terms of individual situations, again, if a particular individual were to come to us and tell us that a plan declined to enroll them, we would certainly resolve that situation. I can't think of any case that I'm aware of where that's actually happened, but I don't, obviously, do case work on a day to day basis. But I can tell you that the combination of marketing

guidelines and very strong, rigorous enforcement of those guidelines would make it really difficult for plans to cherry pick.

The other part of that, which I've discussed a little bit before, is the design of the benefit package. And, again, we're rigorous in our review of those benefit packages to ensure that the design is not such that it would discourage particular categories of beneficiaries from choosing that plan.

ED HOWARD: Abby, do you want to talk a little about the risk adjustment factor, and whether or not that is progressing to a level of usefulness that others say it hasn't achieved yet?

ABBY BLOCK: Well, I would certainly have to agree with all of the previous speakers that risk adjustment is not a perfect tool, and it's a tool that we're always trying to improve. Whether it can ever be a 100-percent predictor on an individual basis is really, I think, another question.

But in terms of the discussion about overpaying and underpaying, I think that we need to remember that these are insurance plans, and insurance plans, insurance premiums, are based on a risk pool. And that risk pool hopefully and typically should include a range of utilizers across the board. And so, when you look at risk adjustment on average, it should come out reasonably close to what the costs are. It is never going to predict specifically what any individual cost will be.

VICKI GOTTLICH: Hi. I'm Vicki Gottlich for the Center for Medicare Advocacy. I had questions about changes in benefit design packages. In the past, we'd seen enhanced benefits, like drug coverage and ten dollar doctor co-pays, but on the other hand, these were in exchange, perhaps, for co-payments on home health services that don't exist in traditional Medicare, co-payments for the first 20 days of SNiP care, as Brian alluded to, increased hospital payments, as Abby mentioned, concerns and high costs for some chemotherapy services that, had you had a Medigap policy, would have been covered. Are we seeing any reduction in fees for services that Medicare provides without a fee? There are savings to plans for not having to provide prescription drug coverage. So are they reducing the out-of-pocket costs for these skilled nursing services, basically?

MARSHA GOLD: Well, CMS may have the answer for now. We're in the middle of analyzing that. We're trying to build on the work we did for Kaiser Family Foundation work for AARP. We don't know the answer to that yet.

We do know that plans are still covering certain Medicare benefits that they didn't have. I think realistically a lot of that analysis depends on the ACR filings. And so I don't know how much, even with what we're doing, we'll be able to look at. Those data will always be proprietary. CMS, I think, has funded some work on that area by RTI. I don't know

if they've done the analysis and if that will be made public. If so, that would help answer the question as to whether they've reduced things.

Abby, can you help on that?

ABBY BLOCK: I haven't seen the results of the analysis yet, so I think it would be premature for me to give you definitive answers. But clearly, there are tradeoffs made in the design of a benefit package. And what we are looking at again, carefully, is whether those tradeoffs are specifically designed so that the effect is discriminatory versus are they tradeoffs that really simply give people choice given their knowledge of their own situation, both their health status and their financial situation.

ED HOWARD: Go ahead, Karen.

KAREN IGNANI: Vicki, what I know is anecdotal primarily, but I can tell you that in 2002 to 2003, 2004, and 2005 was the beginning of the turnaround, but really definitely the beginning. But from 2002 to that three year period, we saw plans were just trying to survive, given the overall financial dynamics that we've talked about. And we know that there were increases in premiums, increases in co-pays as they were trying to survive, maintain some kind of drug coverage, not take classes or categories of benefits away, but try to just survive in the market.

What I'm hearing anecdotally, based on '06, and we will hopefully have the data soon to know, is that there's been a definite and substantial improvement we can see already on the premiums, but we know anecdotally on a number of the services. So I think that the analysis will bear that out. I can't say it concretely because we don't have the data, but that's what we're hearing from our medical directors.

OLGA PIERCE: Hi. I'm Olga Pierce with United Press International. I'd like to ask sort of about the general expectations for the plan. Is it a flash in the pan that's going to die out, like Medicare Plus Choice? It is a sort of sneaky way to completely replace fee-for-service Medicare altogether? Or is it something in the middle? [Laughter] If it is something in the middle, what sort of proportion of beneficiaries can we kind of expect in a more long term way once things kind of hit their stride? What's a reasonable expectation for the program?

KAREN IGNANI: I know this is a boring answer to your question, but there's no way to know the answer to your question in terms of what the future holds. I think what we see since the beginning of open enrollment, we see that there are a little more than a million new beneficiaries. People are voting with their feet and they're telegraphing an important message, that "These health plans are meeting our needs."

Is that going to serve the needs of every individual? No. We've never set up the programs with that expectation on the part of the public. What we've tried to do is to be very clear about the fact that we provide important services that are not available in the traditional Medicare program. Some people prefer to stay in traditional Medicare. But looking at the satisfaction rates, looking at the low, very low, under 2-percent disenrollment, it gives you a sense of how people are relying on this. There are numbers of other people who are very comfortable in the traditional program with Medigap. There are others who are comfortable in other kinds of environments. And the idea, from our perspective, is that government should be agnostic about that and let individuals make their decisions on what suits their needs.

ED HOWARD: Abby, do you want to—oh. Brian? Go ahead.

BRIAN BILES, M.D., M.P.H.: As a factual response, CBO, in their March baseline, projected group plan enrollment growing from 6.2 million in 2006 to 8.4 million in 2012, and then off to 9.3 in 2016. So that's certainly their current projection, which I think would fall somewhere in the middle range.

ED HOWARD: Abby, if you want to share that sneaky strategy, we promise no one in the room will tell anyone else. [Laughter]

ABBY BLOCK: You won't tell anyone. Well, all I can say is if there's a sneaky strategy, it hasn't been shared with me.

ED HOWARD: Yes, I think we have the final question here.

LAURIE FEINBERG: I'm Laurie Feinberg from the office of Secretary Espy. I'm curious. What kind of health outcome data, other than patient satisfaction, is available to not only compare fee for service with MA plans but then to look at the results of the different types of MA plans? And if there is none now, what kinds of efforts are there to develop it?

MARSHA GOLD: It's a good question, and it's a hard question, and Laurie knows that. There are HETUS measures that are collected for health plans. There are many less requirements on PPOs, and I don't think there are any on private fee-for-service plans. Or there may be some. CMS can go through the specifics. The problem is that those plans aren't responsible for health, so they don't have the data, or don't feel appropriate to do it. And at the same time, CMS doesn't get the claims data from them, so it's hard to do.

And so I don't know the answer, and I think it's a really hard issue as to how to compare. If the data are there, we can look at them, because the contract codes show what kind of plan they are.

ED HOWARD: Abby, did you have something to add?

ABBY BLOCK: Well, I think, as you know, CMS is extremely interested in quality measurement, quality improvement and looking very carefully at all of those issues. The private fee-for-service product is such a new product that I think we need some time to see how that operates and really get to understand it better. But certainly in the HMO world, we do a great deal of quality measurement. And some of that bumps over into the PPO world as well.

The whole issue of quality measures for PPOs is a very interesting area, one that I've been interested in personally for a very long time. And I think we'll be looking very carefully at what more can be done to develop measures that are actually appropriate for that type of delivery system.

ED HOWARD: Stu? Final closing thoughts?

STUART GUTERMAN: Well, I want to thank everybody for coming, and particularly the panelists. [Applause]

[END RECORDING]