

Medicare HMO withdrawn File

Options for Medicare+Choice Initiative

The following is a series of proposals to address issues related to plan terminations and service area reductions. The proposals address several areas, such as risk adjustment, payment options, ACR schedule, and beneficiary protections. The proposals are organized into two groups: (1) proposals where there is staff consensus that we move ahead and (2) proposals that lack consensus on how (or if) to proceed. **NONE OF THESE PROPOSALS HAVE BEEN REVIEWED BY THE SECRETARY.**

Proposals Where There is Consensus to Proceed

Phase-in of Risk Adjustment -- The BBA mandated that Medicare+Choice payment rates incorporate risk adjustment for enrollee health status beginning in 2000. As a result, plans will now be paid more for treating enrollees with chronic and substantial complex health care needs than for healthy enrollees with minimal needs. Given available evidence that plans on average experience favorable selection, implementation of risk adjustment will reduce payments to plans thus eventually eliminating the current overpayment that is estimated to be ___ in ___. While implementation of risk adjustment is key to the long term effort to assure the solvency of the Medicare trust funds, implementation of risk adjustment without a transition could have a negative impact on the stability in the Medicare+Choice program. For this reason, the President's Budget will provide for a transition that would This transition will cost the Medicare program ___ over 5 years.

Non-legislative
[9095]

Jan. 15th

\$1.5 billion
a year

Modification to Funding of Medicare+Choice Program - The BBA mandated that the Secretary initiate an campaign to educate Medicare beneficiaries about the Medicare program and their Medicare+Choice options. The funding for this program is provided through a "user fee" on Medicare+Choice plans. In 1998, payments to plans were reduced on average by .29 percent. This proposal would change the funding mechanism by providing a direct tap on the trust funds (such as is used for the Peer Review Program). As a result of this proposal, payments to plans would be increased by ___ over 5 years.

Medicare Tap
in the
program

\$100 million

Enrollment of ESRD Beneficiaries - Under current law, beneficiaries with ESRD cannot enroll in a Medicare+Choice plan. However, beneficiaries who develop ESRD while enrolled in a plan can remain in that plan. In addition, an individual with ESRD who prior to Medicare entitlement had been enrolled in a health plan can upon entitlement remain in that health plan if it has a contract with Medicare. In the case of a plan that terminates its contract or reduces its services area, however, plan enrollees who have ESRD cannot enroll in another Medicare+Choice plan during the mandated special enrollment period. This proposal would allow such beneficiaries to enroll in another Medicare+Choice plan. It would also create a special open enrollment period for beneficiaries affected by the plan decisions for 1999.

✓

Notification of Changes in Benefits and Premiums - Medicare+Choice regulations provide that plans must inform their enrollees of changes in benefits and premiums 30 days before the effective date of such changes. This proposal would mandate that plans notify enrollees of benefit/premium changes effective January 1 by October 15th of the previous year (in time for the November

✓

Option for Medicare+Choice Initiative - page 2

coordinated open enrollment period). Plans would still be required to provide 30 day notice of any mid-year changes in benefits/premiums.

Medigap Reforms

- o **Initial Open enrollment for Disabled and ESRD** - Under current Federal law, only aged beneficiaries have an initial open enrollment period for Medigap. This proposal would expand the initial 6-month open enrollment period to new disabled and ESRD beneficiaries. Mandate that insurers who write policies for new aged beneficiaries offer these same policies to new disabled and ESRD beneficiaries.
 - + Enactment of this proposal would assure Medigap access in all states for disabled and ESRD beneficiaries both upon initial eligibility for Medicare but also in the case of Medicare+Choice plan termination.
- o **Expand Choice of Medigap Plans During Special Enrollment Periods** - The BBA provided special enrollment opportunities for Medigap under certain situations (such as, for an enrollee of a Medicare+Choice plan whose plan terminates its contract or reduces its service area). Beneficiaries in these situations, however, only have access to plans "A", "B", "C" and "F", none of which include coverage of prescription drugs. This proposal would expand the BBA special open enrollment opportunities to include access to all Medigap options offered to new enrollees.
 - + Rep. Cardin had introduced legislation on the last day of Congress to expand these options to include the three drug packages for individuals who had drug coverage in their Medicare+Choice plan.
- o **Increase CMPs for Violation of Open Enrollment Requirement** - Issuers who violate the open enrollment requirement are subject to a CMP of \$5,000 for each violation. This proposal would increase the CMP for failure to \$50,000 for each violation plus \$5,000 per day.
- o **Authorize Periodic Reexamination of the Standardized Packages** - The 10 standard Medigap packages were created as a result of OBRA 90. There is no authority in the statute to periodically reexamine these packages. Authorize the Secretary, in consultation with the NAIC, to review the standard Medigap packages on a periodic basis to determine whether any changes should be made to the content or number of the packages.

Proposals That Lack Consensus on How (or If) to Proceed**Medigap Reforms**

- o **Expand the November Medicare+Choice Coordinated Open enrollment period to**

Option for Medicare+Choice Initiative - page 3

included access to all Medigap options offered to new enrollees

- + Option 1 - Provide access to Medigap option for all Medicare beneficiaries
- + Option 2 - Limit access to Medigap options to beneficiaries enrolled in a Medicare+Choice plan

Discussion - Option 1 is the same proposal as was included in the FY 98 President's Budget. It would maximize choice for beneficiaries but could create significant selection problems for Medigap insurers which would have a negative impact on the affordability of Medigap premiums particularly for plans providing coverage for prescription drugs. Option 2 expands on the "free try" concept included in the BBA by affording Medicare+Choice enrollees an annual opportunity to move to original Medicare with the Medigap policy of their choice. The "free try" would no longer be contingent on the length of time the beneficiary stays enrolled in the Medicare+Choice plan nor would it have to be the first time that the beneficiary enrolled in such a plan. This option also has selection implications. Any premium effect, however, would be much less than under Option 1.

o Create Federal Standards for Medigap Premium Rating

- + Option 1 - Mandate move to community rating by 2002 subject to a timetable and transition rules developed by the NAIC.
- + Option 2 - Ban use of attained age rating
- + Option 3 - Limit the difference between the highest and lowest rate when attained age rating is used.

Handwritten notes:
 Kathy had
 already - income
 at age

Discussion - Option 1 is the same proposal as was included in the FY 98 President's Budget. Community rating is currently mandated by 5 states (Connecticut, Maine, Massachusetts, Minnesota, New York and Washington). It provides the most protection to older beneficiaries. It would, however, increase premiums for younger beneficiaries. When community rating was implemented in Connecticut in 1994, premiums for 65-69 year olds went up by as much as 25%. Premiums for 74 year olds and older went down by as much as 30%.

Option 2 had some bi-partisan support on the Ways and Means Health Subcommittee in 1997. It would be less controversial than Option 2 while still providing significant protection to older beneficiaries.

Option 3 would seek to limit the negative impact of attained age rating rather than banning it. We could either specify the limit in statute or have the NAIC determine it.

Option for Medicare+Choice Initiative - page 4

ACR Schedule - Under the Medicare risk contract program, plans submitted Adjusted Community Rate (ACR) proposals in mid- November. The Balance Budget Act of 1997 changed the schedule for ACRs submission in order to provide sufficient time for HCFA to prepare comparative materials, based on approved ACRs, for the November coordinated open enrollment period. Beginning with the ACRs for 1999, the submission date was moved back to May 1st. Plans have indicated that this submission date is problematic because of the 8 month lag before the start of the benefit year. Plans that participate in the FEHB program, however, are required to provide similar information to OPM by the end of May.

The main consideration in options to revise the ACR schedule is the impact that such a change would have on the production and mailing of "Medicare and You". Options still being explored would involve spending more on the publication to speed production or significantly modifying the content.

Payment Options - Under current law, the Medicare+Choice rate for a county is based on the greater of a blended rate, the minimum payment or a minimum increase (2%) over the previous year's rate. Blended rates are adjusted to assure that total payments under this "greater of" methodology equal that would have occurred if payment had been based on local rates (note, GME and IME are carved out of the local rates). For both 1998 and 1999, no county rate is based on the blended rate because the reduction required for budget neutrality reduced the blended rates for all counties below the other two payment options. This is due to the fact that updates have not been significantly greater than the 2% minimum increase.

- + Option 1 - Apply budget neutrality to both blend and minimum increase rates (for 1999, this would have reduced the minimum increase to 1.29%
- + Option 2 - Apply budget neutrality adjustment to minimum increase rates (for 1999, this would have reduced the minimum increase to .88%)
- + Option 3 - Reduce the minimum increase to 1% or alternatively provide a minimum increase of the greater of the growth in Medicare per capita minus 3% or 1%.
- + Option 4 - Eliminate the budget neutrality requirement -- would provide full blend payment --- \$300 million cost in 1999.
- + Option 5 - No proposal.

greater for low pay
+ skip w

CODE	STATE	COUNTY	HMO	----- 1999 rate (Aged only) -----			Percentage change over curre			
			nrollment	BA1997	Option 1*	Option 2*	Option 3*	Option 1*	Option 2*	Option 3*
01360	ALABAMA	JEFFERSON.....	12444	546.69	542.86	540.68	541.33	-0.70	-1.10	-0.98
03060	ARIZONA	MARICOPA.....	137245	509.45	505.88	504.41	504.45	-0.70	-0.99	-0.98
03090	ARIZONA	PIMA.....	54365	482.99	479.61	479.62	478.66	-0.70	-0.70	-0.90
05000	CALIFORNIA	ALAMEDA	54601	582.36	585.71	589.84	588.66	0.58	1.28	1.08
05060	CALIFORNIA	CONTRA COSTA	43432	595.25	597.27	601.48	600.28	0.34	1.05	0.85
05090	CALIFORNIA	FRESNO.....	20989	388.03	407.18	410.05	409.23	4.94	5.67	5.46
05140	CALIFORNIA	KERN.....	26625	532.77	529.04	527.45	527.54	-0.70	-1.00	-0.98
05200	CALIFORNIA	LOS ANGELES.....	298405	647.70	643.17	640.58	641.35	-0.70	-1.10	-0.98
05310	CALIFORNIA	MARIN	11332	517.98	531.11	534.85	533.78	2.53	3.26	3.05
05400	CALIFORNIA	ORANGE.....	108938	595.82	591.65	589.27	589.98	-0.70	-1.10	-0.98
05410	CALIFORNIA	PLACER.....	11106	493.03	499.58	503.10	502.09	1.33	2.04	1.84
05430	CALIFORNIA	RIVERSIDE.....	96862	537.00	533.24	535.27	534.20	-0.70	-0.32	-0.52
05440	CALIFORNIA	SACRAMENTO.....	57233	522.19	520.15	523.82	522.77	-0.39	0.31	0.11
05460	CALIFORNIA	SAN BERNARDINO.	81642	554.46	550.58	548.36	549.03	-0.70	-1.10	-0.98
05470	CALIFORNIA	SAN DIEGO.....	156261	538.09	535.58	539.36	538.28	-0.47	0.24	0.04
05480	CALIFORNIA	SAN FRANCISCO	36956	547.15	544.32	548.16	547.06	-0.52	0.18	-0.02
05490	CALIFORNIA	SAN JOAQUIN.....	18776	456.34	466.91	470.20	469.26	2.32	3.04	2.83
05500	CALIFORNIA	SAN LUIS OBISPO...	12493	402.25	422.50	425.48	424.63	5.03	5.78	5.56
05510	CALIFORNIA	SAN MATEO	38719	469.66	486.86	490.29	489.31	3.66	4.39	4.18
05520	CALIFORNIA	SANTA BARBARA	19202	406.13	421.93	424.90	424.05	3.89	4.62	4.41
05530	CALIFORNIA	SANTA CLARA.....	60601	500.17	512.81	516.43	515.40	2.53	3.25	3.04
05580	CALIFORNIA	SOLANO.....	12272	511.85	524.18	527.88	526.82	2.41	3.13	2.92
05590	CALIFORNIA	SONOMA.....	23790	489.55	498.60	502.11	501.11	1.85	2.57	2.36
05600	CALIFORNIA	STANISLAUS.....	21151	478.70	482.41	485.81	484.84	0.78	1.49	1.28
05660	CALIFORNIA	VENTURA.....	30221	518.54	517.70	521.35	520.31	-0.16	0.54	0.34
06000	COLORADO	ADAMS.....	15385	498.56	495.07	495.20	494.21	-0.70	-0.67	-0.87
06020	COLORADO	ARAPAHOE.....	14729	457.34	459.86	463.10	462.17	0.55	1.26	1.06
06150	COLORADO	DENVER.....	24993	524.14	520.47	518.37	519.00	-0.70	-1.10	-0.98
06200	COLORADO	EL PASO.....	13030	440.42	445.01	448.15	447.25	1.04	1.76	1.55
06290	COLORADO	JEFFERSON.....	18459	445.05	450.72	453.90	452.99	1.27	1.99	1.78
10050	FLORIDA	BROWARD.....	83831	676.64	671.90	669.20	670.00	-0.70	-1.10	-0.98
10120	FLORIDA	DADE.....	100447	778.45	773.00	769.89	770.82	-0.70	-1.10	-0.98
10150	FLORIDA	DUVAL.....	25192	547.66	543.83	541.64	542.29	-0.70	-1.10	-0.98
10280	FLORIDA	HILLSBOROUGH....	37300	506.36	502.82	501.49	501.39	-0.70	-0.96	-0.98
10350	FLORIDA	LEE.....	17667	496.18	492.71	494.35	493.36	-0.70	-0.37	-0.57
10470	FLORIDA	ORANGE.....	25964	542.46	538.66	536.49	537.14	-0.70	-1.10	-0.98

10490	FLORIDA	PALM BEACH.....	51791	588.84	584.72	582.36	583.06	-0.70	-1.10	-0.98
10500	FLORIDA	PASCO.....	29159	561.24	557.31	555.07	555.74	-0.70	-1.10	-0.98
10510	FLORIDA	PINELLAS.....	59120	520.29	516.65	514.57	515.19	-0.70	-1.10	-0.98
10630	FLORIDA	VOLUSIA.....	33493	454.78	454.20	457.40	456.49	-0.13	0.58	0.38
12020	HAWAII	HONOLULU.....	11214	397.69	420.16	423.12	422.27	5.65	6.39	6.18
14141	ILLINOIS	COOK.....	96922	581.87	577.80	575.47	576.16	-0.70	-1.10	-0.98
19160	LOUISIANA	EAST BATON ROU	11796	563.22	559.28	557.02	557.70	-0.70	-1.10	-0.98
19250	LOUISIANA	JEFFERSON.....	14482	660.91	656.28	653.64	654.43	-0.70	-1.10	-0.98
19350	LOUISIANA	ORLEANS.....	11813	638.50	634.03	631.48	632.24	-0.70	-1.10	-0.98
21020	MARYLAND	BALTIMORE.....	14371	562.52	558.58	556.33	557.00	-0.70	-1.10	-0.98
21030	MARYLAND	BALTIMORE CITY...	11911	658.26	653.65	651.02	651.80	-0.70	-1.10	-0.98
22020	MASSACHUSET	BRISTOL.....	10794	467.90	473.87	477.21	476.26	1.28	1.99	1.79
22170	MASSACHUSET	WORCESTER.....	29129	548.27	544.43	542.24	542.90	-0.70	-1.10	-0.98
24260	MINNESOTA	HENNEPIN.....	27742	422.01	429.64	432.67	431.80	1.81	2.53	2.32
24610	MINNESOTA	RAMSEY.....	17383	439.48	443.54	446.67	445.78	0.92	1.64	1.43
26470	MISSOURI	JACKSON.....	18598	525.22	521.54	519.44	520.07	-0.70	-1.10	-0.98
26940	MISSOURI	ST LOUIS.....	28801	490.03	486.60	484.64	485.22	-0.70	-1.10	-0.98
26950	MISSOURI	ST LOUIS CITY.....	11068	563.89	559.94	557.69	558.36	-0.70	-1.10	-0.98
29010	NEVADA	CLARK.....	33551	530.04	526.33	528.10	527.04	-0.70	-0.37	-0.57
31100	NEW JERSEY	BERGEN	11690	527.72	528.75	532.48	531.42	0.20	0.90	0.70
31150	NEW JERSEY	BURLINGTON.....	11992	537.40	533.64	531.75	532.13	-0.70	-1.05	-0.98
31160	NEW JERSEY	CAMDEN.....	13629	581.83	577.76	575.43	576.12	-0.70	-1.10	-0.98
31270	NEW JERSEY	MIDDLESEX	10414	544.63	540.82	538.64	539.29	-0.70	-1.10	-0.98
31310	NEW JERSEY	OCEAN	11805	505.24	503.91	507.46	506.45	-0.26	0.44	0.24
32000	NEW MEXICO	BERNALILLO.....	24791	399.19	407.59	410.46	409.64	2.10	2.82	2.62
33020	NEW YORK	BRONX.....	22485	757.66	752.36	749.33	750.23	-0.70	-1.10	-0.98
33240	NEW YORK	ERJE.....	26110	414.79	417.99	420.94	420.10	0.77	1.48	1.28
33331	NEW YORK	KINGS.....	38695	733.87	728.73	725.80	726.67	-0.70	-1.10	-0.98
33370	NEW YORK	MONROE.....	15099	428.60	425.60	428.51	427.65	-0.70	-0.02	-0.22
33400	NEW YORK	NASSAU.....	35568	610.30	606.03	603.59	604.31	-0.70	-1.10	-0.98
33420	NEW YORK	NEW YORK.....	19931	741.93	736.74	733.77	734.65	-0.70	-1.10	-0.98
33590	NEW YORK	QUEENS.....	50080	685.46	680.66	677.92	678.74	-0.70	-1.10	-0.98
33610	NEW YORK	RICHMOND.....	15183	798.35	792.76	789.57	790.53	-0.70	-1.10	-0.98
33700	NEW YORK	SUFFOLK.....	33768	568.77	564.89	568.87	567.73	-0.68	0.02	-0.18
33800	NEW YORK	WESTCHESTER.....	22665	584.38	580.29	582.20	581.04	-0.70	-0.37	-0.57
36170	OHIO	CUYAHOGA.....	47928	564.30	560.35	558.09	558.77	-0.70	-1.10	-0.98
36250	OHIO	FRANKLIN.....	10697	482.96	479.58	477.65	478.22	-0.70	-1.10	-0.98
36310	OHIO	HAMILTON.....	19297	494.07	490.61	488.64	489.22	-0.70	-1.10	-0.98
36580	OHIO	MONTGOMERY.....	12170	485.54	482.14	480.20	480.78	-0.70	-1.10	-0.98

37540	OKLAHOMA	OKLAHOMA.....	10486	453.28	450.11	451.94	451.04	-0.70	-0.30	-0.49
37710	OKLAHOMA	TULSA.....	17434	450.75	447.59	446.70	446.33	-0.70	-0.90	-0.98
38020	OREGON	CLACKAMAS.....	10460	390.49	408.93	411.81	410.99	4.72	5.46	5.25
38250	OREGON	MULTNOMAH.....	22647	402.45	416.60	419.54	418.70	3.52	4.25	4.04
39010	PENNSYLVANIA	ALLEGHENY.....	63060	619.63	615.29	612.81	613.55	-0.70	-1.10	-0.98
39080	PENNSYLVANIA	BEAVER.....	10328	533.84	530.10	527.97	528.60	-0.70	-1.10	-0.98
39110	PENNSYLVANIA	BERKS.....	10015	424.85	427.59	430.60	429.74	0.64	1.35	1.15
39140	PENNSYLVANIA	BUCKS.....	24355	598.89	594.70	592.30	593.02	-0.70	-1.10	-0.96
39210	PENNSYLVANIA	CHESTER.....	12173	532.32	528.59	531.56	530.50	-0.70	-0.14	-0.34
39290	PENNSYLVANIA	DELAWARE.....	23590	613.96	609.66	607.21	607.94	-0.70	-1.10	-0.98
39560	PENNSYLVANIA	MONTGOMERY.....	37737	537.16	533.40	531.25	531.90	-0.70	-1.10	-0.98
39620	PENNSYLVANIA	PHILADELPHIA.....	58953	732.70	727.57	724.64	725.51	-0.70	-1.10	-0.98
39750	PENNSYLVANIA	WASHINGTON.....	10000	579.00	574.95	572.63	573.33	-0.70	-1.10	-0.98
39770	PENNSYLVANIA	WESTMORELAND.....	18480	582.45	578.37	576.04	576.74	-0.70	-1.10	-0.98
41030	RHODE ISLAND	PROVIDENCE.....	14186	479.48	476.12	478.77	477.81	-0.70	-0.15	-0.35
45130	TEXAS	BEXAR.....	52654	502.07	498.56	496.55	497.15	-0.70	-1.10	-0.98
45390	TEXAS	DALLAS.....	30373	534.86	531.12	528.98	529.61	-0.70	-1.10	-0.98
45610	TEXAS	HARRIS.....	55754	619.21	614.88	612.40	613.14	-0.70	-1.10	-0.98
45910	TEXAS	TARRANT.....	32794	514.29	510.69	510.50	509.48	-0.70	-0.74	-0.94
46170	UTAH	SALT LAKE.....	12956	381.21	393.22	395.99	395.20	3.15	3.88	3.67
50050	WASHINGTON	CLARK.....	11839	382.37	403.19	406.03	405.22	5.44	6.19	5.98
50160	WASHINGTON	KING.....	54927	445.57	453.25	456.45	455.54	1.72	2.44	2.24
50260	WASHINGTON	PIERCE.....	15742	413.75	428.90	431.92	431.06	3.66	4.39	4.18
50300	WASHINGTON	SNOHOMISH.....	23890	418.93	434.07	437.13	436.26	3.61	4.34	4.14
50310	WASHINGTON	SPOKANE.....	10118	426.41	436.60	439.68	438.80	2.39	3.11	2.91
* Option1 : Budget neutral adjustment applied to both blend and minimum. In essence, minimum update is reduced to 1.29%.										
Option 2 : Budget neutral adjustment applied to minimum update only. In essence, minimum update is reduced to .88%.										
Option 3 : Minimum update is set at 1%. All other rules are the same as under BBA1997.										

MASS HMO withdrawal issue

A24

THE BOSTON GLOBE • THURSDAY, NOVEMBER 12, 1998

The Boston Globe

BENJAMIN B. TAYLOR, *Publisher & Chairman*

MATTHEW V. STORIN, *Editor*

H.D.S. GREENWAY, *Editor, Editorial Page*

WILLIAM B. HUFF, *President*

HELEN W. DONOVAN, *Executive Editor*

STEPHEN E. TAYLOR, *Executive Vice President*

GREGORY L. MOORE, *Managing Editor*

Founded 1872

CHARLES H. TAYLOR, *Founder & Publisher 1875-1921*

WILLIAM O. TAYLOR, *Publisher 1921-1955* WM. DAVIS TAYLOR, *Publisher 1955-1977* WILLIAM O. TAYLOR, *Publisher 1978-1997*
JOHN I. TAYLOR, *President 1969-1975* LAURENCE L. WINSHIP, *Editor 1955-1965* THOMAS WINSHIP, *Editor 1965-1984*

Another chance on Medicare

The federal government has given the health plans of Massachusetts an opportunity to safeguard the medical care and preserve the peace of mind of thousands of elderly people. The plans need to continue unlimited drug coverage for Medicare recipients for one more year, giving the Legislature time to devise a long-range solution.

Led by Harvard Pilgrim Health Care, these managed care organizations were prepared to limit the drug benefit to \$800 a year, enough for many seniors but not for those who require thousands of dollars' worth of medicine a year to sustain their lives. Now the Health Care Financing Administration, which oversees Medicare, has given the plans until Tuesday to present revised proposals.

Senator Edward Kennedy and his staff worked hard to persuade the agency to reopen the issue of drug coverage. Kennedy, Governor Paul Cellucci, and Attorney General Scott Harshbarger have been trying to persuade the health plans to revise their initial proposals. All three deserve praise for intervening on behalf of vulnerable constituents.

Health plans are jostling for position in a market made viciously competitive by a 1997 federal law limiting the increase in Medicare payments for HMOs. Harvard Pilgrim in particular has a large population of patients with the unlimited drug benefit. These patients are costing the plan a disproportionate amount for hospitalizations and doctor visits as well as prescription drugs.

Harvard Pilgrim's financial condition will be better known when it releases a report to the insurance commissioner tomorrow. Like Blue Cross, Fallon, and Tufts - the three other major health insurers in the state - it is a nonprofit organization chartered to promote the public welfare.

The Legislature needs to provide more money next year to defray drug costs for needy seniors. The elderly need assurances now from their health plans that until that relief comes, their coverage will continue. Harvard Pilgrim and the others will affirm their commitment to the common good if they maintain the coverage their older members have come to expect.

150,000
at
546
220,000

Med Re Good / Suspect enrollment

= HMOs / Harvard
= Fallon / B.C. / BS / Tufts if HMO does
- Unlimited 28 per cent
\$15 base \$75⁰⁰ a month

Business

THE BOSTON GLOBE • WEDNESDAY, NOVEMBER 11, 1998

US approves delay of senior drug-benefit cap

■ BENEFITS

Continued from Page C1

ing seniors pay for increasingly expensive medications. Some health plans declined to offer a moratorium, saying that the federal government locked them into the limited benefits they had filed in May with the US Health Care Financing Administration, the agency that regulates Medicare HMOs.

Yesterday, HCFA, in a meeting with five health plans, opened the door to a reprieve for seniors by saying that Massachusetts HMOs have until Nov. 17 to change their drug benefit plans.

But the opportunity is double-edged, because it also gives HMOs a chance to scale back drug coverage as well as expand it.

"It's hopeful," said Clare D. McGorrian, attorney with Health Law Advocates, a public interest law firm. "Now there's nothing in the way for HMOs to do the right thing. But it could also go either way."

Dr. Robert A. Berenson, director of HCFA's Center for Health Plans

and Providers, said that while health plans are now free to cut back their drug coverage, he encouraged them to offer the unlimited drug benefit. "We were providing them with the opportunity to provide a more generous drug benefit, but what they do will be up to them," Berenson said.

Encouraged by HCFA's announcement, state Attorney General Scott Harshbarger, US Senator Edward M. Kennedy, state Senator Mark Montigny and Governor Paul Cellucci have renewed their calls for a one-year moratorium on capping benefits.

In a letter to HMO executives yesterday, Harshbarger said, "I ask you to do what is right for the elders of Massachusetts and reinstate the unlimited drug benefit by taking advantage of this golden window of opportunity that HCFA is providing to us."

Kennedy said, "It's clear that HMOs can voluntarily provide full drug benefits to senior citizens. Every Medicare HMO in our state should agree to provide these benefits. Seniors citizens urgently need this coverage."

Sources at Blue Cross and Tufts said the HMOs are willing to consider a one-year moratorium if all

health plans agree, but Harvard Pilgrim Health Care, Fallon Community Health Plan and United Health-Care of New England yesterday declined to comment specifically.

"We are assessing the situation," said Patti Embry-Tautenhan, a spokeswoman at Harvard Pilgrim. "We're in the evaluation mode right now."

Blue Cross, which has promised to set up a foundation to pay for the medications of its seniors in Blue Care 65, said through spokeswoman Susan Leahy, "Specific plans are under review."

John Wardle, senior vice president of United, which has proposed a \$300-a-year limit on drug benefits for each beneficiary, said his company will consider changing its proposed drug benefits, but would not comment further.

Fallon spokeswoman, Candy Race, said, "We're evaluating our options and we won't have an announcement for at least another 48 hours."

Indeed, Fallon has the most to gain from HCFA's decision. Until now, Fallon was the only HMO with plans to offer unlimited drug benefits in 1999. The Worcester-based HMO feared that it would be inundated with sick seniors with higher medical costs if it remained the only HMO offering unlimited drug benefits. HCFA's ruling now lets Fallon change that.

Feds let HMOs decide on keeping drug benefits

By Eric Convey/Boston Herald
November 11, 1998

Federal regulators yesterday left it to the state's major Medicare HMOs to decide whether 60,000 Massachusetts senior citizens will keep their unlimited prescription drug coverage next year.

The state's health maintenance organizations had planned to end the benefit under a new federal law. Responding to pressure to keep the benefit, the HMOs said federal rules would not allow them to make the change.

But in an extraordinary move, the federal Health Care Financing Administration yesterday gave the HMOs the chance to restore those benefits, letting them have until Nov. 17 to decide what coverage to offer next year. But as of late yesterday, only one major HMO - run by Blue Cross and Blue Shield of Massachusetts - had decided to keep the drug coverage at issue.

Spokeswomen at Harvard Pilgrim Health Care, Tufts HMO and Fallon Community Health Plan said those HMOs will consider restoring the coverage.

"I'm encouraged by what HCFA did today," said Geoff Wilkinson, executive director of Massachusetts Senior Action Council.

Also applauding the regulators' decision were state officials and Sen. Edward M. Kennedy (D-Mass.), who lobbied HCFA to allow the new filings.

"HCFA has now created a level playing field for all HMOs in Massachusetts," Kennedy said. "It's clear that HMOs can voluntarily provide full benefits for seniors citizens. . . Senior citizens urgently need this coverage."

"We think this is a great victory," said Barbara Anthony, chief of the Public Protection Bureau of the attorney general's office.

"This is exactly what we were looking for - the opportunity for an extension," said Consumer Affairs Director Daniel Grabauskas. "We hope the HMOs will also do the right thing."

One problem for the plans is that none wants to be stranded as the only HMO offering a benefit that could draw sick, high-cost customers. At the

same time, they're legally barred from discussing business strategies with each other.

Members of Kennedy's staff have been acting as intermediaries in a bid to foster an agreement among the plans that all will offer the benefit, sources said.

The flurry of activity this week follows a federal judge's Oct. 30 decision to strike down a Massachusetts law that forced Medicare HMOs to offer unlimited drug coverage. Under a 1997 federal law, states are not allowed to dictate coverage options to HMOs.

Right after the ruling, the state launched an investigation into whether some HMOs should have told seniors when they signed up this year that the benefit would be dropped next year. The state has threatened fines of up to \$5,000 for each case.



Business

THE BOSTON GLOBE • THURSDAY, NOVEMBER 12, 1998

THE BOSTON GLOBE • THURSDAY, NOVEMBER 12, 1998

Fallon backs senior drug cap delay

Harvard only major holdout on moratorium plan

By Alex Pham
GLOBE STAFF

Fallon Community Health Plan yesterday said it would support a one-year delay in implementing limits on drug coverage caps for senior citizens if other Medicare health maintenance organizations in the state agree to do the same.

"If the other health plans agree to a one-year moratorium, then Fallon would," said Jay Egan, co-executive director of Fallon Community Health Plan in Worcester. "It's a tremendous way to continue an important benefit for the market we have served for so long. If there is any way we can continue to provide

the full drug benefit, it would be in our strong interest to do so."

At issue is whether health plans will proceed with plans to limit drug benefits starting Jan. 1 for about 220,000 seniors enrolled in Medicare HMOs. Politicians and senior advocates have been lobbying HMOs for a one-year reprieve while lawmakers hammer out a permanent solution.

So far, Blue Cross and Blue Shield of Massachusetts and Tufts Health Plan have also said they would be open to a moratorium, leaving Harvard Pilgrim Health Care as the only major health plan to hold out. Harvard Pilgrim yesterday would not comment on the possibility of a one-year delay.

"We're giving thoughtful consideration to our options," said Harvard spokeswoman Patti Embry-Tautenan, who declined to elaborate.

All Medicare HMOs in the state have until Tuesday to decide what drug benefits they will offer in 1999.

Fallon, the oldest Medicare HMO in the nation, has 33,000 seniors in its Fallon Senior Plan, 16,000 of whom buy the full drug plan. Fallon has offered unlimited prescription drugs for the past 18 years. Egan said that Fallon would like to continue to offer the benefit, but would only do so if other major health plans do likewise. In the absence of an agreement, however, Fallon would have to "evaluate its options," Egan said.

Any agreement, however, would face antitrust hurdles, which prohib-

it competing HMOs from talking with each other about prices or benefits. The state attorney general's office has said it is working on a way to get health plans to agree without running afoul of the law.

Still, some health plan executives are skeptical that all hurdles will be cleared in time. "The reality of making this happen seems daunting," said one health plan executive.

Business

THE BOSTON GLOBE • WEDNESDAY, NOVEMBER 11, 1998

Seniors drug cap delay OK

HMOs can postpone plan
one year, US agency says

By Alex Pham
GLOBE STAFF

Giving a ray of hope to seniors, the federal government yesterday gave Medicare health maintenance organizations in Massachusetts an unusual chance to delay their plans to cap prescription drug benefits for the elderly.

The move was welcomed by advocates for seniors as an opportunity to persuade HMOs to extend unlimited drug benefits for at least one year instead of capping them beginning Jan. 1, as the health plans have announced recently.

So far, two big health plans, Blue Cross and Blue Shield of Massachusetts and Tufts Health Plan, have indicated they were willing to extend benefits for another year if Harvard Pilgrim Health Care also agreed to do the same. But Harvard Pilgrim Health Care yesterday refused to sign on.

Most HMOs in the state decided to proceed with limiting drug coverage after a federal judge last month struck down a Massachusetts law - the only one of its kind in the country - requiring Medicare HMOs to offer seniors a plan with unlimited drug benefits.

Since then, advocates and various politicians have feverishly lobbied health plans to agree to a one-year moratorium on capping drug benefits while policymakers try to hammer out a more permanent solution to help

BENEFITS, Page C6

Medicare HMO withdrawal file



United States Senate
COMMITTEE ON FINANCE

Daniel Patrick Moynihan
Ranking Minority Member

To: Chris

From: Katie

Total Pages (including cover): 14

Fax #: 456-5557

Date: _____

Time: _____

Comments: - Info. on medicare and plan

with documents.

- Not sure if you have this info.

from HIFA

203 HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510
TEL: (202) 224-5315
FAX: (202) 228-3004

Fact Sheet on Non-Renewals

Background and General Information on Medicare Health Maintenance Organizations (HMOs) and Non-renewals:

- For many years, the law has allowed Medicare to contract with HMOs to enroll beneficiaries. Currently, about 6 million beneficiaries receive their Medicare benefits through Medicare-contracting HMOs. The law that governs Medicare-contracting HMOs through 1998 (the "older" law) is being replaced by a new law. This new law creates the Medicare+Choice program. The Medicare+Choice program allows HMOs as well as other health plans to contract with Medicare. Beginning January 1, 1999, if HMOs that had been operating under the older law want to continue their Medicare participation, they must contract under the new Medicare+Choice program. Some currently-contracting HMOs have decided to continue under the Medicare+Choice program; others have decided not to continue.
- Under both the older law and the new Medicare+Choice program, Medicare HMOs must make annual business decisions about whether or not to continue to participate in the Medicare program. Under the older law, a decision not to participate was generally referred to as a non-renewal, because the HMO was deciding not to "renew" its existing contract with HCFA. This year, however, since under the Medicare+Choice law existing HMO contracts cannot be renewed, a "non-renewal" represents a decision by an HMO not to enter into a new Medicare+Choice contract for 1999. Non-renewal decisions can apply to a plan termination or to a service area reduction.
- For plans that want to contract with HCFA to enroll Medicare beneficiaries, HCFA initially approves the plan for its contract and then conducts periodic monitoring reviews. However, HCFA has no control over the annual business decisions of plans to continue participating in Medicare, that is, HCFA cannot require plans to enter into a Medicare+Choice contract for 1999 or maintain their existing service area under such a contract.
- Regulations governing contracts under the older law require HMOs to notify HCFA 90 days before the contract ends (i.e., October 2) of a decision to nonrenew and to notify affected enrollees 60 days prior to the end of the contract (i.e., November 2).

Information for Medicare Enrollees In Non-renewing Plans:

1. **In General.** Non-renewing HMOs will continue to provide services to their Medicare enrollees through December 31, 1998; that is, current enrollees can remain in their HMO through December 31, 1998. They can also disenroll prior to that time and either (1) return to the original Medicare plan or (2) enroll in another Medicare-contracting HMO or other Medicare+Choice plan if one is available in their geographic area (see item 3 below on effective dates and exceptions regarding who is eligible to enroll in another plan). All beneficiaries have the option of returning to the Original Medicare Plan. Non-renewing

HMOs are required to send all affected enrollees an information package by November 2, 1998. This package will provide information on enrollees' options with respect to either (1) returning to the original Medicare plan with supplemental coverage or (2) enrolling in another Medicare-contracting HMO or other Medicare+Choice plan.

2. **Returning to the Original Medicare Plan.** Individuals can return to the Original Medicare Plan in one of two ways: (1) they can remain enrolled in the Non-renewing plan until December 31, 1998 and be automatically returned to the Original Medicare Plan starting January 1, 1999; or (2) they can return to the original Medicare plan before December 31, 1998, by (a) submitting a written request to disenroll to the Non-renewing plan or (b) contacting the Social Security Office or Railroad Retirement Board Office. The member will be disenrolled effective the first day of the first month following the month the request for disenrollment was made. For example, if the individual requested disenrollment on November 20, he/she will be returned to the Original Medicare Plan effective December 1, 1998.

Individuals should understand that, until their disenrollment is effective, they must continue to comply with plan rules when seeking medical services.

3. **Choosing Another Medicare HMO.** Individuals may be able join another Medicare-contracting HMO or other Medicare+Choice plan. Beginning January 1, 1999, beneficiaries can enroll in any Medicare+Choice plan that serves their geographic area if they are entitled to Medicare Parts A and B and do not have permanent kidney failure (End Stage Renal Disease). If individuals choose to enroll in another plan before December 31, 1998, they will automatically be disenrolled from their current plan. Medicare-contracting HMOs and other Medicare+Choice plans that will be available in their geographic area will be required to accept enrollments in November 1998 to be effective January 1, 1999. It should also be noted that some of these plans may also accept enrollments during the month of December. Be sure to enroll no later than December 31, 1998 for your coverage to begin January 1999.

4. **Supplemental Insurance through Medigap.**

Requirements for Medigap Insurers:

- As long as individuals apply for a Medigap policy no later than 63 days after the coverage with the Non-renewing plan terminates, they are guaranteed the right to buy any Medigap plan designated "A", "B", "C" or "F" that is offered in the State. Accordingly, if individuals who remain enrolled until the Non-renewing plan terminates their coverage on December 31, 1998 apply for one of these Medigap policies no later than March 4, 1999, companies selling these policies cannot place conditions on the policy (such as an exclusion of benefits based on a pre-existing condition) or discriminate in the price of the policy because of health status, claims

experience, receipt of health care or medical condition.

CAUTION: While individuals can apply for a Medigap policy before December 31, 1998, the protections described here will NOT be guaranteed if they voluntarily disenroll before the HMO contract terminates December 31, 1998. Individuals must keep a copy of their plan's termination letter to show a Medigap insurer as proof of loss of coverage under this plan.

- If individuals dropped a Medigap policy to join the Non-renewing plan and they were never enrolled in a similar managed care plan since starting Medicare, they may be able to return to the Medigap policy that was dropped if (1) the Medigap policy dropped is still being sold by the same insurance company; (2) they disenroll from their current HMO before December 31, 1998; (3) they have been enrolled in their current HMO for no more than 12 months; and (4) they apply for the Medigap policy no later than 63 days after their coverage from their current HMO terminates.

If the previous Medigap policy is no longer available, the individual is still guaranteed the right to buy from any Medigap carrier a Medigap Plan designated "A", "B", "C", or "F" that is offered in that state (as described above).

CAUTION: If the previous policy is no longer available, the individual is still guaranteed the right to buy from any Medigap carrier any Medigap plan designated A, B, C or F that the carrier offers in that State (as described above.). However, in this situation the 63-day period for filing your the new Medigap application will begin on the effective date of disenrollment.

The individual should therefore make sure the old policy is still available from the original insurer before disenrolling from the non-renewing plan. If it is not available, the individual will have more time to make a decision about Medigap options by simply remaining enrolled until the current health plan terminates coverage on December 31. The individual will then have 63 days from the last day of coverage under the current plan to apply for a plan designated A, B, C or F.

Requirements for Plans:

- By law Medicare HMOs must arrange for individuals to be protected against any pre-existing condition exclusions under a Medigap policy for up to six months after a plan terminates coverage. Plans will provide individuals with specific information regarding the arrangements that will be made available to beneficiaries in the information package that Non-renewing plans must send by November 2, 1998.

5. **Supplemental Coverage Through a Former Employer.** Beneficiaries who have coverage with a Medicare HMO through their former employer should consult with their former employer's retirement office before making any changes.
6. **Possibility of Seeing the Same Doctor as Before.** Beneficiaries who choose to return to the Original Medicare Plan may be able to continue to see the same physicians that they had seen through the HMO because most HMO physicians (except those in staff or group model HMOs) also provide services under the Original Medicare Plan. If there are other Medicare-contracting HMOs or other Medicare+Choice plans in their geographic area, some of their current physicians may also participate with those plans.
7. **Information on Other Medicare HMOs.** On November 2, comparative information on Medicare-contracting HMOs and other Medicare+Choice plans that plan to contract with Medicare for 1999 will be available on the worldwide web at www.medicare.gov under "Medicare Compare". Information can be accessed by zip code or by state and county. Some plans are available only in certain counties within a state or zip codes within a county. Many libraries and senior centers can help beneficiaries obtain information from this source.
8. **General Assistance for Medicare Beneficiaries on Health Insurance Matters.** Beneficiaries can contact their State Health Insurance Assistance Program (SHIP) for assistance; they can also contact the U.S. Administration on Aging (AoA) central toll-free number (1-800-677-1116) to be referred to their local area agency on aging.

Questions and Answers

The Health Care Financing Administration (HCFA) is the Federal agency that administers the Medicare program. This includes administration of Medicare risk-based contracts with health maintenance organizations (HMOs). Some of these plans have decided not to renew their contracts with HCFA to provide Medicare services to Medicare beneficiaries in certain states and selected counties.

The following is designed to assist you in answering the most commonly asked questions arising from managed care plan non-renewals and service area reductions.

Q1 HMO plans are leaving Medicare. How do beneficiaries get information about whether this is true?

A1 Individuals affected by a termination will be receiving notification from the HMO no later than November 2, 1998.

Q2 Why are HMOs terminating their contracts with HCFA?

A2 HMOs are independent businesses that make business decisions to either participate or not participate in a contract with HCFA. HMOs voluntarily choose to enter into contracts with HCFA to serve Medicare enrollees. Each year HMOs have to make a choice to continue their contracts, adjust premiums and/or benefits, or not renew the contracts. Some HMOs have made business decisions to terminate their Medicare contracts in certain areas. In some cases, the termination of the contract was the result of the merger between the two plans where only one corporate entity will continue in the Medicare program.

Q3 Can the Health Care Financing Administration (HCFA) force Medicare HMOs to continue their contracts to provide services to Medicare beneficiaries?

A3 No. While HCFA is responsible for ensuring that contracting HMOs meet their contractual obligations, we do not influence their core business decisions, nor can we force them to stay in the Medicare program.

Q4 How are HMOs paid by the Federal government?

A4 HCFA pays HMOs a monthly amount for each enrolled Medicare member in exchange for providing all Medicare covered services to these members. The amounts vary from county to county and are determined based on a methodology prescribed in the statute. HCFA will make monthly payments to plans terminating their contracts through December, 1998. NOTE: \$379.84 is the lowest Federal government reimbursement rate for the aged allowed for 1999 by the Balanced Budget Act (BBA) of 1997. These rates are only the

base rate and the actual payments to HMOs reflect adjustments to the base rate for factors like age, sex, etc.

Q5 Are there any other HMOs in the affected areas that Medicare beneficiaries can join?

A5 In most instances, there is at least one other managed care option available. Beneficiaries will receive a notification from the terminating HMO with a list of options along with an available Medicare supplement (Medigap) option no later than November 2, 1998.

Q6 Are all HMOs terminating?

A6 No. The changes for January 1999 only affect certain Medicare contracts.

Q7 How many Medicare beneficiaries are affected by these changes?

A7 As a result of decisions by HMOs, approximately 48,000 Medicare beneficiaries -- less than one percent of the 6 million enrolled in Medicare managed care -- no longer have any Medicare HMOs in their areas. Approximately 7 percent of Medicare beneficiaries in managed care plans will be affected by these changes. This represents about 1 percent of the total Medicare beneficiaries.

Q8 After a plan terminates, what health care coverage will be available for Medicare beneficiaries who were enrolled in these plans?

A8 Many beneficiaries who are currently members of the terminating HMOs will be able to enroll in other Medicare managed care plans available in their area. Also, the Original Medicare Plan continues to be available to all Medicare-eligible individuals. Beneficiaries who return to the Original Medicare Plan and wish to purchase a Medicare supplement (Medigap) policy will have specific rights, discussed below. Each terminating HMO will be mailing a list of all health care options to its members by November 2, 1998.

Q9 Is there anything that will be made available to individuals being terminated from an HMO, such as a Medicare supplemental (Medigap) insurance policy?

A9 Current members of HMOs have certain beneficiary protections. First, as long as you apply for a Medigap policy not later than 63 days after your HMO coverage terminates on December 31, 1998, all Medigap insurers must sell you any Medigap plan designated "A", "B", "C", or "F" that they offer. The insurance company cannot place conditions on the policy (such as an exclusion of benefits based on a pre-existing condition) or discriminate in the price of the policy because of your health status, claims experience, receipt of health care, or your medical condition.

In addition, your HMO is required to make arrangements that ensure beneficiaries are protected for up to six months for out-of-pocket expenses related to any pre-existing condition exclusion in a Medigap policy. However, beneficiaries are free to seek other coverage which may or may not have a pre-existing condition exclusion.

Members should contact their State Health Insurance Assistance Program (SHIP) for further information.

Q10 What health coverage is available for members who are under the age of 65, and eligible for Medicare because of a disability?

A10 For beneficiaries under age 65 (i.e., entitled to Medicare because of a disability or as a result of End Stage Renal Disease (ESRD)), Medigap insurers have the same responsibility to sell you a Medigap policy designated "A", "B", "C" or "F" that they do for beneficiaries over age 65. However, terminating HMOs must only make arrangements for Medicare supplemental (Medigap) insurance based on what is available in the local marketplace. Members should contact their local State Health Insurance Assistance Program (SHIP) for further information.

Q11 What if I dropped a Medigap policy before I joined this plan? Can I return to this Medigap policy? What happens if I do this before December 31, 1998?

A11 If a beneficiary was previously enrolled in a Medigap policy and this was the first managed care plan the beneficiary enrolled in since starting Medicare, the beneficiary has the right to return to the Medigap policy if:

1. the Medigap policy dropped is still being sold by the same insurance company;
2. the beneficiary has not been enrolled in this plan for more than 12 months;
3. the beneficiary disenrolls from this plan before December 31, 1998; and
4. the beneficiary reapplies for that previous policy no later than 63 days after coverage from this plan terminates.

If the previous policy is no long available, the beneficiary is still guaranteed the right to buy a Medigap Plan designated "A", "B", "C", or "F" that is offered in that state. Before the beneficiary disenrolls, the beneficiary should make sure the policy is still available from the original insurer before disenrolling from the plan.

Q12 Will members be able to keep prescription drug coverage, or is new coverage being made available?

A12 If a member currently has prescription drug coverage through a terminating HMO, this coverage will also end December 31, 1998. Members have the option to enroll in other managed care plans available in their area which may cover prescription drugs. However, the Medigap policies that must be made available to members of terminating HMOs (plans "A", "B", "C" and "F") do not include prescription drug coverage. Similarly, the requirement that terminating HMOs make certain supplemental coverage available does not require them to make arrangements that include prescription drug coverage. Medicare supplemental plans that contain prescription drug coverage are available, but members must seek them out on their own. These plans may refuse to sell you a policy based on your health status, and may impose waiting periods for pre-existing conditions.

Q13 How soon will a decision need to be made for new health care coverage?

A13 Members may remain enrolled in their HMOs until December 31, 1998, or they may disenroll from their HMOs and return to the original Medicare plan before December 31, 1998 (As noted above, this decision may affect which Medigap options are available). It is recommended that members apply for a Medicare supplemental (Medigap) plan as soon as possible, in order to have Medigap coverage begin when the beneficiary returns to the Original Medicare Plan on January 1, 1999. However, as long as members apply within 63 days after HMO coverage terminates on December 31, 1998, their rights to get a new Medigap policy will be protected.

Members currently enrolled in an HMO who have Part B only and who wish to enroll in another Medicare managed care plan must do so no later than December 1 in order to ensure they can continue to be enrolled in a Medicare managed care plan option. The Balanced Budget Act does not allow beneficiaries with Part B-only coverage to enroll in a Medicare+Choice health plan option.

Q14 What are the benefits under the Original Medicare Plan?

A14 Beneficiary focused information, including an explanation of Medicare benefits, is available at www.medicare.gov.

Q15 Will members be able to go to their same doctors?

A15 For those members returning to the Original Medicare Plan it is very likely that they will be able to continue seeing the same doctors and other providers as they had seen through the HMO. Most physicians also participate in the Original Medicare Plan. Members need to check with their doctor and other providers to find out. If the providers participate in Medicare, there is no need for a change. If a member chooses to enroll in a new Medicare

HMO, he or she may need to select a new primary care physician (PCP) and begin using a new network of providers. Before making a decision to enroll in a new health plan option, the member should check with each managed care plan.

Q16 What happens if a currently enrolled member, who is hospitalized prior to January 1, 1999, is still a hospital inpatient after January 1?

A16 Most participating acute care hospitals are paid by Medicare based on the Prospective Payment System (PPS); non-PPS hospitals operate only in the state of Maryland. Other hospitals, like rehabilitation hospitals, free-standing psychiatric hospitals, and long-term care hospitals, are paid on a cost basis and not under PPS. For PPS hospitals, the HMOs will continue to be responsible after December 31, 1998, for inpatient hospital charges until the member is discharged. For non-PPS hospitals and for other charges, such as physician charges, related to inpatient PPS hospital stays after December 31, 1998, the original Medicare plan will be responsible for payment, minus normal deductible and copayment amounts. Members with Medicare supplemental insurance may have these deductible and copayment amounts paid by their Medigap policy.

Q17 What if a currently enrolled member is receiving other services at home? How can he or she receive assistance during this transition?

A17 Members who are currently receiving ongoing care, such as home health care, or who are using medical equipment, such as oxygen or wheelchairs, need to call the phone number shown on their HMO identification card and ask for Utilization Management (UM) when they are ready to change insurance plans. UM will help members make the change to receive care under the Original Medicare Plan or under a new managed care option. Members who select a new HMO should contact that HMO as soon as possible and ask for the UM department. Members who elect to return to the Original Medicare Plan should instruct their providers to bill Medicare directly after January 1, 1999.

Q18 What happens if a member needs to get additional information after January 1, 1999?

A18 HCFA requires HMOs to provide appropriate assistance to their members for as long as necessary. Individuals can also contact their State Health Insurance Assistance Program (SHIP) for additional assistance.

Q19 Does a current member of a terminating HMO have to wait until January 1, 1999 to change his or her Medicare coverage?

A19 No. If a member chooses to enroll in another Medicare managed care plan prior to January 1, 1999, that enrollment will automatically disenroll the member from his or her HMO. If a member chooses to disenroll and go to the Original Medicare Plan before January 1, 1999,

the member must submit a request to disenroll in writing to the plan or go to the local Social Security District Office; disenrollment will be effective through the end of the month in which the plan or Social Security Office receives the request. If the member takes no action, the member will be returned to the Original Medicare Plan on January 1, 1999.

Q20 How can members receive additional assistance or more information about their choices?

A20 Individuals can contact their State Health Insurance Assistance Program (SHIP). The following agencies can also give beneficiaries information on Medicare supplemental insurance plans and help with other health care decisions.

- County Aging Services
- Senior Centers
- State Insurance Departments
- The U.S. Administration on Aging
- HCFA Regional Offices

INFORMATION ON MEDICARE SUPPLEMENTAL INSURANCE

Questions and Answers

A Medicare supplement policy, also known as Medigap insurance, is an insurance policy offered by private entities (insurance companies or associations) to individuals entitled to have benefits paid by the Original Medicare Plan. Medigap provides reimbursement for certain expenses incurred for services or items for which payment may be made by the Original Medicare Plan but which are not reimbursable because of deductibles or coinsurance. A Medigap policy may also pay for certain items or services not covered by Medicare at all, such as prescription drugs. Medigap only works with the Original Medicare Plan. It will not cover out-of-pocket expenses, such as copayments, in a managed care plan.

The following is designed to assist you in answering the most commonly asked questions arising from managed care plan terminations and service area reductions.

What Happens If Your Managed Care Plan Terminates Coverage in Your Area Because it Does Not Continue in the Medicare Program?

If your health plan will no longer continue its contract with the Medicare program to provide health care to Medicare beneficiaries, the following alternatives are available to you:

1. You may remain enrolled in the non-renewing health plan until the end of the contract period. If you choose this option, you need take no further action; you will automatically be disenrolled from the plan and returned to the Original Medicare Plan as of the effective date of the health plan's termination. Until your disenrollment from the non-renewing health plan is effective, you must continue to use health plan providers.
2. You may join another managed care plan in your area that contracts with the Medicare program. If you choose this alternative before the end date of your coverage, you will automatically be disenrolled from the non-renewing health plan when you enroll in the new HMO. Health plan(s) in your area that have contracts with Medicare will be identified for you. They are required to accept your enrollment. Contact these plans concerning benefits and premiums in order to make the best selection for your personal needs.
3. You may disenroll from the non-renewing health plan and return to the Original Medicare Plan before your coverage terminates. If you choose this option, you may disenroll by notifying the non-renewing health plan. You may also disenroll by writing to or visiting your local Social Security office or your local Railroad Retirement office if you are a railroad retiree. You will be disenrolled effective the first day of the month following the month in which you requested disenrollment. For example, if you request disenrollment on November 20th, you will be returned to the Original Medicare Plan effective December 1.

If I Choose to Enroll in the Original Medicare Plan, Can I Purchase a Medigap Policy?

Yes. If you return to the Original Medicare Plan, you may wish to purchase a Medigap policy. A Medigap policy requires an additional monthly premium and will pay for some of your out-of-pocket costs which are not covered under the Original Medicare Plan. Your non-renewing plan has a legal obligation to arrange for you to be protected against any pre-existing condition exclusions under a Medigap policy for up to six months after the plan terminates your coverage. The plan may do this in a number of ways. The plan must notify you of what arrangements it has made for such coverage no later than November 2, 1998.

Some plans will identify a Medigap insurer, and the insurer will waive (i.e., not apply) the waiting period for coverage of pre-existing conditions. You may then enroll for the new policy between specific dates identified by the non-renewing managed care plan. Your Medigap insurance will have an effective date that should coincide with the ending of the plan's Medicare contract so that you will have continuous coverage.

May I Shop Around for a Medigap Policy Rather Than Accept the One Chosen by the Non-renewing Plan?

Yes. You may shop for a Medigap policy on your own and find the one that meets your needs and provides coverage at the lowest premium available in your state.

Am I Eligible for Any Protections If I Choose a Medigap Policy Other than the One Chosen by the Non-renewing Plan?

The law has an important protection for you in these circumstances, if you purchase Medigap plans "A", "B", "C", or "F". The insurance company selling the policy may not:

1. deny or apply any condition to the sale of the policy;
2. discriminate in the pricing of the policy because of your health status, prior history of claims experience, receipt of health care, or medical condition; or
3. impose a preexisting exclusion for any condition you may have.

However, you only have 63 days after your coverage ends in which to apply for coverage from a Medigap insurer. Contact your State Health Insurance Assistance Program for further information.

How Do I Go about Finding a Medigap Insurer?

Begin your inquiries as soon as you receive the non-renewing plan's notice of termination. This way, you will have time to find the best coverage to meet your needs and have it go into effect on the day following the effective date of your non-renewing plan's termination from the Medicare program.

Your best course of action in such situations is to contact your State Health Insurance Assistance Program (SHIP) or State insurance department. Your SHIP has been trained to assist you in resolving situations like these. The telephone number for the SHIP in your state is available on www.medicare.gov. To find out about your state's health insurance assistance program, check the State Government listing in your telephone book, and contact your State's Office on Aging or Insurance Commission.

Do These Special Protections Apply to All Medicare Beneficiaries?

Effective July 1, 1998, a Medigap insurer must make any plans "A", "B", "C", and "F" that the insurer makes available in the marketplace, available to all beneficiaries (aged, disabled, and individuals with End Stage Renal Disease) whose Medicare managed care plans are terminated or not renewed. The protections discussed above apply in these cases.

PRESIDENT CLINTON ANNOUNCES NEW INITIATIVE TO HELP MEDICARE BENEFICIARIES WHO HAVE BEEN ABANDONED BY THEIR HMOs AND TAKES STEPS TO PREVENT IT FROM HAPPENING AGAIN

October 8, 1998

Today, the President unveiled a three-part initiative to respond to the decision by some Health Maintenance Organizations (HMOs) to renege on their commitment to Medicare beneficiaries by dropping out of the program. The Department of Health and Human Services' preliminary analysis indicates that because of these withdrawals only one percent of Medicare beneficiaries currently in HMOs will have no managed care alternative in their area. However, the President stated his concern for any beneficiary who has lost their HMO option because of the decision by some of these plans. Addressing the action taken by selected HMOs, the President:

- **Criticized health plans for renegeing on commitment to Medicare beneficiaries but reiterated that the Administration would not grant the industry's request to raise premiums and reduce benefits for all Medicare beneficiaries in HMOs.** The President underscored that Medicare should not be held hostage to threats by HMOs to leave the program unless they can increase cost-sharing and reduce benefits to Medicare beneficiaries.
- **Initiated a new Medicare campaign to help beneficiaries understand their rights and options.** To assure Medicare beneficiaries, affected by HMO withdrawals, that they are automatically eligible for traditional fee-for-service and that the law guarantees them access to a number of Medigap policies, which help fill Medicare's coverage gaps, HCFA will:
 - Enlist a wide range of public and private partners that represent tens of millions of older Americans to provide their members with the information they need through newsletters, conferences, training partners, conducting targeted information campaigns. These partners include AFL-CIO, American Association of Retired Persons, the Leadership Council of Aging Organizations, National Council of Senior Citizens, and National Rural Health Association, as well as the Social Security Administration, HCFA Regional Offices, and State Health Insurance Assistance Programs;
 - Post new information today on the Medicare Internet site that provides commonly asked questions and answers for Medicare beneficiaries, their families, and insurance counselors;
 - Announced that Medicare.gov will be updated on a region-by-region basis to ensure information is available on any changes in plan options, resulting from these HMO withdrawals;
 - Distribute a model letter to all health plans who have chosen to drop out of the program to help notify beneficiaries of their options.
- **Announced new policy to encourage HMOs to enter markets that have been abandoned and to expedite their approval.** HCFA will expedite their review and approval of HMOs seeking to enter markets that have been left without an HMO option. Any such applications will receive first priority for review and HCFA will seek to expedite their entrance into the market as long as they meet necessary solvency, quality, and other standards.

- **Instructed Secretary Shalala to develop new legislative options to help assure beneficiaries are protected from these types of withdrawals in the future.** The President emphasized his determination that the Administration should take all possible actions to help assure an adequate range of health plan options for beneficiaries and reduce the likelihood that beneficiaries will face these kinds of situations in the future. To that end, he directed the Secretary to recommend a specific legislative proposal to be included in the President's next budget that is designed to enhance plan participation and beneficiary protections.

HMO Plan Withdrawals in the Federal Health Benefits Program for 1999

In 1999, there will be 272 HMOs participating in the Federal Employees Health Benefits Program, 64 fewer than in 1998. Federal employees, retirees and members of their families will still have more than adequate access to quality health care. Regardless of where they live, they will be able to choose from among at least 6 available health plans during the upcoming open enrollment period.

The HMOs which decided not to participate in 1999 all made independent business judgments. Though only a few plans cited any reason for their decision, low enrollments relative to other lines of business, competitive pressures in the market and merger/acquisition activity were cited as the primary factors dictating their decisions. From 1997 to 1998, 24 HMOs withdrew from the Federal Employees Health Benefits Program. The primary reason for the decline in HMOs during that period was the consolidation taking place in the HMO marketplace; 31 plans were acquired, merged with another plan, or reconfigured their service areas.

HMO participation in the Federal Employees Health Benefits Program has always fluctuated up and down; more in some years than in others. From the perspective of running the program, two matters are material to OPM in this context. First, OPM is committed to the principle of adequate access and choice in the program. Secondly, to the extent a health plan decides to withdraw from the program, it is important that the decision be made on the basis of an independent business judgment. Since both principles have been maintained for 1999, there does not appear to be any reason for concern about the program.



FAX Transmission

U.S. Department of Health and Human Services
Office of the Secretary

DATE:

TO:

Chris Jenkinson

FAX:

PHONE:

FROM:

Ellen Dahl

Office of the Assistant Secretary for Public Affairs

Phone: (202) 690-7578

Fax: (202) 690-5673

TOTAL NUMBER OF PAGES TRANSMITTED:

COMMENTS:

Will send finals soon!

10/7/98

NOTE TO: COS (Summy)
HCFA (Hash and Peacock)
ASL (Horvath)
ASPE (Claxton)
IGA
GC

FROM: Melissa Skolfield

I'm going to re-edit these now, since the computer just ate my revisions (!) but can you please go ahead and review these Medicare HMO Q and As from HCFA? Edits should go to Lauren Shaham by 4:00 PM TODAY. She's in our press office (638-E) and at 690-6343. Thanks.

Good News!
Attached are the
newly revised Q+As!

1. How many plans say they're leaving Medicare? Why are they leaving? How many states are affected?

As a result of decisions by HMOs to leave some Medicare markets, 49,481 Medicare beneficiaries -- less than one percent of the six million beneficiaries enrolled in Medicare managed care -- no longer have an HMO in their area. (43 contracts are not being renewed and 51 plans are reducing their service areas.) It's important to remember that a third of this total comes from plans in Utah that announced they were leaving in May -- a couple of months before HCFA published its June regulation. HMOs have also announced they are not renewing or reducing the service areas for 94 contracts, affecting 412,191 beneficiaries; however, these seniors DO have another managed care option in their area.

The vast majority of the 49,481 Medicare beneficiaries affected live in just four states: California (11 percent of the total), Florida (22 percent of the total), New York (11 percent of the total) and Utah (36 percent of the total.)

Despite this "shakeout" in the managed care market in some areas of the country, it's clear that managed care continues to be attractive and profitable for HMOs. HCFA has 347 contracts currently in effect and 48 new applications are in the pipeline; the number of beneficiaries enrolling in managed care plans has been growing by 70,000 to 80,000 a month.

BACKGROUND: Medicare HMOs make annual business decisions whether or not they will continue to take part in the Medicare program. These decisions can apply to an entire service area or only to selected counties in a company's service area. These are called nonrenewals.

For HMOs that want to contract with the Health Care Financing Administration to enroll Medicare beneficiaries, HCFA initially approves the plan for its contract and then conducts periodic monitoring reviews. However, HCFA has no control over the annual business decisions of HMOs to continue to participate in Medicare.

2. Doesn't the fact that all these plans are leaving Medicare mean that Medicare+Choice isn't working?

Absolutely not. Congress and the Administration created Medicare+Choice to modernize the Medicare program, letting Medicare beneficiaries make their own choices about how they want to receive their health care, whether its fee-for-service traditional Medicare or managed care. Just as importantly, one of the goals of Medicare+Choice is to give them the tools -- the information -- for them to make informed decisions. Our actions today continue our commitment in this area.

3. What is the Clinton Administration doing about the plans leaving?

The Health Care Financing Administration, the agency responsible for Medicare, will work closely with beneficiaries -- and a broad range of public and private partners -- to make sure they know their rights and options. HCFA is posting questions and answers and regional information

on its *Medicare.gov* website and is distributing a model letter to all plans dropping out of Medicare to encourage them to notify beneficiaries of their options.

HCFA will also expedite review and approval of HMOs seeking to enter markets that have been left without an HMO option. Any application will receive first priority for review, and HCFA will help them enter these areas quickly -- as long as they meet necessary solvency, quality and other standards that protect beneficiaries.

The President has also asked Secretary Shalala to explore legislative options to help assure that beneficiaries are protected from these types of withdrawals in the future. Her guiding priority in making that determination will be what's in the best interests of our beneficiaries.

4. **Many health plans say they wanted to resubmit their proposals, but you wouldn't let them. Why didn't you agree with this request which would have enabled beneficiaries to stay in Medicare managed care? Are there things you can do to bring the plans back into Medicare?**

The HMOs' proposal was not in the best interests of Medicare beneficiaries, and we believe HCFA was right not to let them raise premiums or drop benefits. On September 16, just two weeks before the deadline for plans to submit their nonrenewal notices to Medicare, the American Association of Health Plans made a broad request to the Health Care Financing Administration that would have allowed plans to significantly change benefits and costs for potentially millions of Medicare beneficiaries in managed care. HCFA decided not to allow such broad revisions to approved adjusted community rate proposals, of ACRs, because virtually all of the six million beneficiaries currently enrolled in Medicare managed care plans could have paid more premiums and cost-sharing while potentially receiving reduced benefits.

HCFA asked the AAHP to submit a narrower proposal and specific assurance that reopening these calculations would result in a number of health plans reconsidering their decisions about whether to continue participating in Medicare. However, HCFA received neither.

5. **Isn't this just more political managed-care basking by the White House? Isn't this just another effort to turn attention away from the House vote on impeachment?**

Absolutely not. This Administration has worked hard to help beneficiaries have more choices in the way they receive health care and the October 2 deadline for HMOs to decide whether or not to continue in the Medicare program was set by statute. HCFA's number one priority in making its decision was what's in the best interest of Medicare beneficiaries. Plans have left a relatively small number of beneficiaries -- less than one percent of the six million in Medicare managed care, with another 32 million in fee-for-service Medicare -- but we want to make sure that these 50,000 beneficiaries know exactly what their rights and options are.

6. **Now what can beneficiaries do to get health care? Won't they have difficulty getting continuity of care if they have to go back to Medicare?**

First of all, beneficiaries are not left without Medicare: all affected beneficiaries will be automatically enrolled in traditional fee-for-service Medicare --- the choice of 32 million of Medicare's 38 million beneficiaries. About 90 percent of the beneficiaries affected by these plans not renewing their contracts have other managed care choices in their communities. It's the one percent who have no other options who we are most concerned about.

Plans that are not renewing their contracts for 1999 will continue to provide services to their Medicare enrollees through December 31, 1998. If enrollees want to go back to original Medicare and buy a Medigap insurance policy, if they have been in the HMO for a year or less, they can buy one of four Medigap policies (know as A, B, C, and F). If they had a Medigap policy and were in the HMO for up to a year, they can go back to that policy, but they must meet certain conditions. This is just one of the reasons we want to make sure that beneficiaries know their rights and options after plans decide not to renew their contracts to provide managed health care to these beneficiaries.

7. **Many seniors go into managed care so they can get prescription drugs. If someone goes back to fee-for-service Medicare, won't they lose their prescription drug benefit?**

Yes, that's one of our key concerns and why we're taking the actions we are today. But remember, there are less than 50,000 people who don't have the option to enroll in another HMO and even fewer who may not be able to buy a Medigap plan that covers prescription drugs. We believe our expanded education campaign will help them make the choice that's right for them.

It's also important to remember that prescription drug coverage is one of the more attractive benefits that HMOs offer to get Medicare beneficiaries to join up -- but because it is also one of the most expensive benefits, it's also often the first benefit HMOs cut when they start to cut costs..

8. **Won't having to change plans or go back to fee-for-service mean beneficiaries will have to change doctors?**

No. Most doctors in the U.S. -- well over 90 percent, in fact -- participate in original fee-for-service Medicare. Many doctors also participate in other HMOs.

9. **AAHP says conditions have changed since May 1 when they were required to submit their benefit packages. So why not let them make changes that better reflect the health care market? Isn't your refusal to consider their request simply a bureaucratic response?**

Plans knew last Fall, when the law was passed, how their rates would be set. The actual rates were published in February. Under the statute passed by Congress, May 1 was the date specified for plans to submit information. This enables a responsible review of their material so that beneficiaries would be able to make informed decisions in the Fall.

A number of plans have said that prescription drugs have been increasing in cost, and that is a reason they want to reopen their benefit packages. However, for quite some time it has been clear that prescription drug prices have been increasing. So they should have had this information when they proposed their benefit package in May. We think it was not in the best interests of beneficiaries to let them -- at the last minute -- reopen their proposals and subject potentially millions of beneficiaries to higher costs and copayments and reduced benefits.

10. Don't you and the plans have an obligation to make sure beneficiaries don't lose their health care?

Absolutely. We have an obligation to protect the beneficiaries, making sure they will continue to get the best health care possible. That's why we're concerned and have announced our new initiatives, especially for those beneficiaries who will not have any managed care choices. It is for these people that we are encouraging HMOs to enter those markets that have been abandoned. We'll expedite the approval process for them, as long as they meet necessary solvency, quality and other standards that protect beneficiaries.

Now, as far as the plans are concerned, we hope they feel an obligation to the enrollees as well. They are required, however, to send their enrollees an information package by November 1. This packet will explain the enrollees' options -- either enroll in another HMO in their community or return to fee-for-service Medicare -- and then they can buy a Medigap insurance policy. And if they don't do anything at all, they will automatically be enrolled in original fee-for-service Medicare on January 1.

The HMOs are also required to make arrangements for Medigap insurance that guarantees coverage and waives exclusions or waiting periods for pre-existing conditions. That means pre-existing conditions will be covered the day the insurance is effective and the beneficiary cannot be denied coverage due to his or her health status.

11. Where can beneficiaries go to find out what to do?

There's a number of places. First of all, beneficiaries can call the Health Care Financing Administrations' regional offices. A list of offices is attached to the fact sheet. They can go on the Internet at www.Medicare.gov. They can also contact their State Health Insurance Programs or their local Area Agency on Aging. Groups like AARP and the National Council for the Aging are prepared to help them. And we're preparing to provide those groups with information that will help them advise seniors and their families.

12. Aren't you surprised by the small number of new types of plans (such as PSOs) that have applied to serve Medicare beneficiaries?

Not really. While the law was enacted a year ago, the regulations only went into effect in June and we expect to see more plans applying to provide service next year. The plans have to submit business plans, organize their networks of hospitals and doctors and generally look at all the business aspects of providing health care to Medicare beneficiaries. It all takes time and two

months is not a lot of time when an organization is just beginning the process. And we want to make sure that new plans consider their decision to enter Medicare carefully, so that they'll be in for the long haul.

13. Will you update the Medicare & You handbook to reflect these changes?

The handbook is being mailed to beneficiaries in only five states -- Ohio, Florida, Arizona, Washington and Oregon -- early in November. The handbook includes information about the plans that are available in those states and is already at the printer, AND these states are not heavily affected by HMO pullouts. So the handbook won't be updated. Updated information will be available at www.Medicare.gov.

14. What legislation will the Secretary propose? Are you ruling out giving more money to the plans? Who will she consult?

She was just given this directive today to determine whether legislation is needed. Based on what we know so far, we think the answer is yes. But let's review the bidding.

The fact that HMOs have left about 50,000 beneficiaries without managed care plans doesn't necessarily mean that major changes are needed. In fact, a third of this total comes from plans in Utah that announced they were leaving in May -- well before HCFA published its June regulation.

Many of the key deadlines that HMOs are complaining about, such as the May 1 date for HMOs to determine what the benefits they would provide and charges for beneficiaries, was set in the law passed by Congress. That's one of the possible areas for change we'll be considering, but before we decide anything we want to carefully consider what any change would mean for beneficiaries. For example, that May date was established to make sure beneficiaries would have the information they need on a timely basis.

HMOs have also complained that they're not getting paid enough in the formula established in the law. While we're not entirely ruling out the possibility that a different payment scheme may be in order, there has been substantial evidence -- from independent studies to the HHS Inspector General -- showing that plans are paid quite well by Medicare.