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REPORT

Outlook 2006: Medicare Drug Benefit of Highest Concern

Implementation of the new Medicare Part D prescription drug benefit tops the list of issues that health insurers, managed care programs, pharmacy benefit management companies, and health care industry experts will be watching this year, according to a survey of *BNA's Health Plan & Provider Report* advisory board.

Other top issues cited by the advisory board members include work on health care technology and interoperability, taming the rise of health care costs and its impact on employers and consumers, pay-for-performance programs, the growth of consumer-driven health plans, further consolidation in the managed care/health insurance industry, and improving health care quality.

Plans Watching Part D Enrollment

The addition of a prescription drug benefit to the Medicare program is a historical change for the program. However, uncertainty remains about how beneficiaries will take to the new Medicare drug benefit—specifically whether enough healthy beneficiaries will enroll in the program to offset the droves of chronically ill patients expected to sign up for or be auto-enrolled in a plan.

It also remains to be seen whether federal lawmakers will tinker with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that enacted the Part D program, and how vulnerable the program and beneficiaries are to fraud and abuse schemes expected to abound as the benefit became effective Jan. 1. Nevertheless, few observers of the Medicare program expect major changes to the new drug benefit in 2006. Instead, they expect Congress to take a wait-and-see approach before modifying the program.

Moreover, some observers said lawmakers may be loath to make changes to the Part D program because 2006 is an election year. Several commenters said they expect the success or failure of the benefit in its early months to have some affect on November poll results.

If beneficiaries are dissatisfied with their drug plans, then Medicare could be an issue that decides elections, attorney Robert L. Roth, Crowell & Moring LLP, Washington, D.C., said, adding that only under extraordinary circumstances would Congress consider changes to the program.

Among such circumstances that could motivate earlier changes, Roth said, is if Part D beneficiaries, including those in nursing homes, are unable to get necessary medications under the program. He said some issues continue to hang in the balance, such as whether CMS will be able to implement ''real time'' claims payments.

''If successfully implemented, the agency will deserve significant credit for creating a process of unprecedented complexity in a remarkably short time,'' Roth said. ''However, if this system does not work and pharmacies are unwilling to dispense needed medications, the consequences could be disastrous.''

L. Howard Wizig, Vivius Inc., Leawood, Kan., commented that implementation of the Part D program ''will be such a confusing mess for eligibles that it would be political suicide to change anything in the first year.''

Wendy Krasner, an attorney with Manatt, Phelps & Phillips LLP, Washington, D.C., said it is ''very unlikely'' that Congress will delay or allow only the low-income population to get Part D. ''But if they did, they would have to figure out a way to compensate plans for the hundreds of millions of dollars that plans have spent on bidding or marketing—if they did not, there is no way that privates plans would ever go after government business again.''

Insurance providers offering prescription drug plans are expected to feel pressure in 2006, in part because they are challenged with marketing their plans and en-

Top Managed Care Issues for 2006

Among the top issues facing health plans and providers listed by *Health Plan & Provider Report* advisory board members are:

1. Implementation of the Medicare Part D Drug Benefit
2. Health care information technology/data interchange
3. Consumer-driven health care
4. Taming health care cost inflation
5. Pay-for-performance programs
6. Continued erosion of the employer-sponsored market
7. Adaption of the high-deductible health plan benefit designed into a managed care model of financing and delivery
8. Hospital system cost transparency
9. Health care quality and measurement

rolling participants, but also because they simultaneously must prepare bids for the 2007 plan year with little historical data to make adjustments.

Early program results could motivate plan providers to make changes in their offerings, or even leave the program if outcomes are very poor, some said. They added, however, that most plans will have too little data by the time 2007 bids are due (in spring 2006) to make informed decisions. In other words, insurance providers will find it difficult to adjust their plans for the 2007 benefit year because they will have little time to analyze 2006 data before 2007 bids are due to CMS.

'Negative Publicity.' Academy of Managed Care Pharmacy Executive Director Judith A. Cahill called the Part D benefit a ''brand new program with a myriad of complexities.'' She noted that CMS and health plans must overcome an ''enormous amount of negative publicity'' to get the Part D program launched effectively in early 2006, coupled with the pressure of preparing, at the same time, for the 2007 benefit year.

Commenting on expected changes, Krasner noted that CMS has said it will be making changes for 2007, especially to its formulary policies. ''It is not clear what those changes are going to be, and of course [there will be the] fundamental tension between the time they would need to make the changes—by spring so they could be factored into plan bids and negotiations—and the timing of when they are going to know realistic enrollment figures—not until June since beneficiaries have until May before the penalty kicks in.''

Cost figures also will not be known for some months, she noted, adding ''it appears that this could become a program where there are a lot of changes—both benefit and price wise—every year.''

Among considerations plans may have to make, according to HIP Health Plans Legislative Affairs Senior Vice President George Strumpf, is the potential for consumer demands for plan standardization.

''I think the biggest issue may be widespread complaints about consumers not being able to understand the Part D program and unable to find the information needed to compare the many options they have,'' he said, noting that the solution could be one akin to the Medigap scenario where plans could present many options but with a standardized offering.

Strumpf added that plans would be faced in 2006 with evaluating enrollment numbers versus acquisition costs. If enrollment is low and costs per member high, PDPs will have to decide whether they should continue participating in the Part D program in the face of operational losses, he said.

Program Stability. However, program stability also could be undermined, Strumpf said, if plans start the 2007 benefit year with significant financial losses because they underpriced their Part D benefit in 2006 or overestimated enrollment. Plans would not have that information, though, until after it is too late to withdraw 2007 bids, he said.

More immediately, plans are concerned about implementation, including the accuracy of enrollment files submitted by states for dual eligibles, Strumpf said. Plans worry that some dual eligibles might not appear in the CMS database and that those individuals could be left out of the system until they try to fill a prescription in 2006.

''This can result in very negative public perception of the program and significant problems for one of the most vulnerable groups,'' Strumpf said.

Employers' Experiences. Future Part D program stability also could be affected based on employers' experiences this year. National Committee to Preserve Social Security and Medicare President and Chief Executive Officer Barbara Kennelly told BNA it is too early still to determine whether retiree subsidies to employers that continue offering comparable prescription drug coverage are effective in maintaining a broad base of retiree coverage by private companies.

However, Strumpf said some companies already are indicating they could push beneficiaries to the Part D program instead of continuing to take the 28 percent subsidy.

''Any significant shift by employers into Part D would result in a major increase in the cost of the program and would have the potential for demand for legislative changes,'' he said.

In terms of costs for the program, Cahill commented that ''We won't truly know the costs for a while, but we can guess that it will be higher than most had anticipated at the outset.''

Compliance Issues. Compliance matters also are of concern for insurance providers, although many industry experts agree CMS likely will not make fraud and abuse a primary focus for 2006.

Nevertheless, Strumpf said, there already has been attention called to potential problems with external brokers with which plans contract to enroll beneficiaries and how well insurance companies monitor the work of subcontractors. Furthermore, plans have gotten no final guidance from CMS about requirements for fraud, waste, and abuse plans.

Cahill said she didn't think plan sponsors ''are 'worried' about being watched for fraud as much as they are worried about just getting everything done correctly and on time.''

Commenting on the lack of final guidance from CMS, Arthur Lerner, an attorney with Crowell & Moring LLP, Washington, D.C., said ''These unknowns impact employee training, written policies and procedures, and

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moreover, the relationships between the sponsors and subcontractors, as CMS has indicated it will require sponsors to ensure that subcontractors have adequate training, etc. in their own organizations. Just how far CMS expects Part D plans to go in their relationships with subcontractors is not clear.''

Strumpf cautioned to watch for CMS Program Memoranda and changes in the Medicare Managed Care Manual, which ''CMS uses to regulate the contractors instead of going through the lengthy process of issueing NPRMs and final regs.''

''While CMS has done a truly admirable job in getting this program up and running in a very short period of time, the net effect has been that in '06, the contractors are in the position of having to shoot their arrow while CMS threw up the target months later. Many plans may be surprised to learn how many costly and difficult changes they will have to make in their systems, policies, and procedures as CMS continues to issue policies... .''

Health Care IT

Another hot topic health plans and insurers will watch in 2006 is the evolving effort to standardize health care records and information. In November, a Department of Health and Human Services advisory board and its deputy chairman agreed to consider federal regulation, among other options, to induce physicians to use electronic systems and the Internet to prescribe medications and communicate orders to pharmacies. The American Health Information Community, as the advisory panel is called, is charged with recommending electronic health information innovations that can be put into use in 18 to 36 months.

In addition, the national coordinator for health information technology, David Brailer, announced that HHS has awarded three contracts totaling $17.5 million to lay the technical and privacy policy foundation for an interoperable nationwide health information network, or NHIN. President Bush appointed Brailer in July 2004 to launch a 10-year transformation of the nation's clinical health information from paper to interoperable digital form.

Cahill commented that ''Health care IT is the 'Next Big Thing' in health care and will continue to be a strong focus for years.''

''The scale and the user base of a truly interoperable health care IT system will be much broader and deeper than any existing system known today—tying together every individual clinic and physician's office, hospital, laboratory, pharmacy and health plan,'' Cahill said. She noted that the biggest roadblock is the investment that exists in a wide variety of legacy systems that currently have no interoperability, plus the enormous amount of data that currently resides on paper and film. In addition, she said, national standards must be agreed upon for data capture and transmission.

Cahill noted that either a platform that can provide the required interoperability has to be established or expensive and time-consuming retrofits have to be made to existing legacy systems—''neither of which will be cheap, fast, or easy.''

The questions for this year and the future, Cahill said, are who will guide this migration to a new platform, who will define standards and protocols, and who will pay for it?

According to predictions from Wizig, ''personal health records will never be successful until they are integrated into the payor system. The only way to successfully implement such a system will be to do so via the payor.'' This is so, he said, because the incentive exists for the providers to communicate with the payor—the provider wants to get paid.

''A provider-centric system won't work, because the provider only sees a slice of the patient's care. A patient-centric system won't work, because the individual patient has no market power to force the provider to submit the data in a common format. A government solution 'could' work, but I think the best and fastest will be a payor-centric system,'' Wizig said.

Wizig said the ''carrot'' to providers to participate should be real-time claims adjudication, not just real-time submission, because real-time adjudication would reduce the provider's costs of administration.

Krasner noted that for 2006, plans are faced with how to ''deal most effectively with the growing movement to develop regional health data exchanges in a manner that doesn't marginalize health plan involvement except as a financier; that preserves and enhances the competitive advantage plans have because of their large investment in data capacity; and that still facilitates data exchange in a manner that will improve quality and save money for the plans and the community.''

Lerner predicted there will not be a lot of progress in 2006 in terms of actual implementation in this area. He noted, ''Ironically, a new safe harbor for hospitals to subsidize technology for physicians, but only where the physician has not already invested in the technology, creates an incentive for physicians not to invest in technology, and to instead wait for a subsidy from a hospital.'' Lerner was referring to a HHS Office of Inspector General proposed safe harbor regulation, announced in October, to provide hospitals and other entities safe harbor from federal anti-kickback laws for donating health records software and training services to physicians (11 HPPR 1065, 10/12/05).

Consumer Driven Health Care

Wizig also cited the continued growth of consumer-driven health care and ''greater flexibility from the Feds'' as issues to watch in 2006.

''It might be a further loosening of the use-it-or-lose-it of FSAs [flexible savings accounts], greater deductibility of health insurance, or greater flexibility of HSA plan design . . . but regardless, I think consumer-driven health care will continue to benefit from favorable regulatory environment at the federal level.''

Wizig predicted that more carriers will offer consumer-driven products; those already offering them will do so ''with greater zeal;'' new entrants will enter the market, such as banks and other financial institutions and technology companies; and new products will be developed.''

Along insurance lines, Wizig predicted that there will be a ''continued erosion'' of the employer-sponsored market in 2006. This erosion will take a few forms, he noted: the continued 'quiet' growth of individual health coverage; the renewed call for socialized health care in light of economic current events such as the downturn in the airline industry and changes in the General Motors health care program; and the continued growth in Medicare as the population ages.