



HEALTH CARE FINANCING ADMINISTRATION



Medicare fimo File

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REMARKS:

This is the packet that is going on the internet today at 11:15.

Status of Medicare Managed Care Non-Renewals As of October 8, 1998

SUMMARY

- 43 risk contracts (health plans paid on a prepaid capitation basis) are non-renewing their contracts, affecting 221,091 beneficiaries. These plans have participated in the program for one to five years, with an average of about three and one-half years.
- 52 risk contracts are reducing their service areas, affecting 193,201 beneficiaries. These plans will continue to serve other parts of their current service areas.
- A total of 414,292 beneficiaries (about 7 percent of total risk enrollment) are affected by non-renewals and service area reductions in 371 counties. Of these, 56,142 beneficiaries are in 120 rural counties. There are 3,223 counties in the country, of which 1,122 currently have risk contracts. A total of 29 states, and the District of Columbia, are affected by these actions.
- The average payment rate for the counties being dropped is about \$486, and ranges from \$380 to \$798. The average payment rate across all counties is \$471.

AREAS WITH NO MANAGED CARE OPTIONS

- 72 counties will have no other risk (or cost) plans available, affecting 45,074 beneficiaries, less than 1 percent of current risk enrollment. Of these, 51 counties are rural, affecting 15,158 beneficiaries.
- In the 72 counties, 22 are at the payment floor of \$380. The range of the other counties' payment rates is from \$380 to \$721. The average payment rate across these counties is about \$434.
- At this time, there are 3 pending applications that will serve some of these areas.

PENDING APPLICATIONS

- There are 48 pending risk applications [43 Health Maintenance Organizations, 1 Preferred Provider Organization, 3 Provider Sponsored Organizations (PSO), and 1 PSO with an approved Federal waiver to state licensure]. In addition, 25 current risk plans have requested an expansion of their service areas.

OTHER NON RENEWAL ACTIVITY

- 5 cost contracts (health plans paid on a cost reimbursement basis) are non-renewing in 40 counties, affecting 20,290 beneficiaries.
- 15 Health Care Prepayment Plans (Part B only health plans) are non-renewing, affecting 12,532 beneficiaries.
- 2 Choices Demonstrations are non-renewing, affecting 23,178 beneficiaries.

TOTALS

A total of 117 contracts are non-renewing all or a part of their service area, affecting 470,292 beneficiaries. Although about 7 percent of the beneficiaries will be affected, less than 1 percent will have no managed care option available.

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 Nonrenewing 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 nonrenewing 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 nonrenewing 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 (ESRD). 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. However, if individuals wait until December to enroll, they will be transferred to the original Medicare plan for January, with enrollment in the new plan effective February 1.

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 nonrenewing plan terminates (in this case, December 31, 1998), they are guaranteed the right to buy any Medigap plan designated "A", "B", "C" or "F" that is offered in the State. 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 may 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 nonrenewing 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 disenrollment from their current HMO.

CAUTION: If individuals disenroll before December 31, 1998 and the previous policy is no longer available, they may NOT be guaranteed the right to buy Medigap policies "A", "B", "C" or "F" as described above.

Individuals must make sure the policy they dropped is still available from the original insurer before they disenroll.

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 nonrenewing 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. They can also contact the office of their State Insurance Commissioner or the HCFA regional office if additional assistance is necessary.



Questions & Answers

The Health Care Financing Administration (HCFA) is the Federal governmental entity which 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 the 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 common questions arising from managed care plan terminations 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 HMO's 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 contract, adjust premiums and/or benefits, or not renew the contract. Some HMOs have made a business decision to terminate their Medicare contracts in certain areas or, 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 assuring that contracting HMOs meet their contractual obligations, we do not influence their core business decisions of plans, nor can we force them to stay in the Medicare program.

Q4. How are HMOs paid by the Federal government?

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A4. HCFA pays HMOs a monthly amount for each enrolled Medicare member in exchange for providing all Medicare covered services to these members. These 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). 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 options 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 HMO's terminating?

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

Q7. How many Medicare beneficiaries are affected by these changes?

A7. 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, the Medigap insurer must sell you any Medigap plan they offer that is designated "A", "B", "C" or "F". 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 that beneficiaries who purchase Medigap policies have coverage, for up to six months, of out-of-pocket expenses related to any pre-existing conditions. 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 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 if it is already available in the local marketplace to beneficiaries under age 65.

Members should contact their 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 you enrolled in since you started Medicare, the beneficiary may be able to return to the Medigap policy if:

1. the Medigap policy you 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 did not disenroll from this plan before December 31, 1998; and
4. the beneficiary reapplies for a policy no later than 63 days after disenrolling from this plan.

If a beneficiary disenrolls before December 31, 1998 and his/her previous policy is no longer available, the beneficiary will not be guaranteed the right to buy Medigap policies A, B, C and F as described above. Before the beneficiary disenrolls, the beneficiary must

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 that they make arrangements that includes 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 the HMO until December 31, 1998, or they may disenroll from their HMO 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 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 a 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 that they can continue to be enrolled in a Medicare managed care plan option. The Balanced Budget Act, which takes effect on January 1, 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. Please refer to Your Medicare Handbook or contact your State Health Insurance Assistance Program (SHIP).

Q15. Will members be able to go to the same doctors?

A15. For those members returning to the Original Medicare Plan it is very likely that members

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 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. For members who elect to return to the Original Medicare Plan, instruct your 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. Individual 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 that 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 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. The individual can contact their State Health Insurance 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



MEDICARE SUPPLEMENTAL INSURANCE

Questions & 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 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 common 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 health maintenance organization (HMO) or competitive medical plan in your area which contracts with the Medicare program. If you choose this alternative before the end date of your contract, 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 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 this plan terminates your coverage. The plan may do this in a number of ways. You must contact your plan to find out what your rights are.

Some plans will identify a Medigap insurer, and the insurer will waive the waiting period for coverage of pre-existing conditions. You may then enroll under this 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 where you live.

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

The Medigap program 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 condition 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 have only 63 days after your coverage ends in which to apply for coverage from a Medigap insurer. Contact your insurance counseling agency or 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 date 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. Their telephone numbers can be found in the back of your *Medicare & You* booklet or your *Guide to Health Insurance for People with Medicare*.

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.

Health Care Financing Administration's Beneficiary Information and Outreach Strategy for Managed Care Plan Service Terminations and Service Area Reductions

To ensure that each managed care beneficiary facing the non-renewal of his or her current health plan is informed of their health plan options, HCFA has developed an aggressive Beneficiary Information and Outreach Strategy structured around six strategies used in the National Medicare Education Program (NMEP). In addition, HCFA has prepared a model letter that non-renewing health plans must disseminate to all affected beneficiaries.

The six NMEP strategies included in HCFA's managed care information and outreach strategy are: meeting the needs of individual beneficiaries, enlisting and training partners, providing toll-free telephone service, conducting special information campaigns, and utilizing print and the Internet as a means of distributing information.

HCFA actions include:

- distributing a model notification letter to non-renewing health plans for dissemination to all affected beneficiaries. The notification letter includes information regarding: how beneficiaries may return to original Medicare; other Medicare managed care options (where applicable) and enrollment processes; potential referrals for additional information, (i.e., State Health Insurance Assistance Programs, the HCFA Regional Offices, an automated Medicare Special Information Number); and Medigap.
- distributing managed care termination and service area reduction information and a set of questions and answers which address enrollment and supplemental insurance for beneficiaries affected by plan changes on the Medicare.gov Internet site, <www.medicare.gov>.
- providing information to partners, including the Social Security Administration, the State Health Insurance Assistance Programs, and other NMEP partners, regarding managed care termination issues. HCFA has scheduled a meeting of the NMEP coordinating committee and advocacy groups on October 8, 1998.
- educating all call center personnel, including Medicare+Choice call center personnel, about beneficiary issues resulting from managed care terminations and service area reductions. The Medicare call center will become operational in the five pilot states (i.e., Arizona, Florida, Ohio, Oregon, and Washington) on November 2, 1998.
- updating the Medicare Compare data base with FY 1999 Medicare health plan data during the first week of November. The Medicare Compare data base is located at <www.medicare.gov>.

Preliminary Data
Status of Medicare Managed Care Non- Renewals
Noon, October 6, 1998

SUMMARY

- 43 Risk contracts are non renewing, affecting 220,827 beneficiaries. The average life of time in the program is 3.5 years, and ranges from one year to 5 years.
- 51 Risk contracts are reducing their service areas, affecting 191,364 beneficiaries.
- A total of 412,191 beneficiaries (about 6% of total Risk enrollment) are affected by non renewals and service area reductions in 360 unduplicated counties (552 duplicated), of which 120 are rural (146 duplicated). (There are 3,223 counties in the country, of which 1,122 have risk plans now.)
- The average monthly payment rate in the counties being dropped is \$486.06, and ranges from \$379.84 to \$798.35 (Richmond, NY). The average current monthly payment to all plans is about \$471.

AREAS WITH NO MANAGED CARE OPTIONS

- 72 unduplicated counties (84 duplicated) will have no other Risk plans available, affecting 49,481 beneficiaries. Of these, 57 counties are rural, affecting 14,755 beneficiaries.
 - In the 72 counties, 22 are at the payment floor of \$379.84. The range of the other counties' payment rates is from there up to \$720.81 (Okeechobee, FL). The average is \$434.55.
- At this time, there are no pending applications for these counties.

PENDING APPLICATIONS

- There are 48 pending risk applications (43 HMO's, 1 PPO, 3 PSO's, and 1 PSO with an approved Federal waiver to state licensure) and 25 service area expansions.

OTHER NON RENEWAL ACTIVITY

- 5 cost plans are non renewing, affecting 20,290 beneficiaries.
- 16 HCPP's are non renewing, affecting 11,333 beneficiaries.
- 2 Choices Demonstrations are non renewing, affecting 23,178 beneficiaries.

HMO disenrollment file

October 5, 1998

MEMORANDUM FOR ERSKINE BOWLES

FROM: Chris Jennings CCJ

SUBJECT: HMO disenrollment from Medicare and Response by Administration

cc: John Podesta, Rahm Emanuel, Jack Lew, Bruce Reed, Gene Sperling, Ron Klain, Larry Stein, Sylvia Mathews, Elena Kagan, David Beier, Janet Murguia, Dan Mendelson

We are attempting to schedule a meeting later this morning with you, Secretary Shalala and her staff to go over a range of options that could respond to Health Maintenance Organizations (HMOs) that chose to selectively terminate some of their plans from participation in the Medicare program. Because of the growing news coverage of this issue, Rahm and Bruce believe it is advisable for us to move quickly to determine our strategy and public positioning on this issue. They asked me to draft this memo in preparation for such a meeting.

Background

As of late last night, HHS had not completed its analysis of the impact of the roughly 25 (mostly large) HMOs that chose to selectively terminate some of their plans from participation in the Medicare program. Preliminary data and projections appear to indicate that the decisions by these HMOs will affect between 325,000 to 400,000 beneficiaries in about 375 counties. Because the Medicare program has about 6.5 million of its over 38 million beneficiaries in HMOs, about 5 percent of Medicare HMO enrollees and about 1 percent of the entire Medicare population seem likely to be impacted in any way at all. Having said this, because most of the beneficiaries affected will have another Medicare HMO option in their county, there appears to be a much smaller number of beneficiaries enrolled in HMOs (between 30,000 and 80,000 -- about 1 percent of the Medicare HMO population) who will no longer have any such option. (They will, however, always have access to their traditional fee-for-service plan, as well as to at least some supplementary "Medigap" coverage.)

Congressional reaction. The Congress, so far on a bipartisan basis, has been critical of the decision by some within the HMO industry to selectively withdraw from Medicare. On Friday, the Republican Leadership left the Commerce Committee in the hands of the Democrats and some of their party's most vociferous critics of HMOs (such as Dr. Ganske) to excoriate the industry's representative. Mr. Thomas, the Chair of the Ways and Means Subcommittee on Health, has also indicated at least his initial support of our decision not to allow plans to charge more and/or reduce benefits. Having said this, members of states that will be disproportionately affected can be counted on to pressure us to take more actions. Senator Dodd has already weighed in, and we can be sure others will follow.

Reaction from the AARP. The American Association of Retired Persons (AARP) support last week's decision by the Administration to reject the industry's request for changes in their coverage and cost sharing. They have indicated that they want to work with us to make sure that beneficiaries know all of their options and rights (discussed below) relating to the plan terminations from the program. Although they acknowledged that their sentiments may change as more beneficiaries complain, AARP indicated that they now see no reason to move quickly to respond to initial "scare" articles by taking any position that appears to reward "bad apple" HMOs. Having said this, they also do not believe we need to take a strong and public position that appears we have drawn lines in the sand on against doing something on this issue. They are of the mind that we should wait to see how big the problem is and how the public responds to it before taking any formal, final position. They think a quick tough position may unconstructively unify the HMO industry against us.

Options to Respond to HMO Industry's Actions.

Before briefly outlining some options, it is important that you are aware of actions we can and should take regardless of our broader strategy on the Medicare HMO issue. Clearly, we must be quick to ensure that HCFA collaborates with the aging advocates (like AARP), the aging network (like the Area Agencies on Aging), state-based insurance counselors, and others in and outside the Administration to ensure that beneficiaries in impacted areas know that they can always return to the program's fee-for-service plan. Beneficiaries also need to know that the law requires Medicare supplemental insurers to offer beneficiaries access to certain "Medigap" coverage without being underwritten in any fashion. As a result, insurance that fills in the voids that Medicare does not cover is truly accessible for this population. Finally, to illustrate our commitment to find ways to assure this never happens again, we may also want to indicate our intention to introduce legislation that would help ensure that this never happens again. (For example, we might want to contemplate provisions that penalize plans for "cherry-picking" the high reimbursement areas or disallow HMOs to enter any new market if they have withdrawn in others.) Being proactive could help immunize us against any suggestions that we are insensitive to the needs of the beneficiaries.

Options for responding to last week's decision by many HMOs to pull out of Medicare:

1. **Explicitly announce a "no action is merited" position.** In short, draw a line in the sand quite publicly and reject any proposal to allow HMOs to shift costs back onto beneficiaries. Blame any subsequent mess on HMOs who signed a contract in May and who now want to renege on their commitment. Highlight all the "selfish" reasons why some HMOs are dropping out and underscore our commitment to never be "black-mailed" into changing the contracts we signed on behalf of the beneficiaries.

Pros: Strong and decisive action; Puts industry on the defensive and initiates a much more public war with one of the nation's most unpopular industries -- HMOs.

Cons: Republicans, some Democrats, and AARP may feel we are acting too politically and too abruptly; Charges of callousness to harmed beneficiaries may ensue; If we don't stay tough throughout inevitable "horror" stories, we will look much weaker.

2. **Tacit "do nothing" position, but leave door (quietly) open option.** Under this scenario, we would continue to say we are looking into impact to determine severity, but would say we continue to be skeptical that there is a valid argument to do anything. We would background the press on the weaknesses of the HMOs' arguments, but would hint that we might not reject out of hand any future intervention if our review turns up major problems for beneficiaries.

Pros: Appears that we are standing up to the industry, but also gives us time and flexibility in case we want to alter our current course; would likely be supported by the Republicans and AARP for now, might be safest -- but certainly not boldest --option for the moment.

Cons: Could appear weak and indecisive; In the alternative, could appear we are insensitive to beneficiaries' woes; Opens door to HMOs to come in to cut a deal that may viewed by the validators as setting very bad precedent for the Medicare program.

3. **Expedite approval of new plans coming into counties now not served.** This option would highlight our commitment to work with and give expedited approval to HMOs that were not in a service area when another HMO dropped its coverage. These so-called "good-guy" plans could give a less comprehensive benefit or cost-sharing protection package than the one that it would replace.

Pros: Rewards good players and punishes "bad apple" HMOs; Supports our contention that we are taking reasonable actions to help beneficiaries keep access to an HMO option; In combination with base administrative and legislative package (outlined above), would illustrate that our "first and foremost" commitment is to beneficiaries -- not HMOs.

Cons: Very few new plans can be expected to come into these marginal markets; Will not significantly reduce the number of "victim" stories that will be reported; Makes us potentially more vulnerable to criticism that we did not do everything we could to help beneficiaries; If we pursue this option but eventually cave to HMOs' desires for other plans to get a similar offering, we would be perceived as very weak.

- 4. Expedite approval of new plans, but allow selected old plans to apply to come back in if no other option is available.** This approach would allow a plan that withdrew from a service area, which now has no HMO option, to downgrade its benefits package to a level the HMO believes is financially viable.

Pros: Would help more beneficiaries at least retain some of their current HMO coverage; Would be more responsive to the inevitable pressure from the Congress to do more to give hope that plans will come back; and if -- as is likely -- the old HMOs do not come back, it is easier to lay the blame on them. (In other words, we did everything the HMOs asked for and they still did not come back.)

Cons: Rewards bad actors; Makes us look somewhat weak -- as though we backed down from pressure of the HMOs, Sets bad precedence for Medicare for future similar disputes with the industry (unless our administrative/legislative package makes it appear certain that we cannot or would not be able to do this again.)

- 5. "Third way" option: try to split the difference between option 3 and 4 to attempt to get the best and avoid the worst of both options.** It might be possible (although we are still trying to develop a way to rationally apply this option) to allow only new plans in, but to give the HHS Secretary emergency authority to approve -- in selected cases -- applications from HMOs from the old service area to come back into the county. Under this approach, no such plan could even be considered unless it was clear that no new plan was a contender. There would have to be additional criteria as well to ensure that there is a substantive difference between option 4 and 5.

Pros: Could argue that we showed how we could respond to beneficiaries' concerns without backing down to the "bad apple" HMOs; See #4 above for similar pros.

Cons: Could be vulnerable to charges that it is "too cute by half;" Might not be able to develop criteria that provided enough direction/cover to the Secretary to differentiate.

Conclusion. There may be other options, but the above outlines what is most likely to be discussed later today. The White House staff (DPC, NEC, OMB, OVP, Rahm, etc.) has not made any final recommendations. In general, however, the White House tends to want to be a bit more aggressive than HHS. Consistent with this, HHS had indicated an interest in option 4 on Friday. However, some of Donna's staff seemed to be cooling to the idea over the weekend. Regardless, it is clear that all views on this issue will be influenced by the degree to which we receive troubling reports about beneficiaries.

HHS' staff will be meeting early this morning to go over their preliminary analysis and options. We will advise you if anything unusual comes back to us prior to your meeting.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration



OCT 1 1998

The Administrator
Washington, D.C. 20201

Ms. Karen Ignagni
Chief Executive Officer
American Association of Health Plans
1129 Twentieth Street, NW, Suite 600
Washington, D.C. 20036

Medicare HMO withdrawal file

Dear Karen:

Thank you for your recent letters regarding several issues about Medicare+Choice implementation. As we implement the changes made to the Medicare managed care program by the Balanced Budget Act, our highest priority is to do what is in the best interests of Medicare beneficiaries.

September 16th was the first time you brought to our attention your request that the Health Care Financing Administration consider changes in several key areas, including a broad request to allow plans to significantly change benefits and costs for a potentially large number of Medicare enrollees. We have decided not to allow such broad revisions to approved adjusted community rate (ACRs) proposals because many beneficiaries would receive fewer benefits while paying more for their health care. We expect plans to provide us with a notice of their intent to non-renew by October 2nd, as required by regulation.

In response to our request that you identify circumstances that would narrow the number of plans or beneficiaries that would be affected by the ACR revisions, you identified on September 29th four areas where plans that have "waived premiums" should be permitted: (1) to increase premiums that plans had voluntarily lowered or waived; (2) to increase cost sharing for prescription drugs; (3) to reduce prescription drug benefits; and (4) to increase cost sharing for hospital and physician services. Our review of this proposal indicates that it does not limit the number of beneficiaries that would pay more for health care or plans that may be eligible for revisions. Indeed, under this proposal virtually all of the 6 million beneficiaries currently enrolled in Medicare managed care plans could pay more premiums and cost sharing while potentially receiving reduced benefits.

During our discussions, we asked that you submit a narrower proposal and that you provide some specific assurances that reopening these calculations would result in a number of health plans reconsidering their decisions about whether to continue participating in the Medicare+Choice program. To date we have received neither. Because beneficiaries depend upon us to carefully review benefit packages, we cannot jeopardize the integrity of that process by forcing a rushed review of potentially hundreds

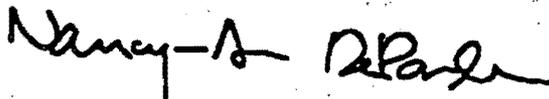
Page 2 - Ms. Karen Ignagni

of revisions. Although you have suggested that we would need to review only a small part of the rate and benefit proposal for each plan, we believe that it would not be responsible to make what might be significant changes affecting beneficiary costs without a thorough review of how the changes affect the remainder of the ACR proposal. In short, we do not believe that your proposal to allow plans to increase their premiums and cost sharing and reduce benefits would be in the best interests of our Medicare beneficiaries. Accordingly, we have concluded that it would be neither in the best interests of beneficiaries, nor administratively feasible, for us to reopen the premium and benefit calculations for virtually the entire Medicare+Choice program.

We would like, however, to continue working with you to address other areas of concern for health plans. Based on extensive discussions with health plans, beneficiary groups, state officials, and others we have made a number of changes in the Quality Improvement System for Managed Care (QISMC) program. We discussed these changes yesterday in a meeting with representatives from AAHP and other industry groups. A revised set of QISMC material will be available through HCFA's Internet site today. We will also continue working with plans to assure that plans have a transition period for certain key implementation areas such as provider contracting requirements. For example, plans will have until January 1, 2000 to implement a compliance plan. We will allow plans to complete recontracting with existing providers by January 1, 2000. However, any new provider contracts should comply with BBA requirements. Finally, we understand your concerns about attestation issues and would be happy to meet with you and our colleagues at the Office of Inspector General and the Department of Justice to discuss these issues.

Although we are committed to working with you on administrative issues, we see no reason at this time to consider allowing virtually all HMOs to increase costs and decrease benefits for their Medicare enrollees. We hope and expect that as the vast majority of plans consider their long-term business goals and objectives, they will continue serving Medicare beneficiaries. In fact, we are encouraged that we are currently reviewing over 45 new applications and over 20 service area expansions from a number of health plans. We remain committed to our mutual goal of providing comprehensive, quality care at the most affordable cost.

Sincerely,



Nancy-Ann Min DeParle
Administrator

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File Family Planning

PRESIDENT CLINTON: INCREASING SUPPORT FOR FAMILY PLANNING

January 22, 1998

"I will continue to do everything I can to make sure that every child in America is a wanted child, raised in a loving, strong family. Ultimately, that is the idea the anniversary of Roe v. Wade celebrates."

President Bill Clinton
January 22, 1998

Today, marks the 25th anniversary of Roe v. Wade, the landmark Supreme Court decision that affirmed every woman's right to choose whether and when to have a child. President Clinton is committed to ensuring this right, and in doing so, to protecting two of our nation's most deeply-held values, personal privacy and family responsibility.

PREVENTION AND FAMILY PLANNING. During the last five years, the Administration has worked hard to reduce the need for abortions and to prevent unintended pregnancy by making comprehensive family planning and sex education programs more widely available. The President's FY 1999 budget calls for:

- **Increased Funding for Title X.** The proposal will increase Title X Family Planning grants by \$15 million -- a 46% increase since FY1992.
- **Medicaid and Other Services.** The proposal will provide almost \$500 million in federal funds to Medicaid to support family planning services. Additionally, the Maternal & Child Health Block Grant, the Social Services Block Grant, and the Preventive Health Block Grant will provide \$100 million to state and local communities for family planning services.
- **Prevention Education and Research.** The proposal will provide about \$200 million for the National Institutes of Health's research on infertility, contraception, and related matters, and CDC's programs to educate teenagers about sexual development and abstinence. Additionally, Health and Human Service's teen pregnancy prevention and related youth programs will continue to engage the Girl Power! education initiative in sustained efforts to promote pregnancy prevention among girls 9- to 14-years-old.

A COMPREHENSIVE APPROACH TO FAMILY PLANNING. Under the President's proposal nearly 5 million clients each year at more than 4,700 family planning clinics nationwide, would have access to a comprehensive set of family planning services including contraceptive services, pregnancy testing, sexually transmitted disease screening and treatment, and education and outreach.

SUPPORTING INTERNATIONAL FAMILY PLANNING. The Administration is strongly committed to international family planning efforts. The President has blocked several Congressional attempts to prohibit funding for international family planning groups that use their own funding to lobby on behalf of abortion rights or perform abortions. Under the President's Budget, bilateral assistance provided through AID and assistance to the United Nations Population Fund will grow to \$425 million in FY 1999, a 32% increase over FY 1992.

Georgetown University
3rd Healy
Tel: 202-687-3455
Fax: 202-687-1656

Georgetown File



Fax

To: *Chris Jennings* From: *Rev William L George SJ*
 Fax: *456-5557* Pages: *3*
 Phone: _____ Date: *Jan 27, 1998*
 Re: _____ CC: _____

- Urgent
- For Review
- Please Comment
- Please Reply
- Please Recycle

Comments:

To your information.

Georgetown University
3rd Healy
Tel: 202-687-3455
Fax: 202-687-1656



Fax

FAXED
1-27-98

To: JOSH GOTBAUM From: Rev. T. Byron Collins, S.J.
 Rev. William L. George, S.J.

Fax: 395-9188 Pages: Two

Phone: Date: Jan 27, 98

By: CC:

Urgent For Review Please Comment Please Reply Please Reply

Comments:

Mr. Gottbaum

Sent to you at
suggestion of Mr
Kieffer.

T. Byron Collins SJ
William L. George SJ



GEORGETOWN UNIVERSITY

Office of the President
Assistant for Federal Relations

January 27, 1998

Mr. Josh Gotbaum
O.M.B.

Tel: 395-9188

Fax: 395-4995

Dear Mr. Gotbaum,

This concerns the 3 million in D.C. Appropriations for F.Y '98 for the Demonstration Medicare Project in the District of Colombia. We send this information at the suggestion of Chuck Kieffer.

The purpose of the appropriations is to use the funds for Medicare co-payments for the elderly, chronically ill who do not receive adequate medical care. We have contacted the D.C. region ministers and they state this is their gravest concern in their communities.

We met with Sharon Arnold (Tel. 410-786-3264), Medicare Demonstrations Director, on January 22, 1998 at the direction of Nancy Ann Departe, Director of HCFA. She has agreed to expedite our program, since we are ready to proceed and could obligate the funds almost immediately. We urgently request the funds be released as soon as possible. If they must go through the District to the Medicare program, we request the release of the funds be so directed.

If there is any other information we can supply, we stand ready.

Many prayerful thanks for considering our request.


Rev. T. Byron Collins, S.J.


Rev. William L. George, R.J.

cc: Chuck Kieffer - Tel. 202.395.4790 Fax 202.395.3729
cc: [unclear] Tel. [unclear] [unclear]

Washington DC 20051

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PROBLEMS WITH THE EPHIC BILL

The "Expansion of Portability and Health Insurance Coverage Act of 1997," (EPHIC), a bill is ostensibly intended to allow small employers to save money by purchasing health insurance through association-sponsored plans. This legislation would federalize the regulation and oversight of Association Health Plans (AHPs), which otherwise would be covered under ERISA as Multiple Employer Welfare Arrangements (MEWAs). It may create conflicts with HIPAA's newly enacted provisions guaranteeing renewability of health insurance coverage through bona fide associations. The bill has several problems which, taken together, would undermine protections now available to workers and plans under state insurance regulation.

- ◆ **EPHICs experience rating provision would cause risk segmentation. Employer groups that join AHPs would be healthier on average than other groups and would gain at their expense.** Any insurance company and any self-insured plan offering health coverage through an AHP would be exempt from state limitations on experience rating.
 - ◆ **EPHIC permits AHPs to "cherry pick"** -They could "cherry pick" within an AHP by varying rates among their employers on the basis of claims experience (so long as rates are not varied "significantly") or by targeting benefit packages to appeal to healthier groups.
 - They could "cherry pick" by varying rates for employers on the basis of age, sex, geography and other factors.
 - They could "cherry pick" outside the AHP by recruiting only "healthy members" to the association, or by marketing or organizing in only low-cost areas or historically healthy regions. Employers with an unhealthy history would be left in remaining state insurance pools, leading to ever increasing premiums in the state-regulated small group market.
 - EPHIC is not targeted to small employers; there is no size threshold for employers. In fact, AHPs can exclude employers on the basis of size of the workforce.
 - The AHP's board is given sole authority to approve applications for participation in the plan.
 - If any "individual" is a member of an association, then the employer may participate in the AHP, thus multiplying the opportunities for fragmentation of the market and risk selection.
 - "Self-insured" plans now offered by associations would be "grandfathered;" unlike other AHPs they would not be required to offer a fully-insured option.
- ◆ **Effects tied to state rating rules** - EPHIC's effects would be larger in states that impose narrower boundaries around permissible rates.
 - In such states, employers with lower than average health costs could derive savings by isolation themselves into experience-rated AHPs.
 - These savings would come at the expense of employers that remain in

state regulated small group markets, whose premiums would rise as less costly.

- ◆ Costs effects could be large - In states with age/sex adjusted community rating, employers joining AHPs could save 24 percent while other employers' costs could rise by 7 percent, assuming that AHPs enroll 20 percent of the market. The effects would be greater in states with tighter rate regulation or if MEWA enrollment is greater.
- ◆ **Participants could be shortchanged on benefits.** Most state laws establishing benefit requirements would not apply to AHPs (except for laws prohibiting exclusion of a particular disease).
 - ◆ Health insurance issuers and AHPs would have sole discretion in selecting specific items and services, and excluding others from coverage.
 - ◆ AHPs could offer limited benefit plans, scaling down their coverage of higher cost benefits and avoiding coverage of expensive services, e.g., certain obstetrical care and mental health benefits.
 - ◆ A loophole is created for insured plans. An insurance company offering a scaled-down health plan through an AHP could market the same plan to employers that are eligible for coverage, but are not participating in the AHP. Although the eligible employer is outside the AHP, the plan remains exempt from state benefit laws. *[See section 2(b)(2)(D) creating 514(d)(2) of ERISA]*
- ◆ **Participants would be shortchanged on state insurance protections.** AHPs would be exempted from provider mandate laws requiring certain specialists be included in plans. AHPs' self-insured plans would be exempted from state marketing and sales standards, quality standards, solvency standards, and other consumer protections such as benefit design laws limiting out-of-pocket expenditures or lifetime limits.
- ◆ **Participants' benefits could be endangered.** The bill's solvency requirements are less rigorous than those required by the states.
 - ◆ The bill does not require that an AHP meet capital and surplus requirements. Although it does specify reserve standards for self-funded options, reserves are not a substitute for capital requirements. State insurance regulation has evolved beyond minimal fixed capital requirements to risk-based capital requirements that set capital standards based on the level of risk being assumed by the plan.
 - ◆ The reserve standards in the bill are inadequate. Certain types of reserves are not included and may be important in various circumstances. These additional reserves include contract reserves, due and unpaid reserves, and paid in advance reserves. Also, it is unclear whether incurred but not reported reserves are a part of the incurred benefit liabilities reserves requirements.
 - ◆ The bill waives actual reserve requirements if the AHP uses alternative means

of compliance, such as letters of credit or assessments of participating employers, that are approved by the Secretary. These alternatives are not cash or cash equivalent options and they may not be appropriate, especially if participating employers are not financially stable.

- ◆ **Savings from most of EPHICs provisions are likely to be small.** While the experience rating provisions could result in large transfers, the savings realized through other provisions are likely to be small.

- ◆ Savings from banding together already available. Some purchasing groups, such as the Health Insurance Plan of California (HIPC), already band together with significant savings under current law. Not all administrative costs would be effectively spread by AHPs, as both the AHP and issuers could incur marketing costs for each prospective employer.
- ◆ Few employers would save much by escaping state mandates. Research shows that self-insured plans, which ERISA shields from mandates, typically are no leaner than insured plans. State "bare bones" laws, which allow small employers to offer leaner benefit packages, have not been very popular, moving only 4 percent of employers to insured status.
- ◆ Few would save from nationally uniform rules. Among firms with fewer than 20 employees, just 2 percent operate in more than one state. Among firms with 20 to 49 employees, just 11 percent cross state borders.
- ◆ Self-insured AHP programs could escape certain other state charges, but these savings would be small. AHP's self-insured programs would be relieved from state premium taxes (typically only 2 percent of premium) and certain other state charges such as guaranty fund assessments (often offset against premium taxes) and assessments to subsidize high-risk pools (typically smaller amounts). These savings would be at the expense of the security of state association backing.

- ◆ **EPHIC's effects on coverage would be small.**

- ◆ Experience rating would have little effect. The availability of experience rated policies might prompt more coverage among healthier groups, but cost increases elsewhere would likely prompt coverage losses. AHPs would weaken successful state small group reforms, which ordinarily include some rating rules. Research shows that over time these reforms may prompt about 9 percent of small employers to offer coverage.
- ◆ Small savings from other provision would add little coverage. Firms that do not offer coverage tend to disproportionately employ workers who typically would turn down coverage when offered - that is who are young, earn low wages, and work part time.
 - Such firms may decline to offer coverage because employees would prefer cash wages.
 - Research shows even large price reductions would prompt only a small

fraction of uninsured workers to buy insurance.

- ◆ **New categories of federally regulated single employer plans and church plans could seek certification as AHPs, creating additional opportunities for risk selection and exemptions from state consumer protections.**
 - ◆ An entirely new category of "single employer" plan can be certified as an AHP. Those arrangements not meeting the statutory exemption criteria for single employer plans would be eligible for certification as an AHP if: the majority of employees covered under a group health plan are employees of a single employer and if the remaining employees are employed by related employers (employers are related if they have common suppliers or customers).
 - The sponsorship requirements for AHPs are not applicable to these "single employer" AHPs; consequently, the sponsors do not have to be organized for a substantial purpose other than obtaining or providing medical care, or be a permanent entity that receives the active support of its members.
 - ◆ Church plans would be federalized. However, they would not be subject to federal solvency provisions; commingling of assets would be permitted, and the government would have limited ability to administer and enforce federal requirements.
 - ◆ Church plans can be marketed without restriction to individuals or employers.
 - ◆ Franchise plans could also seek certification as AHPs.
- ◆ **Insolvency provisions are inadequate.** The bill's provisions for intervention in a faltering AHP do not provide sufficient protections.
 - ◆ The bill does not establish a guaranty fund for federally certified AHPs.
 - ◆ It provides few details with respect to liquidation of plans that become insolvent.
 - ◆ There is no provision for ongoing financial examinations of self-insured AHP programs, a key component of state insurance regulation.
 - ◆ There can be critical delays in notification of financial problems. There can be a delay of up to six months from the time a plan has cash flow problems before the Secretary must be notified; this is extremely long time frame by health insurance industry standards.
- ◆ **Federal and state authorities would have limited ability to administer and enforce applicable requirements.**
 - ◆ The Secretary of Labor has limited discretion over certification of AHPs. The Secretary must certify upon finding that an AHP is "administratively feasible", not adverse to the interests of individuals covered under it, and protective of the rights and benefits of covered individuals.
 - ◆ Protections for participants and the plan are limited. Unlike ERISA's exemption

procedures, there is no requirement that the exemption be in the interests of the plan and its participants and beneficiaries (as opposed to merely "not adverse" to such interests), nor is there a requirement for notice and comment of interested parties.

- ◆ There is no provision for resources. There are vast new federal regulatory and enforcement requirements, with no provision for resources.
- ◆ State enforcement provisions are impractical. States can enter into monitoring agreements with the Department of Labor, but this enforcement is limited to one "domicile state". It would be impractical for one "domicile" state to monitor an AHP's activities in another state.
- ◆ State insurance regulation would be hampered. The state insurance market would be fragmented, making regulation of insurers more difficult.



Division of Diabetes Translation
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention



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|------------|---------------------------|-------------------------------------|------------------------|
| To: | <i>Sarah Bianchi</i> | Date: | <i>10/2/97</i> |
| Telephone: | <i>202-456-5585</i> | From: | Frank VINICOR, MD, MPH |
| FAX#: | <i>202-456-5557</i> | Telephone: | (770) 488-5000 |
| Subject: | <i>Diabetes Pgms Info</i> | | FAX: 770-488-5966 |
| Total | <i>4</i> | <i>(including this cover sheet)</i> | |

Transmittal Message

Sarah -

FYI as requested by Frank

File :

*"Diabetes
Type I*

Grants"

Proposal by the Centers for Disease Control and Prevention for
Special Diabetes Programs for Type 1 Diabetes

BACKGROUND

Type 1 diabetes mellitus (DM- previously referred to as IDDM) remains a challenging disorder in terms of pathogenesis, prevalence, seriousness and cost. Reflecting both a strong genetic predisposition coupled with environmental factors, Type 1 DM a) varies in incidence world-wide; b) appears to be increasing within the United States (U.S.); c) can be predicted several years prior to clinical onset with a combination of genetic, immunologic, and insulin secretory testing. Once Type 1 DM is clinically diagnosed, existing efficacious and cost-effective secondary and tertiary prevention programs can be utilized to limit the development of associated complications. Unfortunately, these strategies are not being applied uniformly or effectively in daily clinical practice, with resultant unnecessary eye, kidney, foot and cardiovascular disease.

A multi-component effort is now being directed to Type 1 DM which includes a) expanded genetic, immunologic, biochemical, clinical, epidemiologic and health services research; b) primary prevention trials for Type 1 DM in Europe and in the U.S. (DPT-1); and c) structured and systematic efforts to improve access to efficient and quality preventive care for those with Type 1 DM. Though activities are ongoing in all these areas, expanded programs and new initiatives are needed to both understand the challenges and reduce the burden of Type 1 DM.

PROPOSED PROGRAMS

Based on findings from recent scientific and clinical studies, deliberations at a recent National Institute of Health conference on diabetes, and the unique expertise, experience and responsibility of the Centers for Disease Control and Prevention (CDC), the CDC proposes to use new funds for Type 1 DM efforts for the following programs:

1. National Diabetes Laboratory

Because of the extensive experience that the CDC has in establishing and providing assistance on reference laboratories, the CDC is proposing to develop a National Diabetes Laboratory. Within the National Center for Environmental Health at CDC, the Division of Environmental Health Laboratory Science's (EHLS) mission includes a responsibility "to assist disease-prevention programs that need special or unusual laboratory expertise." Biomonitoring, standardization of laboratory measurements, quality control and performance evaluation for state public health laboratories, research into the relationship between genetics and environmental exposure in causes of disease, and sophisticated nutrient, toxic, protein and biologic measurements represent activities of EHLS. Researchers within EHLS collaborate with government agencies, including the NHLBI and NCI at NIH; health departments, academic institutions, and international organizations. Also, because of a special interest in cardiovascular disease, the CDC has established an international reputation in the standardization and quality control of many lipid assays.

The proposed National Diabetes Laboratory would focus on 3 main laboratory activities supportive of the emerging scientific efforts in Type 1 DM described above, would build upon existing expertise at CDC, and would consist of genetic and immunologic laboratory measurements; reference measurements of glycosylated proteins, including hemoglobin A1C and advanced glycation endproducts (AGEs); and quality storage mechanisms for essential samples from scientific clinical trials:

- a. Genetic and Immunologic Laboratory: Several clinical trials and individual studies relevant to prevention of Type 1 DM are now underway. Genetic research has identified multiple sites associated with Type 1 DM, e.g. IDDM1, the major histocompatibility complex (MHC)HLA region on chromosome 6p21; IDDM2, the insulin gene region on chromosome 11p15. These two regions contribute approximately 42 and 10% respectively of the observed familial clustering of the disease. Eighteen other chromosome regions show some positive evidence of linkage to the disease, with some combination of genes being risk factors across ethnic groups, while other combinations being specific to certain groups. In addition, certain "immunological markers" are being used broadly to identify those individuals are at increasing risk for Type 1 DM. The National Diabetes Laboratory would provide reference measurements, control materials, and technical consultation for genetic and immunologic laboratory measurements that help identify effective clinical preventive approaches for type 1 DM.
- b. Recent studies, especially the DCCT, have established the efficacy and cost-effectiveness of glycemic control for improvement of long-term health in Type 1 DM. In addition, pathogenetic mechanisms of tissue damage related to hyperglycemia are now being identified. For day to day clinical decisions, comparability ("standardization") of clinical laboratory results is a fundamental reason for measurement reference systems. For example, the present National Glycohemoglobin Standardization Program uses the BioRex 70 HPLC method. More recently, a more accurate reference method based on isotope-dilution mass spectrometry (ID/MS) has been developed for HbA1c measurements, but whose results are 40% lower than the BioRex 70 HPLC method. In a similar manner, scientific studies indicate the importance of AGEs as both a mechanism of microvascular complications, as well as a possible better index of long-term glucose control. The National Diabetes Laboratory would establish reference methods for glucose, appropriate HbA1c assays, and analytical methods for AGEs, as well as technical consultation assistance.
- c. For rigorous and scientific studies of Type 1 DM, appropriate storage facilities for tissue, blood, protein and DNA samples would be critical in facilitating extant scientific investigation, as well as future opportunities for investigation upon new study findings relevant to Type 1 DM. The presence of state-of-the-art storage facilities at CDC, already existing and soon to be completed, will provide an important opportunity for storage of samples from rigorous scientific studies for continued and future investigation.

Requested support: \$3 million/year

2. Enhanced Surveillance System for Type 1 DM:

The extent and distribution of type 1 DM in the U.S. remain incompletely understood. Furthermore, several studies indicate that care for this disease is sub-optimal despite convincing science of the efficacy of glycemic control (secondary prevention) as well as early microvascular complication detection and treatment (tertiary prevention). In order to improve epidemiologic information about Type 1 DM, as well as a) identify potential opportunities for fundamental research opportunities; and b) track and eventually improve the care being provided in order to limit preventable complications, CDC will use its expertise in surveillance to establish pilot "enhanced surveillance systems" of Type 1 DM in selected populations. For example, an increasing number of individuals with DM, including Type 1 DM, are receiving their initial and long-term care in managed care organizations (MCOs). The CDC has established cooperative epidemiologic programs with several large MCOs, and would improve and use these expanding data sources to establish surveillance systems for Type 1 DM. Identification of new onset Type 1 DM, as well as characterization of care patterns, and predictors of complications - particularly using the resources of the CDC Laboratory described above - will permit an

evaluation of this new type of surveillance system. If, upon careful evaluation, the "enhanced Type 1 DM surveillance system" were determined to be an efficient and useful method to identify and track individuals with new onset as well as existing Type 1 DM, the program would be expanded to other MCOs throughout the U. S., as well as other systems of care delivery.

Requested support: \$2 million/year

3. Demonstration Trials to Translate Research Into Better Diabetes Care for Type 1 Diabetes:

Data indicate that care for Type 1 diabetes is inadequate, despite convincing science of its efficacy (DCCT). Remedying this problem requires determining *why* Type 1 diabetes care is inadequate. The answers can be found through demonstration and intervention trials designed to address "gaps in care" for Type 1 diabetes programs. The trials can be conducted within CDC's well-established network of state-based diabetes control programs, managed care organizations, community-based organizations, and other service providers. CDC would implement demonstration projects (multi-site, randomized trials) regarding implementation of glycemic control, reducing the risk of complications, and providing better preventive care among persons with Type 1 diabetes. These demonstrations would address cultural factors, patient and provider characteristics, access factors (such as integrating prevention and control with school systems and family-centered education), and integration with a range of delivery systems. Results would then be disseminated and implemented through CDC's state-based diabetes control programs.

Requested support: \$1 million/year

SUMMARY:

Type 1 DM presents both challenges and opportunities to better understand the pathogenesis and management of this increasingly common disorder. This information can result in more effective primary, secondary and tertiary prevention efforts in order to reduce the devastation associated with the disease. Improved efforts to identify and track individuals with Type 1 DM; as well as augmented laboratory programs for quality control of assays relevant to Type 1 DM; development of new laboratory procedures and tests; and storage of blood, genetic and tissue samples from rigorous scientific studies, will all supplement the important NIH research activities directed to Type 1 DM. This collaborative interaction between CDC and NIH will further expand our existing programmatic coordination, and provide a stronger synergistic effort to control the burden of Type 1 DM.

TOTAL PROPOSED FUNDING:

1. National Laboratory - \$3 million/year
 2. Enhanced Surveillance - \$2 million/year
 3. Demonstration Trials - \$1 million/year
- Total - \$6 million/year