



# HEALTH PLAN & PROVIDER



## REPORT

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### Outlook 2007: Medicare Part D, Medicare Advantage, Top Insurance Concerns

**W**ith a new Democratic-controlled 110th Congress, the health insurance industry will be busy in 2007 watching for legislation, hearings, and investigations on the Medicare Part D prescription drug program, the funding of the Medicare Advantage program, and participating in debate on insurance and health reforms.

According to a survey of health experts on the Advisory Board for *BNA's Health Plan & Provider Report*, market consolidation, consumer-driven health care, and health technology will also be issues of interest in 2007.

#### On Capitol Hill

Health care will figure prominently in the work of Congress, with such issues such as Medicare's prescription drug benefit and providing more federal funding for embryonic stem cell research expected to be considered early in January, according to congressional health policy aides and those interviewed by BNA.

Other health issues likely to receive attention from lawmakers include promoting use of health information technology; prescription drug safety; reducing the number of uninsured Americans; Medicaid oversight; increasing the ability of small businesses to offer health insurance to their workers; allowing prescription drug reimportation; and reauthorization of the Prescription Drug User Fee Act.

"I expect 2007 to be a big year for Medicare legislation," said McDermott Will & Emery LLP attorney Eric Zimmerman. "There is incredible built up demand. It's been more than three years since Congress advanced major Medicare legislation, and there are many areas that cry out for attention. Anything Democrats try to do to the prescription drug benefit, Medicare Advantage

#### Top Managed Care Issues in 2007

According to a survey of the *BNA's Health Plan & Provider Report* Advisory Board, the top issues facing health plans and providers are:

1. Medicare Part D Drug: Price Negotiation, Fraud and Abuse
2. Medicare Payments to Medicare Advantage Plans
3. Pay-for-Performance Programs
4. Continued Growth of the Consumer-Driven Market (HSAs/HRAs) and Consumer Tools (web portals)
5. Entrants of New Players in the Market and Consolidation Among Existing Players
6. Upcoming 2008 President Election: Impact on the 2007 Market
7. Increased Attention on the Impact of Hospital Mergers on Health Plan Costs
8. Continued Erosion of Traditional Employer-Based Insurance Market
9. Possible Expansion of Mental Health Parity
10. Possible Reintroduction of Provisions of the Patient Bill of Rights

program, or physician fee schedule will serve as a vehicle for a variety of other provisions."

But difficulties getting such legislation through the Senate and opposition from the White House could prevent legislation from becoming law, they said, setting the stage for political posturing by Democrats and Republicans for 2008, when elections will be held for president as well as members of Congress, they said.

Promises by Democrats to reduce federal spending also could hamper health initiatives, those interviewed said, as congressional pay-as-you go rules, requiring new spending to be taken from other programs, likely will hamper passage of sweeping new initiatives.

Congressional Republicans are expected to continue advocating increased private sector involvement in health care, such as consumer-directed health plans, according to those interviewed by BNA.

**Part D Drug Negotiation Action.** House legislation revealed Jan. 4 calls for HHS to negotiate drug costs with pharmaceutical companies under Medicare's prescription drug program beginning in 2008. The bill, H.R. 4, is scheduled to be considered by full House Jan. 12 (*see related item in the Federal News section*).

The Senate is likely to follow the House's lead on these two issues, although quick action is unlikely because the Senate will first hold hearings to craft legislation, aides said.

The content of the Medicare negotiation bill in the Senate will be determined after hearings by the Finance Committee, Kate Leone, senior health counsel to incoming Senate Majority Leader Harry Reid (D-Nev.), said at a December Alliance for Health Reform briefing. A hearing is scheduled for Jan. 11. Since incoming Senate Minority Leader Mitch McConnell (R-Ky.) has said he will oppose such a measure, 60 votes likely will be necessary to pass it, she added.

Similar legislation, offered by Sens. Olympia Snowe (R-Maine) and Ron Wyden (D-Ore.), passed the Senate in March 2006 with 54 votes, and Democrats have since picked up several GOP seats, Leone said.

Republicans are expected to oppose this legislation, saying it would amount to unnecessary interference in a program overwhelmingly favored by seniors and the disabled.

"Such a scheme would take a wrecking ball to a popular program that has cut drug costs for consumers through competition, with serious consequences for American seniors and taxpayers alike," House Minority Leader John Boehner (R-Ohio) said in a Dec. 29, 2006, statement, referring to allowing Medicare to negotiate with drugmakers.

Despite GOP opposition, "I think there's a good chance [Part D] negotiation legislation could pass the House," Johnson & Johnson Senior Counsel Michelle Fried told BNA.

"Many of the House members used this issue in their campaigns and it is one of [House Speaker Nancy J.] Pelosi's [(D-Calif.)] top priorities," Fried said. "That said, I think this type of legislation would not likely pass the Senate, given the very slim margin of Democrats and the fact that [Senate Finance Committee Chairman Max] Baucus [(D-Mont.)] has not previously supported it."

"It goes without saying that this is a tremendous mountain for Democrats to climb," consultants from the Gorman Health Group said in a recent statement on Medicare drug pricing legislation.

"Should such a resolution be introduced in the House, it is unlikely any new legislation on this could pass the Senate. And even if such a bill could pass both chambers, it would assuredly be vetoed by the Bush White House."

Among possibilities could be a repeal of the noninterference clause in MMA, called by some a simple solu-

tion that would not mandate direct price negotiations by the health and human services secretary.

However, attorney Wendy Krasner, Manatt, Phelps & Phillips LLP, Washington, said that repealing the non-interference clause could have a significant affect beyond the pharmaceutical industry.

"While it may be portrayed as a simple act to allow the [HHS] Secretary to negotiate drug prices, it is a very complicated and nuanced issue with major political, financial, policy, and structural issues impacting many aspects of our health care system, not just plans and pharmaceutical companies," Krasner said.

On the issue of direct price negotiations, some Democrats have argued that HHS should be allowed to negotiate for lower drug prices like those paid by the Department of Defense and Department of Veterans Affairs, despite some evidence that suggests the Centers for Medicare & Medicaid Services could not effectively negotiate such lower prices.

For example, John Gorman, president of Gorman Health Group, Washington, explained, DOD and the VA are unrealistic comparisons for direct government negotiations for Part D drug prices because both systems function like staff model HMOs in which physicians are employees and formularies are narrower, tiered, evidenced-based, or restricted. Furthermore, he said, physicians' prescribing patterns are monitored and are used to determine pay-for-performance bonuses.

Although Democrats have called attention to the price negotiation issue, some industry watchers called the move an attempt to gain ground for a government-run alternative to private Medicare Rx plans.

**Other Part D Changes.** Lawmakers also could push for other incremental changes to the drug benefit, including the areas of pharmacy contracting, beneficiary open enrollment policies, and the overlap of Part B and Part D drug coverage in outpatient settings, Senate Finance Committee Republican aide Mark Hayes said at a December briefing sponsored by the Alliance for Health Reform.

Filling the so-called doughnut hole gap in Part D coverage is "on the radar screen for just about every member," Leone said, but she and the other aides said filling it completely would be prohibitively expensive. Hayes said it would cost \$400 billion over 10 years to eliminate the doughnut hole.

But Leone said lawmakers could take steps to begin to fill the hole in coverage, while Hayes added that allowing more low-income individuals to qualify for help by revisiting the assets test could keep more enrollees out of the doughnut hole, since low-income individuals are not subject to the doughnut hole under the Medicare drug law.

Democrats will have to tread carefully when proposing changes to the drug benefit, since surveys have found the majority of seniors are happy with it, according to some interviewed by BNA.

"Democrats have a real shot at keeping the House for some time," Brent V. Miller, director of federal government relations for the Marshfield Clinic in Wisconsin, said. "They need to be cautious about what they attack. The 80 percent of seniors that are happy with the Medicare Part D will not tolerate a complete overhaul of the program."

**HSAs, AHPs Shelved.** Health care lobbyists and policy analysts interviewed by BNA said the Democrats' victory means the end of legislation pushed by Republicans in recent years, such as tax incentives to expand health savings accounts and to establish association health plans.

Democrats "will likely continue arguing that HSAs appeal mainly to the healthy, young, and/or wealthy," said Jane Galvin, director of regulatory affairs at the Blue Cross and Blue Shield Association. "As majority party, Democrats will likely block any serious debate or passage of any reforms regarding HSAs."

Republicans, she said, "will be prepared with facts to refute these claims and show that HSAs continue to be offered by different size employers, they appeal to a broad spectrum of individuals and families of different ages, health status, and income and that HSAs are appealing to the previously uninsured, as well as making consumers more cost conscious about their health care decisions."

L. Howard Wizig, of Vivius Inc., Leawood, Kan., told BNA that he thought HSAs are "unfortunately, stuck where they are now. Any vote by Congress to take them away will be vetoed, and I don't think that the Republicans can muster the votes to expand them in the short term. It is possible that if the public gets behind them that the Democrats will give them more support, but I believe that, although it is inaccurate, the Democrats will try to label them as strictly benefiting the healthy/wealthy and paint them, inaccurately, as not benefiting the average citizen."

Washington attorney William G. Schiffbauer told BNA he does not expect the new Congress to engage in any activities to expand HSAs, "but rather to conduct rigorous studies and oversight on the impact of HSAs regarding revenue impact and impact on the uninsured."

The House has passed AHP legislation numerous times in the past several years, but it has stalled in the Senate. With Democrats now in charge of the House, AHP legislation will not be resurrected, although some form of small business health insurance reform legislation could be considered in the Senate and/or House, those interviewed told BNA.

"The change in leadership of the Congress should make it very difficult for AHP legislation to pass in the House and Senate" in 2007, Galvin said.

Commenting on AHP legislation, Schiffbauer told BNA the "new Congress will 'deep six' the association health plan proposal, but will likely explore the [Federal Employee Health Benefit Program] 'buy in' option and other options such as the establishment of interstate health insurance purchasing cooperatives/or 'connectors' in a manner similar to the liability insurance purchasing groups authorized under the federal Risk Retention Act."

One possible alternative to GOP-backed small business legislation (S. 1955) that failed to pass the Senate last year is a bill (S. 2510) Democrats threw their support behind in 2006, introduced by Sen. Richard J. Durbin (D-Ill.) and Sen. Blanche L. Lincoln (D-Ark.).

S. 2510 would have established a national health program administered by the Office of Personnel Management to offer health benefit plans to individuals who are not federal employees, and give small employers a tax credit to defray part of the employer contribution for

low-income workers. That bill may be prohibitively expensive, however, Hunter said.

**Helping the Uninsured.** Help for small business owners for providing health insurance coverage to their workers also could be considered as part of a larger debate on decreasing the number of Americans without health insurance, some sources said.

Helping the uninsured could even provide a chance for Democrats and Republicans to work together, although once again the need to find funding for new initiatives likely will not allow for consideration of sweeping, costly proposals, according to those interviewed by BNA.

Senate Health, Education, Labor and Pensions Committee Chairman Edward M. Kennedy (D-Mass.) has said he would like to eventually move legislation expanding Medicare to everyone under age 65 as a step toward universal coverage, but he acknowledged it may take time to build support for such a bill.

Rather than push for such a bill immediately, Kennedy said, lawmakers should begin addressing expanding health insurance coverage by reauthorizing SCHIP.

At a November 2006 press briefing, Kennedy sounded an optimistic note on finding ways to reduce the number of uninsured Americans, saying Massachusetts lawmakers were able to reach a bipartisan accord on expanding health insurance to residents of that state.

"Our experience with health reform in Massachusetts showed that we can do more," Kennedy said earlier on the Senate floor. "We proved that people from all parts of the political spectrum can come together to provide health care for all."

Other health legislation, such as mental health parity legislation, should be watched in 2007, too. Pamela Greenberg, executive director of the Association for Behavioral Health and Wellness, told BNA that "passage of comprehensive mental health and substance use parity legislations is long overdue and I believe it will be a top health legislative issue" in 2007.

"Congressmen [Patrick J.] Kennedy [D-R.I.] and [Rep. Jim] Ramstad [R-Minn.] are invigorated to get this legislation moving and rumors are that [Speaker of the House] Pelosi has promised Congressman Kennedy action within the first 100 days."

On the Senate side, she said, Sens. Kennedy and Pete Domenici (R-N.M.) "also remain steadfast in their commitment to pass of this legislation. I believe the managed care, business, and behavioral health communities will be able to come to the table and reach a compromise that everyone can support."

**Medicare Provider Cuts.** President Bush also is likely to challenge Congress to reduce federal spending by putting forth Medicare spending reductions in his fiscal 2008 budget proposal, Washington attorney Frederick H. Graefe told BNA. But Bush's Medicare's cuts "will be dead on arrival" in the new Congress, Graefe told BNA.

"I'm prepared for a very severe budget on Medicare" from the White House, added Federation of American Hospitals President Charles N. Kahn III.

Kahn said it could be difficult to move Medicare legislation in 2007, particularly in the Senate, where a bill to increase doctors' pay, for example, could attract numerous other amendments.

Bush's fiscal 2007 budget blueprint "contained a number of significant spending cuts to the Medicare program designed to reduce Medicare expenditures by \$36 billion over five years and by \$105 billion over 10 years," Barbara Kennelly, president of the National Committee to Preserve Social Security and Medicare, said.

"We believe the President's [fiscal] 2008 budget will contain similar cuts to the Medicare program."

In particular, Kennelly, a former Democratic congresswoman from Connecticut, said Bush may propose "automatic across-the-board cuts to all Medicare providers" and the elimination of the inflation-adjusted income thresholds for the means-tested Part B premium.

**Medicare Managed Care Payments.** Medicare payments to managed care plans also will be the subject of congressional scrutiny, with hearings on the issue likely in the House Energy and Commerce Committee, said Bridgett Taylor, Democratic staff aide for the House Energy and Commerce Committee.

Taylor said Democrats are concerned that Medicare is paying managed care plans as much as 119 percent of fee-for-service rates. One troubling federal policy is that Medicare is giving teaching hospitals and managed care plans indirect medical education payments, Taylor said.

"Paying the same thing to two different entities is ridiculous," she said.

BCBSA's Galvin said that there are some "who think MA plans should be funded at the traditional Medicare expense amounts even though the Congress bumped up MA payments in the rural areas to attract new plans."

She added, "now that access to MA plans is almost at the 100 percent level, some think the plans are paid more than they should—so we are back to a funding dilemma."

Health plans lost one battle to protect their funding when Congress during the just completed lame-duck session voted to significantly reduce the managed care stabilization fund contained in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Mohit Ghose, vice president of public affairs for America's Health Insurance Plans, told BNA that AHIP will be working to show members of Congress the advantages of MA plans and that cutting back could have a detrimental affect on their constituents.

The "Coalition for Medicare Choices" will be revived to show lawmakers the value of MA plans at such venues as town hall meetings and visits to senior homes, he said.

Gorman also said that he does not believe "Congress has the votes to enact any major legislative fix to the MMA before 2009, and even if they squeaked something through, it would be veto bait for the President, without the votes to override."

**Health IT.** Congress also is likely to produce health IT legislation in 2007 that is expected to resemble a bill (S. 1418) produced by the Senate in 2005, Taylor said. New legislation is likely to contain federal funding to get providers to use health IT and interoperability requirements allowing the systems of different providers to communicate, Taylor said.

But given the complexity of the issue, most of the progress on health IT could remain in the private sector

in 2007, Garry Carneal, president of InforMed Medical Management Services in Annapolis, Md., told BNA.

"Congress will be less likely to take significant action in 2007 based upon the complexity of the 'health' issue and due to other national priorities such as defining an exit strategy from Iraq," he said, adding, "2007 represents a significant opportunity to experience concrete gains in better population and patient-specific health outcomes and reduced costs through the continued implementation of recent health technology advancements."

## Part D Program in 2007

Regardless of what, if any, changes Congress makes to the Part D program, most industry observers expect beneficiaries to make few plan switches in 2007, though they also expect plans to continue experiencing some of the same systems problems as in 2006, though to a lesser degree.

HIP Health Plans Legislative Affairs Senior Vice President George Strumpf said late December enrollments could cause problems for plans as they try to meet CMS requirements that plans send all enrollment materials to new enrollees before the effective date. While plans have procedures in place to ensure beneficiaries are able to get prescriptions filled shortly after enrollment "the subsequent reconciliations with CMS and other Part D plans often take considerable time, effort, and administrative expense," he said.

The plan switches that do occur could cause some early-in-the-year administrative hiccups, particularly among low-income subsidy beneficiaries, Johnson & Johnson attorney Michelle Fried said.

Lehman Brothers Health Care Services Senior Vice President Joshua Raskin, and Gorman agreed, saying plans could face greater administrative snags for dual eligibles enrolled in Part D in 2006 who were re-assigned new plans in 2007 because their previous plan did not meet the current year low-income subsidy benchmark.

Plans also begin preparing early in 2007 for the 2008 Part D plan year, and many experts predict few changes in plan premiums and do not expect formulary design changes based on cost concerns.

Strumpf said that even small premium increases in 2008 could cause beneficiaries to shop around for a new plan, so premiums are likely to be static in 2008 as part of an effort by plans to retain enrollees.

However, Strumpf also said he expected to see significant plan exits from the Part D program among insurers that did not "attract sufficient enrollment to justify continued contracting."

Mid-year could be the first "organic growth" in membership for Part D plans—particularly MA-PDs—as some retirees begin moving out of employer group plans into Part D, Gorman said. He said he expects the trend to begin slowly in 2007, then picking up in 2008, with public sector employers, labor unions and nonprofit/tax exempt organizations, which receive the lowest subsidy amounts.

## Pay-for-Performance

Another topic to watch in 2007 is the use of pay-for-performance programs in the private industry as a tool to control costs and improve health care quality.

InforMed's Garry Carneal told BNA P4P programs will continue to expand in the private sector next year and that the P4P initiatives are "becoming more sophisticated in how they are benchmarking physician performance both in terms of utilization/practice measures and clinical outcomes."

For example, Carneal said some P4P programs now benchmark and reward physician performance based upon generating an evidence-based medicine scorecard that is risk-adjusted for each physician's patient population. The methodology underpinning these types of applications continue to improve—which helps promote a dialogue with physicians on how they can improve the treatment patterns if they are receiving below average rankings. "Interestingly, he said, "we are now seeing our 'PHO' type clients implement P4P programs for their own physician populations—in addition to the traditional payor-sponsored P4P programs."

However, Wizig said he predicted a "small, incremental increase" in the growth of P4P programs in 2007.

"Health plans (and their employer clients) tend to be slow to adopt these concepts in the short term, but tend to migrate toward them in the long term. If there is continued success with these programs, then I think the breakthrough year will be 2009—as ... product introductions/enhancements tend to slow down as we approach Presidential election cycles."

## Medicare Advantage Growth

The first year of the Part D drug benefit drew strong managed care organization participation into the Medicare Advantage program. The entry of MA-prescription drug plans (MA-PDs), as well as other MA plans that do not offer a drug benefit, produced a busy marketplace with particular success for certain types of plans.

"There has clearly been tremendous growth in plans and enrollment between 2005 and 2006," Patricia Neuman, vice president of the Henry J. Kaiser Family Foundation and director of the foundation's Medicare Policy Project, told BNA. With the strong financial incentive to join MA, in 2007 there will be even more availability.

CMS said that in 2007, there will be 3,971 Medicare Advantage plans, an increase from 3,195 in 2006. These include employer group health plans along with private health plans available to the public.

In addition, there was more market stability between 2006 and 2007 than was expected thought last year, as well as more loyalty to existing plans, Joel Menges, vice president of The Lewin Group, said.

Some industry watchers at the end of 2005 speculated that with the heavy competition a market shake-out would occur in which many plans would not survive to 2007.

Jack A. Rovner, of Neal, Gerber & Eisenberg LLP, Chicago, said he believes that so far the few departures have been tied to compliance problems. There is a cost to exiting, Menges added. Rather than leave the MA program, if a plan finds that it is losing money in Medicare, it can increase charges to beneficiaries.

Also, the commercial market is "flat," and managed care organizations are looking to MA for growth, according to Sharon Woda, a senior manager at Lewin.

AHIP's Ghose said that while his industry group in the past surveyed members to determine how their withdrawals would affect enrollees of late, "we haven't

had to do that." AHIP instead plans to survey enrollees in early 2007 about such matters as the types of benefits they are receiving and cost savings.

MA organizations have been assessing and, for some, reconfiguring their MA and stand-alone drug products to maintain and hopefully grow their market share in some of the more crowded areas.

Blue Cross and Blue Shield of Florida, for example, decided to consolidate two health maintenance organizations (HMOs), Lori Hallauer, a Medicare products manager, told BNA.

In the hotly competitive southern Florida marketplace, the company's now single zero-premium HMO will allow for better benefits for enrollees and lower administrative costs for the company, according to Hallauer, director, senior market solutions product management for the not-for-profit headquartered in Jacksonville.

HMOs are still their most popular product. The company has 20,000 enrollees in the HMO, 100 times the number that is in its local preferred provider organization (PPO).

So for its "BlueMedicare" PPO in 2007, BCBSF decided to halve premiums and eliminate or reduce co-pays for a variety of services, including durable medical equipment. Members will also receive dental benefits for the first time in 2007. Tweaks were also made to their stand-alone prescription drug plans.

So far, however, their enrollees have been very loyal, allowing for a stable population. They have "grown up, knowing us" from their time in BCBS commercial products, Hallauer said.

**MA Migration.** Gorman said that March will be the "high-water mark for both PDPs and Medicare supplemental insurance." After that, beneficiaries will begin migrating to the newer MA products, he declared.

Two types of MA products are drawing attention for having drawn large segments of the enrollee population in 2006.

Special needs plans (SNPs) are coordinated care plans that may exclusively or disproportionately enroll individuals who are dually eligible for Medicare and Medicaid, are institutionalized, or have severe or disabling chronic conditions.

The share of beneficiaries with a SNP in their area will grow from 59 percent in 2006 to 76 percent in 2007, according to the Medicare Payment Advisory Commission.

Raskin said that "this is an attractive population because the revenues are very large and there are no lock-in restrictions. They will continue to grow," he predicted.

**Risk Adjustment and SNPs.** SNPs have thrived due to risk adjusted reimbursement, based on the health of the beneficiary, Ken Yale, vice president of government programs at Matria Healthcare Inc., said. This "reverse cherry picking" will allow for better care to sicker patients.

Because of risk adjustment, it is very important for plans to accurately capture the risk of their enrollees and will be even more critical as payments level off, Woda said.

John Baackes, chief executive officer of Senior Whole Health (SWH), Cambridge Mass., agreed. His company will start serving duals as a SNP in Connecticut and New York in 2007 as an expansion of a CMS-

state demonstration program that he has been involved in for duals in Massachusetts.

Sign-ups of beneficiaries are made at the “kitchen table,” which gives the SWH representative “huge clues to their risk status” that may not have been detected or documented, Baackes said. These observations have to be captured as data and transferred to CMS in order to get the “right compensation.”

Of the 602,881 SNP enrollees in December 2006, most (491,877) are duals. Gorman said that enrollment in dual SNPs will further increase as this population migrates from PDPs into the “one-stop shop” SNPs offer.

MedPAC in November 2006 said that in 2007 there will be more SNPs of the institutional and chronic illness variety.

“We’ll see dramatically increased enrollments in SNPs from the chronically ill as those plans become more widely available. And with growing numbers of states focusing on managed long-term care in Medicaid we suspect we’ll see rapid growth in plans for the institutionalized,” Gorman said.

Manatt, Phelps’ Krasner observed that CMS appears to be “increasingly willing to allow for plans to target specific groups of chronically ill patients and plans are more sophisticated now in providing effective management /coordination services for such defined populations, working out arrangements with states to coordinate Medicaid funding with Medicare funding, doing their homework on how to get the best risk adjustment factor and making a profit.”

**SNP Success.** Rovner said that the success of SNPs is due to the fact that they can form their benefit packages to focus in on specific needs, use disease management, and do not need large enrollments.

“There seems to be an ongoing huge interest in SNPs, despite the fact that most of the population is enrolled in a few big plans,” Krasner said.

According to MedPAC, in 2007 there will be 424 SNPs, up from 276 in 2006.

Gorman said, however, that half of the SNPs have less than 1,000 enrollees. “That’s unsustainable for long, so we suspect we will see substantial consolidation going into 2008.”

Vicki Gottlich, senior policy attorney for the Center for Medicare Advocacy Inc., said her organization will be watching the growth in SNPs and wants to know “what is so special about a special needs plan.”

Gottlich said that many of the things provided are required by law. “It is not clear to us that [enrollees] are getting more benefits,” she said, “and there is ‘little oversight.’”

Similarly, Neuman wondered what services are provided that are worth the extra cost of coverage.

SNPs cover only Medicare services, and are not required to cover Medicaid benefits, although they may contract with a state for Medicaid services.

Baackes said that, unlike most SNPs, his Cambridge-based health plan, which serves 3,000 duals in Massachusetts, has integrated Medicaid into its program. For example, if a claim is denied by Medicare, his company will file it with Medicaid.

However, Gottlich said that a big problem with many SNPs serving the duals is a lack of coordination with Medicaid. The SNP may not cover a drug or a service that is covered by Medicaid in a particular state. While SNP dual enrollees would be entitled to that, they are

unaware and the SNP is not billing Medicaid for the covered service, she said.

Discussing MA overall, Gottlich said that while there is no enrollee exodus, some have switched out of MA plans and back into fee for service as they have gotten sicker because of the additional or higher cost sharing for some expensive drugs, like chemotherapy.

In addition, some of the MA plans have imposed home health copays, while they are no copays in fee-for-service.

These enrollees find it less costly to be in fee for service Medicare with a Medigap plan, she said.

SNPs were authorized through 2008 and CMS must report on their impact on enrollees by the end of 2007.

**Private Fee-for-Service.** The other MA product capturing attention is the private fee for service (PFFS) plan. These plans are actually a payment system for Medicare health care access and do not have a provider network or coordinate care. Plans may offer a drug benefit, as well as additional services and discounts on items such as hearing aids.

Rovner described them as operating like an indemnity product without a network, with low premiums, and a “little extra” benefit.

Washington attorney William Schiffbauer said PFFS plans have proven attractive, because any provider can be used by the beneficiary. However, he said that this capitated fee-for-service arrangement works only because MA payments are higher than the FFS payments.

These plans have been successful, Galvin said, “as they allow access to most Medicare providers. Access to all providers who accept the plan’s terms and conditions is an attractive feature to PFFS options.”

CMS said that as of Dec. 1, 2006, there were 864,100 enrollees in PFFS plans

PFFS plans are “the fast growing MA option,” Strumpf told BNA. “It is relatively easy to market as it is not a managed care plan and appears to the beneficiary to have all of the same characteristics as traditional Medicare.”

However, he added that with payments higher relative to Medicare FFS, the PFFS plan option is a target for Congress to examine with a view to reducing payment levels.”

**Behind the Growth.** Gorman said that PFFS plans are growing rapidly because of two factors: wider availability and employer group retirees. PFFS plans are available to all Medicare beneficiaries, and especially in rural and secondary markets, “they are signing up in droves.”

Menges said that because Medicare pays good rates in rural areas, it is not difficult to make money on this product.

Gottlich said she expects to see more enrollees in PFFS because of the “aggressive marketing” by the plans. However, not all enrollees understand the ramifications of enrollment and some are unhappy when they find out that their doctors or hospitals are not accessible because they do not accept the plans’ payments or do not want to get involved with the paperwork.

Gorman said that the product has been “nothing less than shocking in its massive enrollment of group retirees, made possible by the ‘deemed network’ feature.”

With no network requirement, PFFS plans can serve group retirees on a national basis, which HMOs were never able to do before, Gorman said.

However, he added, “the wild success of PFFS notwithstanding, we think MSAs [medical savings accounts] will outpace PFFS enrollment over the next five to seven years.”

**Medical Savings Accounts.** The new year will bring the first crop of the MSAs-consumer-directed health care plans—to MA.

Gorman said they will be popular because they operate like a high-deductible PFFS plan but offer “the enormously attractive tax-free account funded by Medicare.”

He said, “those account dollars can be used for virtually any health-related expense, even for services not covered by Medicare. That’s going to be a big draw for healthier beneficiaries who are actively involved in the management of their own care.”

Because MSAs must be offered at zero-premium, his firm suspects “they will be wildly popular among retiree groups” seeking to reduce their post-retirement health care liability.

The Indianapolis-based health benefits company, **Wellpoint Inc.**, will offer MSAs under its “**Blue Cross of California**” and “**Unicare**” branded plans.

Under the program, Medicare places a risk adjusted capitated payment in an account for a beneficiary to use tax-free for health care spending. After the high yearly deductible is met, the health plan would pay for Medicare-covered services. Unspent funds would be carried over for future use.

CMS has said that the beneficiaries it envisions enrolling in an MSA are those who desire more control over their health care spending, with protection from catastrophic health care expenses. This includes enrollees who had a health savings account (HSA) in the commercial market before becoming eligible for Medicare, the agency said.

**MSA Enrollment.** James Kappel, a spokesman for Wellpoint, said that he expects enrollees to take advantage who are diligent about saving for health care.

However, even former CMS Administrator Mark B. McClellan said he did not expect a “drastic shift” among beneficiaries because the concept is not familiar to many current retirees.

Raskin predicted that the enrollees in MSAs at the end of 2007 will be less than 3 percent.

National Committee to Preserve Social Security and Medicare’s Kennelly said that if commercial HSAs are any indicator, then enrollment in MSAs will be low. Only about 3 million people, out of 170 million with private insurance have participated in an HSA over the past two years, she said.

However, Richard White, Wellpoint’s vice president for senior markets, pointed out that the more than 3 million in commercial HSAs in 2006 grew from 400,000 in 2004. Some of the future enrollees will come from that group, he said. These will be “innovators” who like the concept of not only picking their own doctors, but managing their own care, White told BNA.

However, even Gorman said he did not expect more than 100,000 MSA enrollees by the end of the nascent year.

White said that Wellpoint plans to contact each MSA enrollee in January to ensure that they understand how the new product works. The educational element will go two ways. Wellpoint marketers wants to find out the

motivation behind the purchase to help with product evolution, White said.

**Regional PPOs.** As of Dec. 1, CMS said that 98,385 beneficiaries were enrolled in 11 regional PPOs out of 43 million beneficiaries.

PPOs have clearly not garnered the interest that was originally intended, Raskin said. “It is very difficult to offer a health insurance plan across a broad region due to the disparity of local costs. I don’t think the regional PPO will take off in 2007 if at all.”

Galvin commented that “regional PPOs are a challenge as many regions are multistate which goes against the way Blue plans are organized,” she said. “We had advocated for 50 state-based PPO regions. However, the regional PPO enrollment should grow over time as more beneficiaries are aware of their features.”

Neuman speculated that the “modest” enrollment could be a result of less aggressive marketing than with the other types of plans and Kennelly said a November 2006 *Health Affairs* article said that regional PPOs accounted for less than 1 percent of all Part D enrollment in 2006.

When seniors compare plans, they will find that PPOs tend to have higher premiums than other private health plans, she said. “Even if these plans provide more generous benefits, seniors might be discouraged to participate because of the higher cost,” she added.

Kennelly said the tax and health law signed by the president in December 2006 will reduce the amounts available to subsidize regional PPOs in the future. Reducing amounts available for this fund is helpful, she said, although it leaves the infrastructure in place for the incentive to be funded again in the future.

**Building Enrollment.** Barbara Ryland, an attorney with Crowell & Moring, Washington, said that increases in regional PPO enrollment would be most likely to occur in rural or smaller metropolitan areas, and, as with the HMO plans, it could take some time to build up enrollment in these areas that have been traditionally underserved by managed care plans.”

Gorman said that, depending on the point of view, the number of beneficiaries enrolled in regional plans could “a lot or negligible . . . It’s too early to tell, really. Another year and we should have a clearer picture. Novel products like regional PPOs take some getting used to, especially for managed care adverse beneficiaries in Medigap which PPOs are targeted at.”

However, he added, “having said that, the fundamental structure of regional PPOs is inherently problematic: the requirement to offer the same product across the entire region means that to be competitive in urban areas the plan is often prohibitively expensive in rural areas. I’d expect no more than 250,000 beneficiaries in regional PPOs in 2007.”

In January, CMS said that 17 percent of beneficiaries are in MA.

Raskin predicted that overall MA penetration would be 19-20 percent by the end of 2007, with a majority in HMOs but most of the growth in PFFS plans.

Similarly, Gottlich said that she expects enrollment to be 20 percent at the end of the year.

Gorman speculated about which beneficiaries will be attracted to each type of plan. “We foresee an emerging micro-segmentation of Medicare Advantage, largely along income lines, with low-income and chronically ill

beneficiaries moving to SNPs, leaving in HMOs and bare-bones PFFS plans the low/middle-income but relatively healthy; and more affluent beneficiaries moving from Medigap and PDPs into PPOs, MSAs, and 'Cadillac' PFFS plans."

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