

**THE PRESIDENT'S PLAN TO
MODERNIZE AND STRENGTHEN**

MEDICARE

FOR THE 21st CENTURY

DETAILED DESCRIPTION

**NATIONAL ECONOMIC COUNCIL
DOMESTIC POLICY COUNCIL**

July 2, 1999

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DRAFT: June 21, 1999

Medicare Reform Rollout

CHRONOLOGICAL ORDER BY DATE

Tuesday, June 22, 1999

5:00 pm Labor – Retirement Benefit Meeting
Gerry Shea, AFL/CIO
John Abraham, AFT
David Blitztein, UFCW
Jeff Gibson, 1199 New York
David Hirschland, UAW
Marie Monrad, AFSCME
Louise Novotny, CWA
Jim Ray, Buildings and Const Trades Dept.
Carol Regan, SEIU
Steve Sleigh, Machinists

Chris Jennings
Gene Sperling (drop by)
Karen Tramontano (drop by)
Jean Lambrew
Gary Claxton
Mark McClellan, Treas. (?)

Wednesday, June 23, 1999

12:00 pm American Hospital Association
Dick Davidson, President and CEO
Rick Pollack, Vice President
Tom Nichols, Vice President

John Podesta
Gene Sperling (if available)
Mary Beth Cahill
Jack Lew/Dan Mendelson

Wed/Thur Women's Groups
Older Women's League
Alzheimer's Assn.
AAUW

Gene Sperling
Jenny Luray
Barbara Woolley

Thursday, June 24, 1999 Proposed Meetings

Catholic Health Assn.
Rev. Michael Place, CEO
Jack Bresch, Vice Presi, Gov. Relations
Fish Brown, Vice Presi for Policy

John Podesta
Chris Jennings
Mary Beth Cahill

10:15 am	Corporates Larry Atkins, Nat. Health Care Lobbyist Rep. Corporate Org.	Chris Jennings Gene Sperling Mary Beth Cahill Jay Dunn
2:30 pm	Pharmacists National Community Pharm Assn, John Rector Nat Assn. Of Chain Drug Stores	Chris Jennings Dan Mendelson Gary Claxton Jean Lambrew Bonnie Washington
	National Assn For Public Hospitals	Chris Jennings
Wed/Thur.	Disability Groups	Gene Sperling Jonathan Young

Friday, June 25, 1999 Proposed Meetings

<p>American Health Care Association (Nursing Homes) David Seckman, President Bruce Yarwood</p>	<p>John Podesta Gene Sperling (if available) Mary Beth Cahill Jack Lew/Dan Mendelson Chris Jennings</p>
<p>American Association of Medical Colleges (Teaching Hospitals) Jordan Cohen, President Ralph Mueller, Chicago, Chair Sam Their Tom Glynn, CEO, Partners Health Care System New York Rep Dick Knapp</p>	<p>John Podesta Gene Sperling Mary Beth Cahill Chris Jennings Jack Lew/Dan Mendelson Larry Stein</p>
<p>BIOTECH Geletex, Chair of Bio Walter Moore, Genentech Amgen Genozyme Berlex BIO Staff, Carl Feldbaum</p>	<p>John Podesta Chris Jennings Dan Mendelson</p>
<p>National Association for Home Care Val Halamandaris, President</p>	<p>Steve Ricchetti Chris Jennings</p>
<p>American Medical Association</p>	<p>Chris Jennings</p>

Monday, June 28, 1999

Proposed Meetings

PhRMA

Amgen, Chair of PhRMA
Merck
SmithKline
PhRMA Staff

John Podesta

Chris Jennings
Dan Mendelson
Gene Sperling

AFL/CIO

John Podesta

Mary Beth Cahill
Gene Sperling
Chris Jennings
Karen Tramontano

Pharmacists [if committed to strong support]

National Community Pharm Assn, John Rector
Nat Assn. Of Chain Drug Stores, Larry Calcott

John Podesta

Chris Jennings
Dan Mendelson
Jean Lambrew
Bonnie Washington

American Assn for Health Plans

Karen Ignangi, President

Steve Ricchetti

Chris Jennings
Gary Claxton

HIAAA

Chip Kahn, CEO

Steve Ricchetti

Chris Jennings
Gary Claxton

CALLS TO VALIDATORS MONDAY EVENING

AARP— Horace Deets, John Rother, Kevin Donnellen

John Podesta

Gene Sperling
Chris Jennings
Mary Beth Cahill
Chris Jennings/B. Woolley
Chris Jennings/J. Young
Gene Sperling/J. Luray/B.
Woolley

Leadership Council on Aging

Disability Groups

Women's Groups

Testimony of Karen Ignagni

President and CEO

American Association of Health Plans

Before the Senate Finance Committee

On the

Future of the Medicare Program

May 27, 1999

I. Introduction

The members of the American Association of Health Plans (AAHP) appreciate the opportunity to submit testimony on the future of the Medicare program. AAHP represents more than 1,000 HMOs, PPOs, and similar network health plans; our membership includes the majority of Medicare+Choice organizations. Together, AAHP member plans provide care for more than 150 million Americans nationwide and have strongly supported efforts to modernize Medicare and give beneficiaries the same health care choices that are available to working Americans.

Our plans have had a longstanding commitment to Medicare and to the mission of providing high quality, cost effective services to beneficiaries. Today, more than 16 percent -- or 6.1 million beneficiaries -- are enrolled in health plans, up from only 6.2 percent five years ago. Recent research indicates that health plans are attracting an increasing number of older Medicare beneficiaries, and that Medicare beneficiaries are remaining in health plans longer. In addition, near-poor Medicare beneficiaries are more likely to enroll in health plans than higher-income beneficiaries. These health plans offer Medicare beneficiaries many benefits that are not covered under traditional Medicare, such as prescription drug coverage.

With passage of the Balanced Budget Act (BBA) two years ago, Congress took significant steps toward the goal of providing Medicare beneficiaries with expanded choices similar to those available in the private sector and toward ensuring the solvency of the Medicare trust fund. The establishment of the Medicare+Choice program was supported by AAHP and regarded as the foundation for moving forward with a program design that can be sustained for baby boomers and future generations of Medicare beneficiaries. Unanticipated events, however, have endangered this foundation and created structural issues that must be resolved quickly. Without Congressional action this year, the promises made to beneficiaries with the passage of the BBA will remain unfulfilled thus preventing the successful implementation of virtually every long-term solution, including premium support, that this Committee might examine.

We appreciate this opportunity to share with the Committee our members' thoughts on reforming Medicare for future generations of seniors and disabled and will comment on several topics, including:

- AAHP's Medicare principles;
- The Medicare Fairness Gap and its effect on beneficiaries; and
- The premium support approach to reforming Medicare.

I. AAHP's Medicare Principles

The Medicare program was enacted 34 years ago and was a reflection of private sector insurance coverage at that time. Much has changed since then -- but prior to the enactment of the Balanced Budget Act of 1997, Medicare had taken few dramatic steps to modernize the program. In the past 34 years, health plans have learned how to organize and deliver health care services in ways that improve coverage and quality while better controlling costs. But Medicare had been slow to take advantage of these improvements: As a result, while more than 80 percent of working Americans with health insurance coverage now receive their care through health plans, only one out of every six Medicare beneficiaries is a health plan member.

Given the challenge of addressing the current Medicare problems and moving toward the goal of sustaining the program for future beneficiaries, our members believe that there are six principles that ought to guide the Committee's work:

- **Strengthen Medicare Through Expanded Choice.** Ensuring a strong Medicare program requires that beneficiaries have an expanded range of health care choices. Consumers in the private sector have benefited from access to affordable, comprehensive coverage due to the widespread availability of health plan options. However, broader choice for Medicare beneficiaries, a central goal of the Balanced Budget Act, has not yet been realized. The promise of the BBA and the foundation for future reform should be fulfilled through midcourse corrections that will make the Medicare+Choice program fair, stable, and predictable for beneficiaries, health plans, and providers.
- **Provide More Information.** Beneficiaries should receive accurate information that allows them to compare all options and select the one that best meets their needs. We are concerned that with its beneficiary information campaign last year, HCFA got off to a very rocky start. The agency conducted a costly campaign that did not meet congressional expectations. Many seniors received incorrect or confusing information and, in fact, information about options other than the traditional Medicare program did not appear in the "Medicare+You" brochure until page 17, some plans were left out altogether, information was inaccurate and the subliminal message to beneficiaries was 'don't switch'.
- **Ensure Payment Adequacy, Accuracy, Predictability, and Stability.** Federal contributions to Medicare+Choice organizations should be adequate and predictable to promote expanded choices for beneficiaries in low payment areas, while maintaining the availability of affordable options for beneficiaries in markets in which health plan options are currently well established. As is now apparent, the BBA payment formula, in combination with the Administration's risk adjustor, will not achieve this goal. New options generally are not developing, while communities across the country with high concentrations of seniors are seriously threatened. This experience is completely contrary to what Congress intended and is an unstable basis from which to proceed to address long-term structural reform.

Mechanisms to improve payment accuracy should ensure that Medicare+Choice organizations are reimbursed appropriately for the broader benefits, better out-of-pocket protections and coordinated care provided to enrolled beneficiaries. Furthermore, implementation of the new risk adjustment mechanism required under the BBA should move forward on a spending neutral basis, as Congress intended; when it is clear that risk adjustment is consistent with objectives of promoting a system that provides high quality cost effective care and disease management; when the risk adjuster accurately measures health status, rather than producing results that are artifacts of data problems or fee-for-service utilization patterns; and when benefits offered to Medicare beneficiaries will not be adversely affected. An accurate, well-implemented risk adjustor will be a critical component of any premium support model or alternative that builds on a competitive model.

- **Ensure Payment Parity and Fair Regulation.** A key component of a stable Medicare program is payment parity and regulatory fairness across all options available under the Medicare program. The rate of growth in reimbursements for beneficiaries under the Medicare+Choice program should be comparable to the rate of growth in spending to serve beneficiaries under the Medicare fee-for-service program. Likewise, the regulatory structure for health plans should not be based on the erroneous view that fee-for-service Medicare is inherently superior to Medicare+Choice. In fact, there is much evidence of better care being provided in the Medicare+Choice program, yet Medicare regulation continues to emphasize micromanaging Medicare+Choice plans over

improving care for the 85 percent of beneficiaries in fee-for-service Medicare. In short, Medicare+Choice organizations should not receive disproportionately low government payments on behalf of beneficiaries or be subject to disproportionately extensive regulatory requirements.

• **Establish Consistent Standards and Meaningful Regulation.** Beneficiaries should have confidence that all options, including both Medicare+Choice plans and the Medicare fee-for-service program, meet standards of accountability that ensure that they will have access to all Medicare benefits and rights regardless of the choice they make. All Medicare+Choice options offered to Medicare beneficiaries should be required to meet comparable standards in such areas as quality of care, access, grievance procedures, and solvency. These standards should be implemented through regulatory requirements that make the best use of Medicare+Choice organization resources to ensure that beneficiaries receive the maximum value from the program. This means that when requirements are established, their benefits must outweigh their costs. In a reformed Medicare system, consistent standards are essential to the creation of a level playing field of choices.

• **Promote Responsive Government.** To foster increased consumer confidence in all aspects of the Medicare program, HCFA should take immediate steps to improve administration of the Medicare+Choice program by: providing consumer-friendly educational information to current and prospective beneficiaries about all types of choices available to them through an equitably financed program; reducing unnecessarily burdensome regulatory requirements that do not add value for beneficiaries and streamlining and stabilizing program administration to permit expanded choice; and improving consistent implementation of HCFA Central Office policies throughout HCFA regional offices and minimizing variation in policy interpretation and administrative determinations across these offices.

do they?
 HCFA Board?

III. The Medicare Fairness Gap

The BBA limited the annual rate of growth in payments to health plans, producing \$22.5 billion in savings from the Medicare+Choice program. In addition, the BBA reduced geographic inequities in the payment formula to encourage the development of choices in lower payment areas of the country. We supported the passage of payment reforms in the BBA and understood the need to contribute our fair share toward the savings necessary to stabilize the Medicare Trust Fund.

We are deeply concerned, however, that unintended consequences of higher than anticipated inflation, 900 pages of new regulations, and the growing gap in funding of the two sides of the program does not serve the best interests of beneficiaries and was not intended by Congress. In 1998 and 1999, because of the low national growth percentage and the inability to achieve budget neutrality, no counties received blended payment rates. Furthermore, HCFA has chosen to implement its new risk adjustment methodology in a manner that will cut aggregate payments to Medicare+Choice organizations by an estimated *additional* \$11.2 billion over a five-year period. This is an administratively imposed 50 percent increase in the \$22.5 billion savings Congress anticipated from the payment methodology as enacted in the BBA of 1997. In fact, the Congressional Budget Office (CBO) recently stated that it had "previously assumed" that risk adjustment in the Medicare+Choice program would be budget neutral.

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AAHP analysis of PricewaterhouseCoopers projections of Medicare+Choice rates in each county over the next 5 years shows that a significant gap opens up between reimbursement under the fee-for-service program and reimbursement under the Medicare+Choice program. This Medicare+Choice Fairness Gap will be at least \$1,000 for two-thirds of Medicare+Choice enrollees living in the top 100 counties, as ranked by Medicare+Choice enrollment. This same Fairness Gap will exceed \$1,500 in major Medicare+Choice markets, including Chicago, Los Angeles, Miami, New York, Boston, Pittsburgh, Cleveland, St. Louis City, Dallas, and Philadelphia. In Miami, the Fairness Gap will be \$3,500 in 2004 and in Houston the gap will exceed \$2,500 in 2004. In New Orleans, the Fairness Gap will exceed \$2,600 in 2004.

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For nearly half of Medicare+Choice enrollees living in the top 100 counties, the Medicare+Choice reimbursement will be down to 85 percent of traditional Medicare payments in 2004, significantly exceeding any estimates of so-called overpayment due to favorable selection by plans. When AAHP examined the top 101-200 counties ranked by enrollment, we continued to find a large Fairness Gap in the smaller markets that plans were expected to expand into under the policy changes implemented by the BBA. In these counties, nearly half of Medicare+Choice enrollees live in areas where the Fairness Gap will be \$1,000 or more in 2004.

A large percentage of the Fairness Gap is attributable to HCFA's risk adjuster. Contrary to ensuring predictability in the new Medicare+Choice program, the impact of this risk adjustment methodology will be to restrict new market entrants and leave beneficiaries with fewer options, reduced benefits and higher out-of-pocket costs. AAHP has found that the impact of HCFA's risk adjuster on Medicare+Choice payments to rural and urban counties is similar - rural areas with Medicare+Choice beneficiaries are cut by about 6 percent, while urban areas are cut by about 7 percent.

Finally, we also are concerned that only health plan beneficiaries are funding the Agency's beneficiary education campaign. Given concerns about the effectiveness of this effort and at a time of growing instability in the Medicare+Choice program, we strongly urge that the program be scaled back and realistic goals set. In addition, we urge that the cost of a newly developed effort be distributed proportionally across the entire system. *what does this mean?*

We have summarized the crisis in the Medicare+Choice program because we believe its success will determine the nation's ability to move to broader reforms. We look forward to a future opportunity to present our analysis and our proposals for addressing these challenges to the Committee when it convenes its hearings specifically on Medicare+Choice.

IV. Premium Support Approach for Medicare

In order to protect and preserve the Medicare program for future generations of beneficiaries, a national conversation should proceed about the need for structural change and future preparedness. The premium support approach that was examined by the National Bipartisan Commission on the Future of Medicare could be the platform for examining how to fundamentally change the way Medicare finances coverage to beneficiaries, offering seniors a wide variety of choices with the anticipation also of curbing long-term spending growth. Since a premium support program would represent a significant change not only for beneficiaries, it will be crucial to consider the best means of structuring the program so that the fee-for-service program continues to be available.

Changing the Medicare program along these lines raises a number of important design issues that should be explored thoroughly. To that end, as the Committee considers fundamental changes to Medicare, it needs to evaluate what has occurred in the Medicare+Choice program. Virtually all stakeholders supported the concept of expanding choice, but many have been disappointed by problems in implementing Congress' intent. Through this prism, our members have developed the following principles for your consideration.

- **Establish a Core Set of Benefits and Allow for Competition Around Additional Services.** *NO* The program should require a core set of benefits, while allowing plans flexibility in offering other benefits. To help beneficiaries compare different plan offerings, benefit descriptions could be standardized.
- **Government Contribution Must Be Actuarially Sound.** Determining the amount of the government contribution will be a critical decision in the design of a premium support program. The level of the government's contribution should be a fixed proportion of an amount necessary to adequately meet the needs and costs of the benefits package for Medicare beneficiaries.
- **Include the Fee-For-Service Program.** *some* In order to allow for a level playing field that promotes effective competition and a broad array of choices, all options, including fee-for-service, should be required to operate under the same premium support rules.
- **Let the Beneficiary Choose.** The federal government's premium contribution should not vary according to the type of program or delivery system selected.
- **Establish Equivalent Quality Standards for Coverage Options.** Health plans have been the frontrunners in meeting quality, access and consumer protection standards. All coverage options, including Medicare fee-for-service, should be governed by equivalent quality and consumer protection standards. Equivalent standards should be flexible enough to recognize that a given quality or consumer protection objective might be achieved in a number of different ways.
- **Develop a New Administrative Framework.** Health plans and other options participating in a reformed Medicare program should be administered under a new framework that focuses on promoting quality medical care, rather than on micromanaging plan and practitioner operations. *A* The new framework should seek to minimize the conflicting objectives evident under HCFA's current role as both purchaser and regulator. ?
- **Pilot Testing and Phase-In.** A premium support approach - including the traditional program - should be pilot tested on a limited basis. Subsequently, the program should be phased-in to allow

time to make necessary adjustments.

In addition, there are two very specific lessons from the current Medicare program that should provide context for your discussion of premium support.

- **Tensions Between HCFA's Role as Purchaser and Regulator.** HCFA's dual roles as purchaser and regulator are, at times, in conflict. Nowhere has this conflict been more evident than in HCFA's implementation of the BBA. The situation plans faced in the Fall of 1998 serves to illustrate the inherent conflict between HCFA's traditional role as a regulator and its changing role as a purchaser. Given all of the uncertainty surrounding the program and the unrealistic compliance timetable, plans across the country and across model types became deeply concerned last Fall about their ability to deliver benefits promised under the originally mandated filing schedule. This led our members to make an unprecedented request to HCFA to allow plans to resubmit parts of their adjusted community rate proposals. In some service areas the ability to vary copayments -- even minimally -- meant the difference between a plan's staying in or pulling out of a market.

While this request presented HCFA with a difficult situation, AAHP strongly believes that an affirmative decision would have been better for beneficiaries. As a purchaser, HCFA had a strong motivation to maintain as many options as possible for beneficiaries by responding to health plans' concerns and adopting a more nimble approach to Medicare+Choice implementation. As a regulator, HCFA would have had a difficult time coping with the predictable political fallout from reopening bids.

These role conflicts remain unresolved, even largely unaddressed. Until ways are found to reconcile them, however, they will stand in the way of designing and delivering a Medicare+Choice program that really works. One of the features of the Bipartisan Commission's premium support proposal was that it addressed this conflict by establishing a separate administrative board to oversee the restructured program. We recommend that the pros and cons of such an approach be thoroughly investigated and stand ready to participate with the Committee in a discussion of these issues.

- **Lessons from the Competitive Pricing Demonstration Project.** Many issues raised by a premium support approach are similar to those experienced under the controversial competitive pricing demonstration projects proposed in recent years for Baltimore and Denver, and HCFA's current efforts to implement similar demonstrations in Phoenix and Kansas City. Successful competitive pricing models in the private sector include all options available to enrollees; HCFA's competitive pricing demonstrations have not and do not include the fee-for-service Medicare program as an option alongside health plans. From the first proposed demonstration site, AAHP consistently has recommended that both sides of the program be included in a model to test competitive bidding.

The competitive pricing demonstration projects proposed for Kansas City and Phoenix would continue to experiment only on seniors who have chosen Medicare+Choice. These projects will lead to benefit reductions and disruptions for the provider community, which explains why in every community coalitions of physicians, hospitals, health plans, employers, and beneficiaries have joined together to raise seniors' concerns about these proposals. This experience provides important lessons for consideration of a premium support model.

V. Conclusion

For well over 10 years, health plans have delivered to beneficiaries coordinated care, comprehensive benefits, and protection against highly unpredictable out-of-pocket costs, but these choices are at risk. Congress and the Administration should act immediately to create a level playing field between the Medicare+Choice program and fee-for-service, and a regulatory environment that holds Medicare+Choice organizations and providers in the Medicare fee-for-service program equally accountable. We are in the process of conferring with the members of the Committee and your staff about our specific suggestions for solving these problems.

Without action this year, beneficiaries may find access to their health plans jeopardized and beneficiaries may find few choices available to them. In addition, employers and unions who have depended on health plans as a source of comprehensive and affordable retiree health care may find their choices severely

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limited. Finally, if the Medicare+Choice program erodes it will seriously set back discussions in the Committee, and throughout the Congress to preserve Medicare for future generations.

Rural Neglect

Medicare HMOs Ignore Rural Communities

A REPORT BY

Families USA

1334 G Street, NW

Washington, DC 20005

202-628-3030

September 1999

RURAL NEGLECT

KEY FINDINGS

- Nationally, three out of four rural Medicare beneficiaries (73 percent) live in a county that is not served by any Medicare HMO. Only one rural beneficiary in four (27 percent) lives in a county that is served by one or more HMOs.
- Just one rural Medicare beneficiary out of ten (10 percent) lives in a county that is served by two or more HMOs.
- There are no HMOs available to rural Medicare beneficiaries in 13 states. Those states are: Alaska, Idaho, Iowa, Kansas, Kentucky, Mississippi, Nebraska, North Dakota, South Carolina, South Dakota, Utah, Vermont, and Wyoming.
- In another 14 states, some rural Medicare beneficiaries have access to an HMO, but they have access only to one HMO that has no competitors. Those states are: Alabama, Colorado, Delaware, Florida, Indiana, Maine, Maryland, Michigan, Missouri, Montana, Nevada, New Hampshire, Virginia, and West Virginia. In 12 of these states, the majority of rural beneficiaries lack access to any Medicare HMO.
- In 22 states, some rural Medicare beneficiaries have a choice of two or more HMOs. However, in only five states do the majority of rural beneficiaries have such a choice; those states are: Connecticut, Hawaii, Massachusetts, Pennsylvania, and Rhode Island.
- Next year, it is likely that even fewer rural Medicare beneficiaries will have access to HMOs. Based on data about current availability of HMOs and managed care organizations' announced intentions to withdraw from certain areas, it is estimated that only 23 percent of rural beneficiaries (2.1 million) will have access to an HMO in the year 2000.

WHAT THE NUMBERS SHOW: HMOs ARE NOT AN OPTION FOR RURAL MEDICARE BENEFICIARIES

In 1993, about 100 HMOs participated in Medicare. By August of 1999, the number had more than tripled, to 310 Medicare HMOs. To serve Medicare beneficiaries and receive reimbursement from the Medicare program, these HMOs

MEDICARE HMOs

Rural Beneficiaries and Access to Medicare HMOs, 1999, by State

State	All Rural Beneficiaries		No Access		Access to Only One HMO		Access to Two or More HMOs	
	Number	Number	Percent of Rural Beneficiaries	Number	Percent of Rural Beneficiaries	Number	Percent of Rural Beneficiaries	
Alabama	238,948	225,012	94%	13,936	6%	0	0%	
Alaska	22,712	22,712	100%	0	0%	0	0%	
Arizona	103,236	0	0%	70,568	68%	32,668	32%	
Arkansas	269,446	223,561	83%	23,538	9%	22,347	8%	
California	168,168	112,894	67%	52,265	31%	3,009	2%	
Colorado	103,049	84,986	82%	18,063	18%	0	0%	
Connecticut	43,582	0	0%	15,601	36%	27,981	64%	
Delaware	29,686	0	0%	29,686	100%	0	0%	
Florida	218,483	140,772	64%	77,711	36%	0	0%	
Georgia	353,615	290,705	82%	47,961	14%	14,949	4%	
Hawaii	42,993	74	0%	8,045	19%	34,874	81%	
Idaho	113,940	113,940	100%	0	0%	0	0%	
Illinois	345,934	251,109	73%	80,186	23%	14,639	4%	
Indiana	258,489	252,777	98%	5,712	2%	0	0%	
Iowa	300,450	300,450	100%	0	0%	0	0%	
Kansas	203,587	203,587	100%	0	0%	0	0%	
Kentucky	345,162	345,162	100%	0	0%	0	0%	
Louisiana	168,657	48,861	29%	70,242	42%	49,554	29%	
Maine	129,675	78,537	61%	51,138	39%	0	0%	
Maryland	58,972	0	0%	58,972	100%	0	0%	
Massachusetts	14,877	3,435	23%	0	0%	11,442	77%	
Michigan	294,171	277,047	94%	17,124	6%	0	0%	
Minnesota	258,999	247,744	96%	6,794	3%	4,461	2%	
Mississippi	302,093	302,093	100%	0	0%	0	0%	
Missouri	319,347	302,283	95%	17,064	5%	0	0%	
Montana	102,678	98,548	96%	4,130	4%	0	0%	
Nebraska	150,025	150,025	100%	0	0%	0	0%	
Nevada	31,779	25,228	79%	6,551	21%	0	0%	
New Hampshire	74,351	44,516	60%	29,835	40%	0	0%	
New Mexico	103,771	77,840	75%	19,079	18%	6,852	7%	
New York	235,363	117,129	50%	63,269	27%	54,965	23%	
North Carolina	449,616	386,842	86%	4,868	1%	57,906	13%	
North Dakota	69,082	69,082	100%	0	0%	0	0%	
Ohio	340,991	93,899	28%	149,156	44%	97,936	28%	
Oklahoma	236,916	96,476	41%	83,503	35%	56,937	24%	
Oregon	170,996	65,654	38%	80,547	47%	24,795	15%	
Pennsylvania	344,802	82,063	24%	82,553	24%	180,186	52%	
Rhode Island	13,416	0	0%	0	0%	13,416	100%	
South Carolina	184,421	184,421	100%	0	0%	0	0%	
South Dakota	85,847	85,847	100%	0	0%	0	0%	
Tennessee	325,853	196,471	60%	100,427	31%	28,955	9%	
Texas	511,387	262,228	51%	163,287	32%	85,872	17%	
Utah	56,408	56,408	100%	0	0%	0	0%	
Vermont	64,711	64,711	100%	0	0%	0	0%	
Virginia	264,985	248,238	94%	16,747	6%	0	0%	
Washington	160,700	57,327	36%	36,147	22%	67,226	42%	
West Virginia	198,618	151,263	76%	47,355	24%	0	0%	
Wisconsin	291,951	263,234	90%	16,502	6%	12,215	4%	
Wyoming	43,525	43,525	100%	0	0%	0	0%	
USA	9,220,463	6,748,716	73%	1,568,562	17%	903,185	10%	

Sources:

- 1) The number of rural Medicare beneficiaries was taken from the Health Care Financing Administration's (HCFA) enrollment file (www.hcfa.gov/medicare/stats/enroll98.htm).
- 2) The number of HMOs in rural counties was determined using HCFA's Medicare Compare database (www.medicare.gov/comparison/default.asp).
- 3) Rural counties were identified using data from the U.S. Census Bureau (www.census.gov/datamap/fipslist/AllSt.txt).

Note: Percentages may not add up to 100 due to rounding.

FACSIMILE FROM THE OFFICE OF

Congressman Jim McDermott

7th District, Washington

To: Jeanne

Fax Number: _____

This fax is from:

Jim McDermott

Mike Williams

Wilda Chisolm

Rita Patel

Peter Rubin

Jennifer Crider

David Bede

Michael Shannon

Intern: _____

Notes: Per your request. For your

info.

Pete

Including this cover sheet, you should find _____ pages.

If there are problems with this fax, please call 202/225-3106.

U.S. Rep. Jim McDermott
2349 Rayburn House Office Building
Washington, DC 20515

Medicare Commission File

United States Senate

WASHINGTON, DC 20510

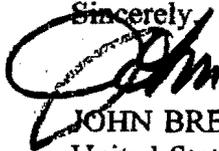
January 29, 1998

Congratulations on your appointment to the National Bipartisan Commission on the Future of Medicare. I am honored to be appointed Statutory Chairman of this commission jointly by President Clinton, Speaker Gingrich, and Majority Leader Lott and I look forward to working with you and the other members of the commission to develop recommendations to ensure the long-term solvency of Medicare. While there are serious demographic and financial problems facing Medicare, we are convinced that by working together in a bipartisan fashion we can reach a consensus about how to preserve the program for current and future generations of Medicare beneficiaries.

As part of the agreement reached between the Republican leadership in the Congress and the White House, Congressman Bill Thomas will serve as Administrative Chair of the Commission. Part of the agreement also charged Congressman Thomas with selecting the Executive Director of the Commission with my concurrence. We are pleased to announce that Bobby Jindal, Secretary of the Louisiana Department of Health and Hospitals, has agreed to serve as Executive Director of the commission. Bobby brings a wealth of academic and professional expertise to the commission. Attached is some background material on Mr. Jindal.

We will be getting back in touch with you soon regarding a schedule and agenda for the commission. In order to ensure bipartisan cooperation, I will ask your support for the agreement reached between the Republican Leadership and the White House. In the meantime, if you have any questions, please feel free to contact us.

Sincerely,



JOHN BREAUX
United States Senate

Attachments

HEALTH CARE FINANCING ADMINISTRATION



Medicaid ~~Plan~~ Managed Care Plan

ADDRESSEE:

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Jeanne, Bob

PHONE: _____

FROM:

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Draft, Not Cleared

Medicare+Choice in 2001: Plan Participation Summary

Medicare HMOs and other coordinated care plans decide each year whether to continue serving beneficiaries in selected counties or entire service areas. A decision not to serve beneficiaries for calendar year 2001 means that the organization does not renew its Medicare+Choice (M+C) contract with the Health Care Financing Administration (HCFA).

The information reported below is accurate as of July 17, 2000, based on information HCFA received from the M+C organizations. Except where noted, "enrollees" refers to M+C enrollees, and "non-renewal" includes both non-renewal of an entire contract as well as service area reductions.

Overview

- About 85% of current M+C enrollees will be able to continue with their current Medicare HMO in 2001.
- Three-year enrollment for the M+C program appears in the following table:

Month and Year	Enrollment
July 2000	6.2 million
July 1999	6.2 million
July 1998	5.8 million

- For 2001, 117 contracts are either withdrawing from the M+C program (64 contracts) or reducing a service area (53 contracts). Approximately 924,000* (15% of M+C enrollees) are affected. This includes 641,000 beneficiaries affected by withdrawals and 284,000 affected by service area reductions. Nearly 50% of the national total was due to the decisions made by Aetna and CIGNA. The affected enrollees live in 467 counties in 34 states, plus the District of Columbia.
- For 2000, 99 contracts either withdrew from the M+C program (41 contracts) or reduced a service area (58 contracts). Approximately 327,000 (5.2% of M+C enrollees at that time). This included 169,000 beneficiaries affected by withdrawals and 158,000 affected by service area reductions. The affected enrollees lived in 329 counties in 33 states.
- For 1999, 99 contracts either withdrew from the M+C program (45 contracts) or reduced a service area (54 contracts). Approximately 407,000 enrollees (6.5% of the M+C program at that time) were affected. This includes 215,000 beneficiaries affected by withdrawals and 192,000 affected by service area reductions. The affected enrollees lived in 407 counties in 29 states, plus the District of Columbia.
- Since July 1998, HCFA has approved 58 applications for M+C organizations to begin service or expand a service area. The one M+C Provider-Sponsored Organization approved during this time is withdrawing from the program for 2001. HCFA recently approved its first Private

*Some figures in this document do not add up due to rounding.

Fee-For-Service (PFFS) option, which serves 11 total states and portions of six others (a total of over 1,200 counties with 8.2 million Medicare eligibles).

- HCFA is currently reviewing five new M+C applications, including two preferred provider-type organizations. Five current M+C organizations have submitted service area expansions.

Counties That Will No Longer Have M+C Coordinated Care Option

- For 2001, about 159,000 M+C enrollees in 193 counties will lose all M+C coordinated care options. This means that about 17% of those beneficiaries losing their M+C plan will not have another coordinated care option.
- For 2000, 79,000 affected M+C members (about 25% of all affected members) lived in a county with no remaining M+C coordinated care option.
- For 1999, 51,000 affected M+C members (about 13% of all affected members) lived in a county with no remaining M+C coordinated care option.

Payments in Affected Areas

In 2001, the minimum payment rate will be \$415. Using 2000 enrollment (to account for generally larger enrollment in higher payment areas), the average payment amount in 2001 is estimated to be about \$575 (\$573.40). The enrollment-weighted average payment rate in 2001 for counties affected by withdrawals is estimated to be about \$540 (\$541.87) or about 95 percent of the national enrollment weighted average payment rate.

About 18 percent of enrollees living in counties with a payment rate less than the national enrollment weighted average are affected by withdrawals compared to about 11 percent of beneficiaries in counties with a higher than average payment rate. The following table shows the percentage of enrollees affected by payment rate.

2001 Aged Payment Rate	3/00 M+C Enrollment	Affected M+C Enrollees	Percent Affected
\$415.01	63,460	21,153	33%
\$415.02-\$449.99	265,284	48,988	18%
\$450.00-\$499.99	858,139	170,003	20%
\$500.00-\$549.99	1,401,649	266,456	19%
\$550.00-\$599.99	1,467,565	192,169	13%
\$600.00+	2,060,423	217,133	11%
Total	*6,116,520	*915,902	

*These numbers do not include M+C enrollees living outside of the service area of their M+C organization.

Geographic Distribution

- The ten states with the most affected enrollees are: Texas (181,000-- 55% of the state's M+C enrollees); Pennsylvania (90,000-- 16%); Florida (88,000-- 12%); Ohio (66,000-- 30%); New

York (64,000-- 15%); Maryland (53,000-- 65%); California (52,000-- 3.5%); Connecticut (51,000-- 48%); Washington (32,000-- 20%); and Arizona (24,000-- 10%).

- The ten states with the highest percentage of M+C enrollees affected are: Maine, 100%; Virginia, 100%; Delaware, 99.5%; Maryland, 65%; Texas, 55%; Connecticut, 48%; Tennessee, 44%; New Mexico, 43%; Georgia, 39%; and Ohio, 30%.
- Enrollees living in Texas have been heavily affected by this year's nonrenewals. About 181,000 of the 330,000 enrollees in the state (55%) are affected for 2001. About 75% of these 181,000 enrollees are affected by decisions made by Aetna and CIGNA.
- The top ten states affected for 1999, 2000 and 2001 combined are: Texas (260,000); Florida (162,000); New York (158,000); California (113,000); Maryland (104,000); Ohio (98,000); Pennsylvania (97,000); Connecticut (73,000); Washington (69,000); Arizona (65,000).

Miscellaneous information

- Organizations that are non-renewing for 2001 have generally spent less time in the M+C program when compared to organizations that are not non-renewing. For 2001, the non-renewing contractors have been in the program, on average, ten fewer months than other M+C contractors (53 months compared to 63 months).
- From March 31, 1999 to March 31, 2000, there was a 5 percent decrease in M+C enrollment in counties affected by a 2001 non-renewal. In contrast, M+C counties not affected saw an 8 percent increase in beneficiary enrollment.

Other Plan Types

- For 2001, about 5,000 cost plan members (a total of four contractors) and 22,100 enrollees in three demonstration plans are affected by non-renewals. Cost Plans have until early October 2000 to notify HCFA, so more beneficiaries may be affected.
- Last year, about 18,000 cost plan enrollees and 7,000 demonstration plan enrollees were affected by non-renewals.

Please note: The number of beneficiaries affected is based on HCFA data from July 1, 2000. The actual number of beneficiaries affected could change because of monthly enrollment fluctuations, network modifications, or other reasons. The numbers may also be changed in August when HCFA finalizes its approval of the benefit proposals for remaining M+C organizations.

Under the auspices of the Balanced Budget Act of 1997, HCFA contracts with a variety of M+C organizations that offer different health plans to Medicare beneficiaries. These different plans include coordinated care plans (health maintenance organizations, preferred provider organizations, and provider-sponsored organizations) and private fee-for-service plans. In addition, HCFA also contracts with cost-based managed care organizations under Sections 1833 and 1876 of the Social Security Act.

This non-renewal analysis focuses on M+C organization non-renewal activity for several reasons. First, M+C organizations must notify HCFA by July 1 of any decision to non-renew for the coming year; cost-based plans have until October. Second, the non-renewal activity is primarily undertaken, over the past several years, by M+C organizations, not the cost-based plans. The assumption of risk by M+C organizations makes such contracts different from those managed care plans that are reimbursed on a cost basis. Third, many M+C organizations offer a full benefit package, especially prescription drugs not available in Original Medicare, which has resulted in significant enrollment into M+C organizations.

DRAFT #5 -- 7/19/00 11:34 AM

**STATEMENT OF HCFA ADMINISTRATOR NANCY-ANN DePARLE
MEDICARE+CHOICE PLAN RENEWALS
July 19, 2000**

Decisions by managed care plans to discontinue service to about 924,000 Medicare beneficiaries – including about 160,000 who will be left without another managed care option – serve as that many more reasons for enactment of the President's legislative proposal to modernize and strengthen Medicare.

That way, all 39 million beneficiaries would have access to a voluntary, affordable prescription drug benefit, and Medicare+Choice plans would be paid in relation to their own costs, rather than the Congressionally mandated administrative prices. This year, about 27 million out of 39 million Americans in Medicare have a managed care choice, and more than 6.2 million chose to enroll in one.

Medicare beneficiaries should know that, regardless of the decisions made by private HMOs, they are still covered by a strong Medicare program. Their HMO is required to cover them until December 31, 2000. And the Health Care Financing Administration has a number of resources available to help them make health care choices, including our 1-800-MEDICARE (1-800-633-4227) help line and www.medicare.gov consumer Website. In addition to those resources, the Health Care Financing Administration has also directed HMOs to provide information to their beneficiaries about their health plan options in 2001.

Each July, Medicare+Choice plans submit their applications to participate in the Medicare program. For 2001, about 85 percent of current Medicare+Choice enrollees will be able to continue with their current HMO next year. About 64 plans have announced they will leave Medicare in 2001 and 53 will reduce their service areas, affecting 924,000 Medicare enrollees.

Since the beginning of the Medicare+Choice program, costs for managed care have increased at a rate faster than for fee-for-service Medicare, due in part to the cost containment and waste, fraud and abuse efforts undertaken by HCFA. Because they believe that they cannot be competitive in Medicare+Choice by charging a premium or reducing benefits, they have simply decided to withdraw from the program. In fact, decisions by two managed-care companies account for about half of the total withdrawals nationwide.

According to the General Accounting Office, plans in previous years left Medicare+Choice for a variety of reasons, which included reimbursement, an inability to compete in a regional market or an inability to establish provider networks, a fact confirmed by a new report showing that half of the largest U.S. hospitals have canceled an HMO contract in the past year.

By law, HCFA does not have the flexibility to modify the payment formula, which uses payment increases even when fee-for-service rates decline, however we believe that a strong

Medicare program should continue to provide a wide range of health care choices for beneficiaries.

And these actions underscore the need for Congress to pass the President's proposal to pay plans directly -- beginning next January -- for providing the prescription drug coverage that most beneficiaries want from managed care. Beneficiaries in original fee-for-service Medicare would also be able to have this benefit, regardless of whether they live in areas where managed care plans have chosen to operate.

By enacting the President's Medicare Restoration Initiative, Medicare+Choice plans would receive a total of \$1 billion over five years through an increase to the payment rates which are based on the fee-for-service Medicare system.

But we also want to make sure that Medicare is a fair business partner, so we have been streamlining requirements for participation by health plans while ensuring that beneficiaries who choose managed care receive the benefits, protections, and information they need and deserve. We have modified many requirements in our contracts and operations to be more consistent with the approaches used by private and other public purchasers. We are beginning to implement a number of important initiatives that will further streamline administrative procedures for health plans and lead to more efficient and consistent oversight.

We are continuing to take strong steps to ensure that no matter what decisions plans make about their participation in the program, Medicare beneficiaries affected by these changes have options. First, we required insurers to provide beneficiaries who are being forced to change their health care coverage, guaranteed access to certain Medigap plans now offered, regardless of their prior use of health care services or their current medical conditions. Second, in order to make the transition easier for these beneficiaries and to help them make the right decisions about their health care coverage, we are providing them with clear information on their new health care options and requiring plans leaving the program to do the same.

Seniors and Americans with disabilities deserve a strong Medicare program and we are committed to making sure they have health care -- whether they through a Medicare+Choice option or original fee-for-service Medicare. The strong action we have taken to date and our proposals for the future of this critical program will ensure that we are able to keep our promise of providing high quality health care services to all 39 million Medicare beneficiaries.

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M+C Questions and Answers

#8 -- 7/19/00 10:43 AM

DRAFT

Q. How many Medicare beneficiaries are affected by Medicare+Choice (M+C) non-renewal decisions?

A. About two percent of Medicare's 39 million beneficiaries (about 924,000 beneficiaries) in 33 states and the District of Columbia will be affected by a private-sector HMO's decision to terminate Medicare contracts or reduce service areas. Whatever decisions HMOs make, though, all beneficiaries remain in a strong Medicare program. Of those, about 159,000 have no HMO available in their counties, although some may have access to a private-fee-for health plan, a health plan option that falls under the Medicare+Choice rules.

The beneficiaries are enrolled in 64 Medicare+Choice organizations that are terminating their contracts with HCFA and 53 that are reducing their service areas.

These beneficiaries need to remember that at no point are they losing their Medicare coverage. They also need to know that before they take any action, they should make sure they understand all their rights and protections. They can call 1-800-MEDICARE (1-800-633-4227) for additional information.

Q. How does this compare to last year?

A. It shows that, yet again, some Medicare beneficiaries have been forced to look at other options because of business decisions by HMOs.

In 1999, 41 Medicare+Choice organizations chose not to renew their Medicare+Choice contracts and 58 reduced their service areas for the year 2000, affecting more than 327,000 Medicare beneficiaries. About 79,000 of those beneficiaries were left with no Medicare managed care options and returned to Original Medicare. In 1998, plan nonrenewals and service area reductions affected approximately 407,000 Medicare beneficiaries enrolled in managed care plans and of those, approximately 47,000 had no other managed care options.

One difference from last year is that two national companies – Aetna and CIGNA – have each made business decisions to substantially reduce their participation in Medicare+Choice. Together, these two companies have reduced Medicare+Choice access for about 450,000 beneficiaries, almost half of the overall number of beneficiaries affected by withdrawals.

Q. Which states have the most number of beneficiaries impacted?

A. The ten states with the most impacted beneficiaries are: Texas (176,500); Pennsylvania (90,000); Florida (88,500); Ohio (77,500); New York (57,000); Maryland (55,000); California (53,000); Connecticut (51,500); Washington (31,000); and Arizona (24,500). *State numbers and percentage of impact are available at hcfa.gov.*

Q. Doesn't the fact that so many plans are leaving Medicare+Choice means the program is in crisis?

A. No. But it does underscore the need for Congress to pass the President's proposal to pay plans directly -- beginning next January -- for providing the prescription drug coverage that most beneficiaries want from managed care. It's important to remember that of the more than 39 million Americans in Medicare, about 27 million have a managed care choice and about 6.2 million chose that option in 2000. Medicare beneficiaries who are affected by plans leaving Medicare should remember that no matter what, they are still covered by a strong Medicare program.

However, the majority of managed care plans that serve Medicare beneficiaries are staying in the Medicare+Choice program. Our early analysis shows that this year, like in 1998 and 1999, plans have been making business decisions in response to the market place and their investors.

In addition, this year, two major national plans -- Aetna and CIGNA -- made business decisions to leave Medicare across the country. These decisions will impact more than half of all the Medicare+Choice enrollees who are affected by plan nonrenewals this year. Yet, at the same time, the two managed care companies that serve the most beneficiaries -- Kaiser and PacifiCare -- are maintaining their full participation in Medicare+Choice. Kaiser and PacifiCare have simply chosen to respond in a different way to ensure that beneficiaries will continue to have a choice in managed health care options.

Essentially, the plans have told us that they are trying to respond to rising health care costs across all lines of their business. But because the private and public markets are structured differently, the plans have to respond to the cost increases differently. For example, in the private sector this year -- and the Federal Employees Health Benefit Program -- managed care organizations have increased premiums for their private customers by an average of 10 percent, according to separate analysis. Over the last two years, you also saw some realignment as plans exited some private markets, as well as the Federal Employees Health Benefit program (this year, FEHBP members will see premium increases.)

However, the Medicare market is different from the private market. Plans cannot increase the reimbursement rates from Medicare because those rates are paid

according to a statutory formula that ties increases in plan payments to fee-for-service spending. Because of cost containment and waste, fraud and abuse efforts HCFA has undertaken, spending increases for fee-for-service Medicare has declined dramatically, even below the payment increase of two percent that Medicare+Choice organizations are guaranteed.

Some plans responded to their rising costs with a fixed government contribution by reducing their benefits or increasing premiums to beneficiaries. There are many examples of plans that have responded to the cost pressure in this manner and stayed in areas with low payments. Yet some managed care organizations believe that they cannot be competitive in Medicare+Choice by charging a premium to beneficiaries or reducing benefits.

According to the General Accounting Office, plans have left Medicare+Choice for a variety of reasons, including reimbursement rates, an inability to compete in a regional market, or an inability to establish provider networks, a fact confirmed by a new report showing that half of the largest U.S. hospitals have canceled an HMO contract in the past year. As in past years, our preliminary analysis shows more withdrawals have occurred in lower payment areas, especially in floor counties. This year, there are also a number of withdrawals in high payment counties as well.

We note that this year, withdrawals have occurred after major acquisitions – Aetna is terminating Medicare+Choice contracts for Prudential and NYLCare plans that have been in the program for many years.

Certainly, Medicare cannot be in a position to increase payments every time HMOs say they aren't making enough especially when plans' own costs are rising far faster than costs in fee-for-service Medicare. However we believe that a strong Medicare program should continue to provide a wide range of health care choices for beneficiaries.

These actions underscore the need for Congress to pass the President's proposal to pay plans directly -- beginning next January -- more than \$20 billion over five years, to provide the prescription drug coverage that most beneficiaries want from managed care. Beneficiaries in original fee-for-service Medicare would also be able to have this benefit, regardless of whether they live in areas where managed care plans have chosen to operate.

As part of that effort, the President's Medicare Restoration Initiative would also dedicate \$21 billion over five years to ensure adequate reimbursement to health care providers, including \$1 billion to managed care plans by increasing the base payment rates which are based on the fee-for-service Medicare system.

And, in an effort to assist the plans, we have been working with them to reduce

administrative burdens, making it easier for them to provide high quality health care services to Medicare beneficiaries.

Q. Isn't the problem really just payment? The plans say that you are not paying them enough to stay in the program. Won't paying the plans more keep them from leaving?

A. As in past years, our preliminary analysis shows more withdrawals have occurred in lower payment areas, especially in floor counties. This year, there are a number of withdrawals in high payment counties as well. Withdrawals across the spectrum of Medicare+Choice payment levels suggest that strategic business decisions play a large role in a health plan's determination to participate in Medicare+Choice.

Studies by the General Accounting Office and the HHS Office of Inspector General have found that government payments to managed care plans are enough for them to provide basic Medicare benefits and still make a profit.

In fact, in 2000, on average, 22 percent of the Medicare payment went towards benefits beyond the basic Medicare required package. However, even by paying the plans more than is needed to cover the basic package, Medicare doesn't always pay enough to cover the extra benefits that managed care plans believe they must offer in order to attract beneficiaries.

According to the General Accounting Office, plans have left Medicare+Choice for a variety of reasons, including reimbursement rates, an inability to compete in a regional market, or an inability to establish provider networks, a fact confirmed by a new report showing that half of the largest U.S. hospitals have canceled an HMO contract in the past year. Medicare cannot be in a position to increase payments every time HMOs say they aren't paid enough.

These actions underscore the need for Congress to pass the President's proposal to pay plans directly -- beginning next January -- more than \$20 billion over five years, to provide the prescription drug coverage that most beneficiaries want from managed care. Beneficiaries in original fee-for-service Medicare would also be able to have this benefit, regardless of whether they live in areas where managed care plans have chosen to operate.

Background: Overall market conditions have been less favorable to managed care plans in terms of rising public concerns about the denial of health care services and providers who are less willing to accept financial risk in treating managed care patients. These larger market forces have, at least in part, also contributed to the reduction in managed care plans participating in Medicare.

Over the past two years, plans have expressed concern that increases in Medicare

payment rates have not been as high as the cost increases they experience. Many of these increases relate to pressures that affect the entire managed care industry, such as costs for outpatient prescription drugs — which are not covered by Medicare and therefore not reflected in the Medicare rates. Some plans are also dealing with a so-called provider pushback -- providers are seeking and successfully negotiating higher payment rates from plans. Plans, in turn, can pass these increases on to beneficiaries in the form of higher premiums and reduced benefits and, in many cases, raise premiums for private employers as well. But some plans have decided to leave Medicare rather than raise premiums or reduce benefits.

The government's payments to the Medicare+Choice plans are fixed by statute. Congress set the formula with the promise that managed care plans could provide care more efficiently. If they show they are unable to provide the basic Medicare services at the congressionally-mandated reimbursement rate, they are permitted to seek additional payments from beneficiaries in the form of premiums or co-payments just as beneficiaries in the traditional fee-for-service must pay for Medigap policies. While these payments are based on fee-for-service rates, managed care plans are guaranteed an increase, even when fee-for-service rates are flat or decrease.

There are also additional factors that are unique to Medicare that may have contributed to the relatively large number of withdrawals. One possible factor is that some Medicare+Choice organizations may be pulling out of the program for strategic reasons. Specifically, there is a general expectation that the Congress may increase payment rates to Medicare+Choice organizations. If Congress enacts a payment change, Medicare+Choice organizations may re-enter the program without penalty.

Q. What will the Administration do to improve Medicare+Choice?

A. A voluntary, affordable prescription drug benefit like President Clinton has proposed, along with our administrative changes that give plans more flexibility, would help plans pay for drug coverage for beneficiaries and make it easier for the private sector plans to stay in Medicare. That is, it would help both beneficiaries and Medicare+Choice organizations.

These actions underscore the need for Congress to pass the President's proposal to pay plans directly -- beginning next January -- more than \$20 billion over five years, to provide the prescription drug coverage that most beneficiaries want from managed care. Beneficiaries in original fee-for-service Medicare would also be able to have this benefit, regardless of whether they live in areas where managed care plans have chosen to operate.

The President is also proposing more than \$1 billion over five years in increased payments to managed care plans by increasing the base payment rates which are based on the fee-for-service Medicare system.

And, implementing competition among managed care plans, like the one proposed in the President's Medicare reform plan, would enable Medicare to pay plans for their real costs of providing care in their local communities. In fact, Medicare began a pilot project to use private-sector competition to set payments and include a meaningful drug benefit. But the HMOs and Congress stopped it cold.

Our main concern has always been managing Medicare+Choice effectively and protecting beneficiaries. Plans have provided additional benefits to entice people into managed care, and then they trim back on those benefits or claim that HCFA doesn't pay them enough to cover the additional benefits. That is why we are working hard to be sure beneficiaries understand their rights and options.

Q. Is there any chance that you would let the Medicare+Choice plans who are leaving return?

A. Only if Congress passes the President's proposal to create a voluntary, meaningful prescription drug benefit which would help plans pay for drug coverage for beneficiaries and make it easier for the private sector plans to stay in Medicare. While the President's plan would go into effect January 1, 2001, it would begin to pay Medicare+Choice plans directly for providing a prescription drug benefit on January 1, 2001.

Q. I've heard of plans closing enrollment to new enrollees? Are they allowed to do this?

A. Medicare+Choice plans that lack the capacity to serve new enrollees can be closed to all new enrollment, even during the upcoming Fall open enrollment periods. When a Medicare+Choice organization contracts with Medicare, it tells us how many enrollees it will be able to serve based on the number of providers the plan has and other capacity related factors. A Medicare+Choice plan may also request a capacity limit if it believes that a large increase in enrollment will hurt the delivery of health care services to current plan enrollees.

However, there are requirements that Medicare+Choice organizations must follow when they request capacity limits to make sure that beneficiaries receive as much advance notice as possible.

Beneficiaries who live in a plan's service area will be able to enroll in the Medicare+Choice plan during the Fall open enrollment period, unless the plan has reached an approved capacity limit. It's very important to note that some Medicare+Choice plans will be closed to new enrollment this year. We -- and the plans -- will provide beneficiaries as much advance notice as possible about the plans that will be closed to new enrollment. This information will be available through 1-800-MEDICARE (1-800-633-4227) and at www.medicare.gov.

Q. What is the impact of all these plans non-renewing on beneficiaries?

A. Beneficiaries who are affected by these plan decisions should remember that they are still covered by a strong Medicare program and they don't need to do anything right now.

- These beneficiaries are automatically eligible to return to original fee-for-service Medicare and will be able to purchase certain Medigap insurance policies with no regard for any pre-existing illnesses.
- They also have the option to join other Medicare health plans that are available in their area.
- Beneficiaries whose plans are leaving Medicare should wait until they receive a letter from their plan this Fall since the Medicare+Choice organizations are required to provide coverage for their Medicare beneficiaries until December 31, 2000.

We are working with organizations that work with beneficiaries and congressional offices around the country to make sure that beneficiaries get the information they need to make the right decisions about their health care. Our regional offices will be hosting a number of outreach activities for beneficiaries such as town hall meetings to make sure that beneficiaries and their caregivers with the Medicare information they need to make an informed decision. Beneficiaries and their families can also get the most up-to-date information on available coverage options by calling 1-800-MEDICARE (1-800-663-4227) or log onto www.medicare.gov.

Q. What should beneficiaries do to make sure they don't lose their Medicare?

A. People enrolled in Medicare+Choice have not and will not lose their Medicare. Those beneficiaries enrolled in a plan that has announced it is leaving Medicare will continue to be covered by the plan until the end of 2000, so they don't have to do anything right now. We've directed plans to send them a letter, which they should be receiving in a few weeks, telling them the same thing. They will also get a letter from their plan this fall that will outline what they need to do at that time. They can also call 1-800-MEDICARE (1-800-633-4227) or their local State Health Insurance Assistance Program. No matter what happens, they will always have original fee-for-service Medicare.

Q. Why are the numbers so large from Texas?

Texas is the perfect example of how withdrawals are the result of business decisions. Last year, Aetna acquired NYL Care and Prudential in Texas, giving Aetna a major presence in the state. As a result, when Aetna decided to leave Medicare+Choice, Texas was disproportionately affected.

DRAFT #3 -- 7/19/00 11:33 AM

MEDICARE FACT SHEET

July 2000

Contact: HCFA Press Office
(202) 690-6145

PROTECTING MEDICARE BENEFICIARIES AFTER MEDICARE+CHOICE ORGANIZATIONS WITHDRAW

Background: *More than nearly 39 million Americans in Medicare currently receive care through original fee-for-service Medicare, however, Medicare managed health care options have been available to some Medicare beneficiaries since 1982. About 70 percent of seniors and disabled people covered by Medicare live in areas served by at least one managed care plan. Only about 6.2 million, or 16 percent, currently have chosen to enroll in a Medicare HMO. Since 1998, most HMO contracts with the federal Health Care Financing Administration (HCFA) have operated under the Medicare+Choice program to provide health care coverage for beneficiaries in certain areas. The Medicare+Choice program was created by Congress in the Balanced Budget Act of 1997.*

Medicare+Choice organizations that decide not to continue serving beneficiaries in selected counties or entire service areas were required to notify HCFA by July 3, 2000, that they would not renew their existing contracts for 2001.

In 2001, about 85 percent of current Medicare+Choice beneficiaries will continue with their current Medicare HMO -- 64 Medicare+Choice health maintenance organizations (HMOs) chose not to renew their Medicare+Choice contracts and 53 reduced their service areas, affecting more than 924,000 Medicare beneficiaries. About 160,000 of those beneficiaries will be left with no Medicare+Choice HMO options, although some may choose to enroll in a private fee-for-service plan if one is available in their community. All beneficiaries who are affected by these nonrenewals may return to Original Medicare.

In 1999, 41 Medicare+Choice organizations chose not to renew their Medicare+Choice contracts and 58 reduced their service areas for the year 2000, affecting more than 327,000 Medicare beneficiaries. About 79,000 of those beneficiaries were left with no Medicare managed care options and returned to Original Medicare.. In 1998, plan nonrenewals and service area reductions affected approximately 407,000 Medicare beneficiaries enrolled in managed care plans and of those, approximately 47,000 had no other managed care options.

As private sector managed care companies continue to make market decisions that affect Medicare beneficiaries, HCFA is continuing to do all that it can to ease the transition for affected beneficiaries and ensure that they receive the rights and protections guaranteed by law.

HCFA Works With Beneficiaries When Medicare+Choice Organizations Withdraw

Through the approximately \$150 million National Medicare Education Program, Medicare &

You, HCFA has been working with public and private partners that represent tens of millions of older and disabled Americans to provide information to beneficiaries about their rights and options. A key piece of this information is that beneficiaries are automatically eligible to return to original fee-for-service Medicare and that they have guaranteed access to some Medigap policies that help fill coverage gaps if their Medicare+Choice organizations leave the program.

Beneficiaries in every community can get the most up-to-date information from HCFA on available coverage options. This fall, HCFA will add new information about health plan options in the year 2001 to already available information at 1-800-MEDICARE (1-800-633-4227), HCFA's Medicare Choices Helpline. HCFA will also post new information about plan withdrawals on Medicare's consumer Internet site, www.medicare.gov.

Key partners include the Leadership Council of Aging Organizations, the American Association of Health Plans, AARP, the National Council of Senior Citizens, the National Rural Health Association, the National Committee to Preserve Social Security and Medicare, the National Council on Aging, the Medicare Rights Center, the National Hispanic Council on Aging, the National Caucus and Center on Black Aged and the Older Women's League, as well as the Social Security Administration, HCFA regional offices, the U.S. Administration on Aging and State Health Insurance Assistance Programs.

Beneficiaries May Have Options in Areas Where Medicare+Choice Organizations Have Not Renewed

HCFA wants to make sure that beneficiaries know their options and continue to have access to health care. Plans that are not renewing their contracts for the 2001 contract year will continue to provide services to their Medicare enrollees through December 31, 2000. These plans are required to send all affected beneficiaries an information package by October 2, 2000 that explains beneficiaries' options to return to original fee-for-service Medicare or enroll in another Medicare+Choice organization, if one is available. All beneficiaries have the option of returning to original fee-for-service Medicare and may also have rights to supplemental coverage if they desire. Beneficiaries also have the option of enrolling in another Medicare+Choice organization if one is available.

HCFA reviews and approves all materials sent by plans to beneficiaries. HCFA also will remind plans of their responsibility to notify beneficiaries and provide plans with a model letter to do so. Most current enrollees can remain in their Medicare HMO through December 31, 2000, or they can disenroll before that time and either return to original fee-for-service Medicare or enroll in another Medicare+Choice organization, if one is available. If they take no action, they will automatically return to original fee-for-service Medicare on January 1, 2001. Beneficiaries may call 1-800-MEDICARE (1-800-633-4227) for assistance in making the right individual health care option decision.

HCFA Encourages Plans to Enter Markets Left Without a Medicare+Choice Option

HCFA will expedite review and approval of Medicare+Choice organizations seeking to enter

markets that have been left without a Medicare+Choice option or any alternatives to original fee-for-service Medicare. HCFA will give these applications first priority for review, and will help plans enter these areas quickly -- as long as they meet quality and other standards that protect beneficiaries. In addition, the Balanced Budget Refinement Act of 1999 provides for bonus payments to these plans. HCFA has begun the process necessary to pay these bonus payments to plans that meet the criteria outlined in the law.

Beneficiaries May Be Able to Choose Another Medicare+Choice Option

Other Medicare managed care plans and private fee-for-service plans that operate in the same area as a nonrenewing plan are required to be open to accept new enrollments during a Special Election Period, October 1 through December 31. Beneficiaries can choose an effective date of November 1, December 1 or January 1, as long as the plan receives the completed election form before the effective date.

Beneficiaries who enroll in another Medicare managed care plan, if one is available, or a private fee-for-service plan do not need to submit a disenrollment form.

Some beneficiaries living in certain states across the country may choose to enroll in a private fee-for-service plan. These plans may help beneficiaries with their deductibles and other out-of-pocket costs while providing for some extended benefits.

Returning to Original Fee-For-Service Medicare

Beneficiaries who wish to return to original fee-for-service Medicare should make sure that they consider their need for supplemental insurance coverage before they disenroll. The best decision for each beneficiary will vary based on their individual needs. However, if beneficiaries choose to disenroll and return to original fee-for-service Medicare before January 1, 2001, they can complete a disenrollment form available from their plan, a Social Security Administration (SSA) office, Railroad Retirement Board (RRB) office if they are railroad retirees, or the Medicare Choices Helpline – 1-800-MEDICARE (1-800-633-4227). The beneficiary's disenrollment will be effective the first day of the month following the month in which the plan, SSA or RRB receives the form. Beneficiaries who do not file a disenrollment form will automatically be enrolled in the original fee-for-service Medicare plan effective January 1, 2001.

Supplemental Insurance Through Medigap

Congress enacted legislation in 1999 that added a new time period where beneficiaries have access to Medigap policies when a plan leaves Medicare. Beneficiaries will continue to have certain rights and protections when purchasing Medigap policies. As long as a beneficiary applies for a Medigap policy no later than 63 days after the coverage with the non-renewing HMO expires (December 31, 2000), the beneficiary is guaranteed the right to buy any Medigap policy designated "A", "B," "C," or "F" that is available in the state. If the beneficiary applies for one of these Medigap policies no later than March 4, 2001, 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.

Under the new legislation, beginning this year beneficiaries in Medicare+Choice plans who want to switch to original fee-for-service Medicare may do so as soon as they receive their final notice from their Medicare+Choice plans. If they choose this option, beneficiaries have 63 days from the date of the notice (from October 2, 2000 until December 4, 2000) to apply for a Medigap policy and be guaranteed the same protections they would have if they waited until their coverage expired on December 31, 2000. To exercise this option, beneficiaries must disenroll from their Medicare+Choice plan in October or November, and arrange for their Medigap policy to start the first day of the next month so they will have seamless coverage between the plans they choose.

CAUTION: Individuals must keep a copy of their HMO's termination letter to show a Medigap insurer as proof of loss of coverage under this HMO, whether they terminate their membership in October or November or wait until their coverage ends at the end of December. They should also keep a copy of their Medigap application to validate that they acted within 63 days of the final notice of termination.

If beneficiaries dropped a Medigap policy to join their current Medicare managed care plan and they have never enrolled in a similar health plan since starting Medicare, they are guaranteed the right to return to the Medigap policy they dropped if: the Medigap policy they dropped is still being sold by the same insurance company; they disenroll from their current health plan no later than 12 months after they initially enrolled in it (they do not have to wait until December 31, 2000); and they reapply for the policy they dropped no later than 63 days after they disenroll from their Medicare managed care plan.

In addition, beneficiaries who were new to Medicare at age 65 and chose to enroll in their Medicare+Choice plan during their initial election period, and are still in their first 12 months in the Medicare+Choice plan, may choose any Medigap policy sold in the State, including those providing some outpatient prescription drug coverage. These individuals must voluntarily disenroll from the Medicare+Choice plan before the 12 months ends and apply for the Medigap policy within 63 days of their coverage ending.

Supplemental Coverage for Retirees Enrolled in an Employer-Sponsored Plan

Beneficiaries whose former employer has an arrangement with the Medicare+Choice organization offering the Medicare+Choice plan in which they are enrolled should consult with their employer before making changes.

Affected Beneficiaries May Be Able to Retain Their Doctors

Beneficiaries who choose to return to original fee-for-service Medicare will probably be able to continue to see the same physicians that they had seen through the HMO because most HMO physicians -- more than 90 percent -- also participate in original fee-for-service Medicare. If there are other Medicare+Choice organizations in the beneficiaries' geographic area, some of their current physicians may also participate with those Medicare+Choice plans.

Information on Other Medicare+Choice Plans

Up-to-date information about other Medicare+Choice plans available in a county is available at 1-800-MEDICARE (1-800-633-4227) and on the Medicare Compare page on www.medicare.gov. This information can be accessed by zip code, by county and by state. (Some Medicare+Choice plans are available only in certain counties within a state or zip code.) Many libraries and senior centers can help beneficiaries obtain information from this source.

General Assistance for Medicare Beneficiaries on Health Insurance Matters

Beneficiaries can contact their State Health Insurance Assistance Program for assistance. They can also contact the U.S. Administration on Aging's toll-free Elder Care Locator at 1-800-677-1116 to be referred to their local area agency on aging.

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