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WORKING WITH PROVIDERS TO ACHIEVE MMA SUCCESS

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Inside Medicare Reform
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MMA Highlights

Key Components of New Bill

- Title I – Medicare Rx Drug Coverage
- Title II – Medicare Advantage
- Title III – Combating Waste, Fraud & Abuse
- Title IV – Rural Health Care Improvements
- Title V – Provisions related to Part A
- Title VI – Provisions related to Part B
- Title VII- Provisions related to Parts A & B
- Title VIII – Cost Containment
- Title IX – Admin, Regulatory, Contracting Reform
- Title X – Medicaid, Miscellaneous Provisions
- Title XI – Access to Affordable Drugs
- Title XII – Tax Incentives: Health Savings Accounts

- Discount Rx Card effective June 2004
- Part D benefit available January 2006
- Change in Medigap policies that provide drug coverage effective January 2006

- M+C restructuring
- Regional PPOs
- Competitive-based program effective January 2006
- Limited cost contract renewals in 2008

- HSA's effective January 1, 2004
- Requires high-deductible plan
- New tax advantages
- Tie to employer offering not required

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MMA Highlights – Effective Dates

Enactment

- M+C payment increase
- Discount drug card program
- Chronic Care Improvement Program
- HSAs
- Generic drug provisions
- M+C renamed Medicare Advantage

2004

- M+C payment increases
- Fee-for-Service contractor reform begins; starts phase-out of Prime Contract

2005

- Part D coverage begins (discount cards discontinued)
- Medigap changes
- New regional PPOs available; no new local PPOs until 2008
- Implementation of stabilization funds

2006

- $10B Medicare Advantage Bonus

2007

- Limited cost contract renewals

2008

- Competition demonstration (brings in FFS Medicare)

2010

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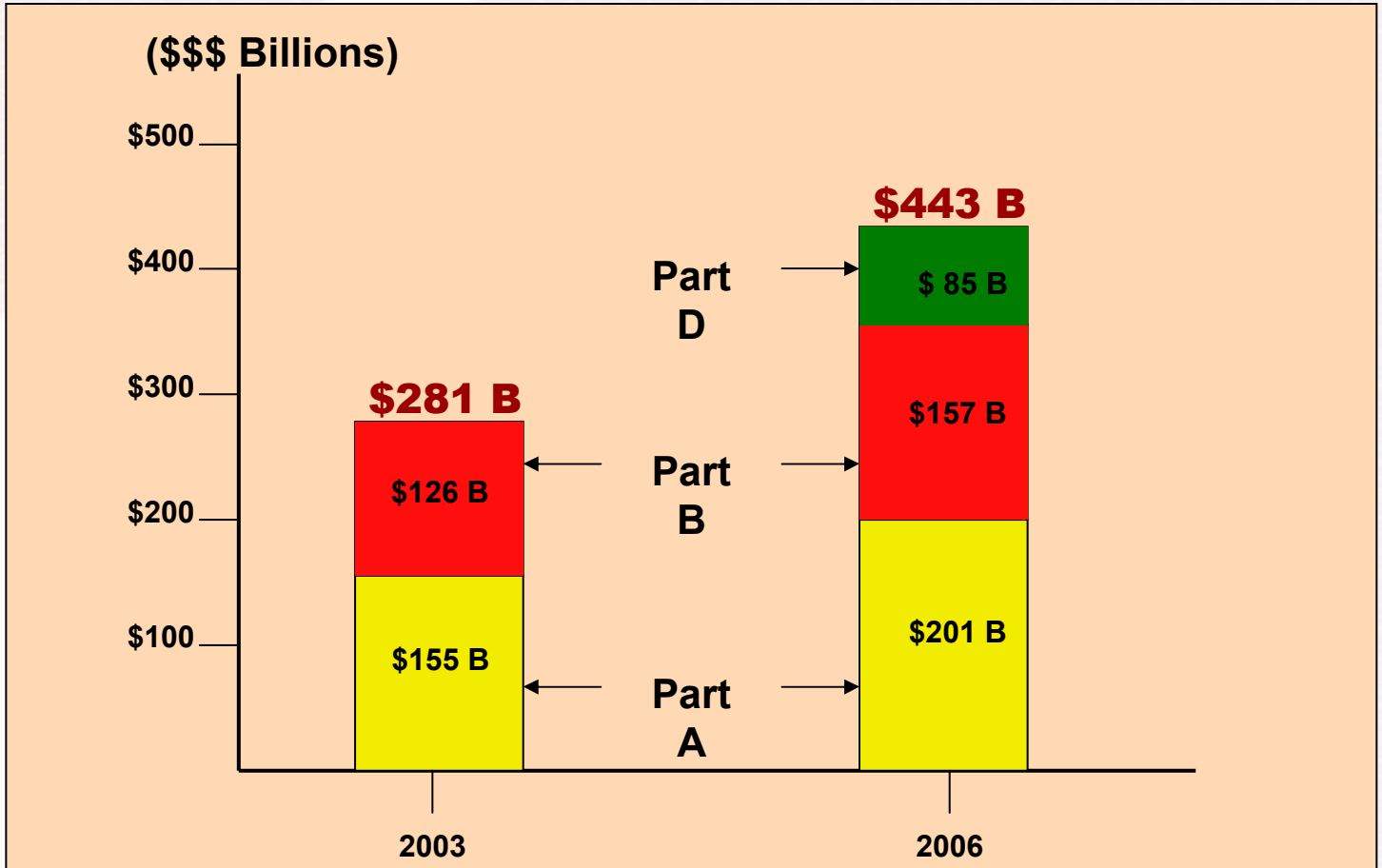
The Coming Medicare Market*



* 2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds

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The Coming Medicare Market*

- Medicare will grow:
  - 2.6% of GDP in 2003
  - 3.4% of GDP in 2006
- Most of the growth ($81.5B) in ℞
- Medicare Advantage will
  - Enroll 4.1 million new beneficiaries
  - Provide $40.1B in increased reimbursements

* 2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds

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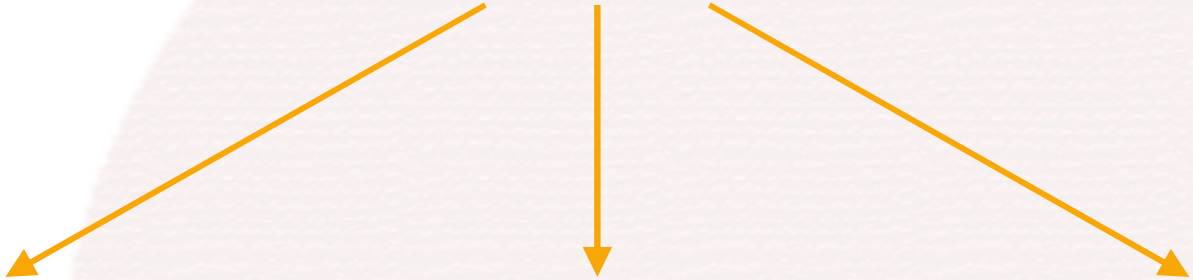
Medicare Advantage - 2006

REPLACES MEDICARE+CHOICE



LOCAL PLANS

- County-based
- 2006-7 Moratorium
- HMO, PPO, POS, FFS
- Employer Groups
- Premiums at 107% of FFS costs

REGIONAL PLANS

- 10 - 50 Regions
- HMO, POS, PPO
- Region-wide Network
- ℞ Plan required
- "Benchmark" Pricing
- Out-of-network coverage required
- Catastrophic limits

SPECIALIZED PLANS

- Special Needs Beneficiaries
  - Institutionalized
  - Medicaid
  - Chronic conditions
- Regs due 12/04

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Medicare Advantage – Regional plan pricing

Step One: Plans submit actuarially-based bids

Step Two: CMS sets risk adjusted "benchmark" based on bids

Step Three:

(a) If bid < benchmark, CMS pays 75% of difference for use in enhancing benefits

(b) If bid > benchmark, Plan charges enrollees

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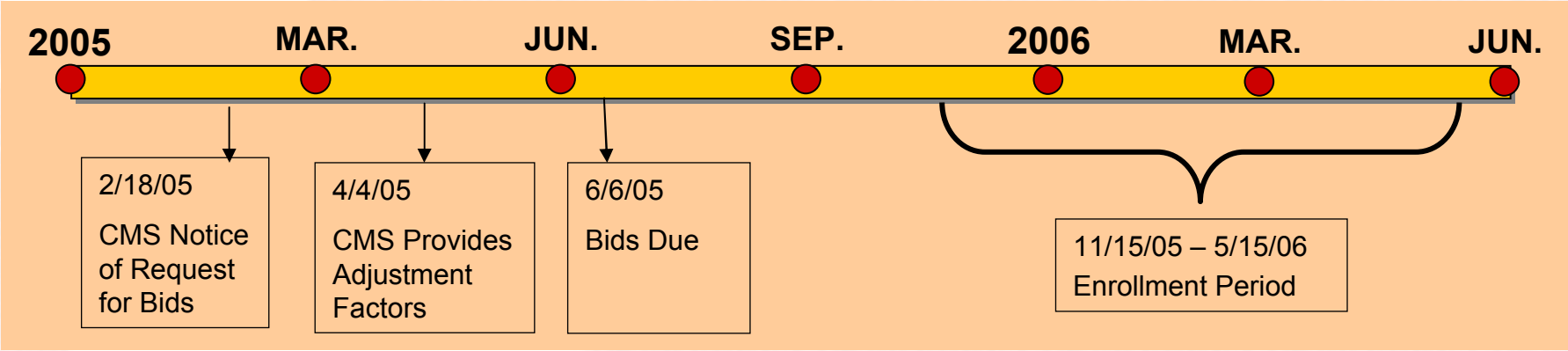
Medicare Advantage – Regional plan bid process

- Bid Content
  - Pm/pm based on national average profile and actuarial basis
  - Breakdown by A, B, Rx, and Supplemental benefits
  - Enrollee cost-sharing
- CMS can negotiate bid amounts
- Schedule:



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Medicare Advantage – Rish sharing for 2006 - 2007

- Plans keep or pay between 97% and 103% of target
- Next ± 5% shared 50/50 by Plan and CMS
- After that, CMS takes 80% of surplus or loss
- $10B Stabilization Fund for 2007 – 2013
  - Available for national or regional bonuses
  - Retention payments

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Challenges

- Plans need to differentiate from Medicare
- Plans worried about staying in the black
- Seniors not used to limits
- Providers don't want price cuts
- Providers worried about risk
- How assemble a regional network?
- Going local? Moratorium coming

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Provider compensation

- Provider costs must enable plan to be attractive alternative to traditional Medicare

  - Higher HHS payments yields demands for more dollars from providers
  - Pressure to use dollars to provide more benefits

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Provider compensation
(cont'd)

- Maintaining competitive provider compensation rates

  - Steerage motivation for reduced rates requires steerage!
  - Narrow provider network = provider alliances and more attractive payment rates?
  - Narrower provider network more feasible for Medicare than for commercial?
  - Preemption of "any willing provider" laws
  - Risks loss of maximum membership potential

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Provider compensation
(cont'd again)

- Don't fall for anti-fads

  - Why not do risk sharing with providers?
  - Can plan manage it?
    - Provide timely usable reports
    - Help providers manage utilization
  - Can providers afford it?
  - Is it just useful incentives? Or is it real sharing or downloading of economic risk?

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Provider compensation
(cont'd more)

- How deal with drug costs?

  - Physicians share in financial risk?
  - Physicians rewarded for in-formulary prescribing?
  - Are PBM operations meshing with physician relationships?
  - How work with physicians prescribing specialty pharmaceuticals?

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Incentives

- Rewards for positive provider performance
  - Quality
  - Patient Satisfaction
  - Cost
- Physician incentive plan regulations relaxed
- New requirements for quality and chronic care improvement may mesh with provider incentives

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Trust

- Communication
  - Inclusion in policy-making
  - Transparency in payment policies
- Staying with program
- Flexibility vs. take it or leave it contracting
- Prompt pay/advance deposit

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Provider empowerment

- Provider network contracting and antitrust
  - Legal risk / legitimizing unstable and unhealthy relationships
  - Risk sharing?
  - Clinical integration?
  - Staying out of antitrust trouble

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Making innovation work for regional plans

- Point-of-Service design permits steerage through lower deductibles for using in-network providers
- Marketing regional plan waiver of preventive care deductibles to differentiate from Medicare and attract rural providers
- Working with FQHCs – HHS will supplement up to full FQHC costs
- "Essential hospital" subsidy where plan not able to secure contract, if regular Medicare Part A rates do not cover hospital's costs. Hospitals incented to "work with" plan to increase gov't payments