

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

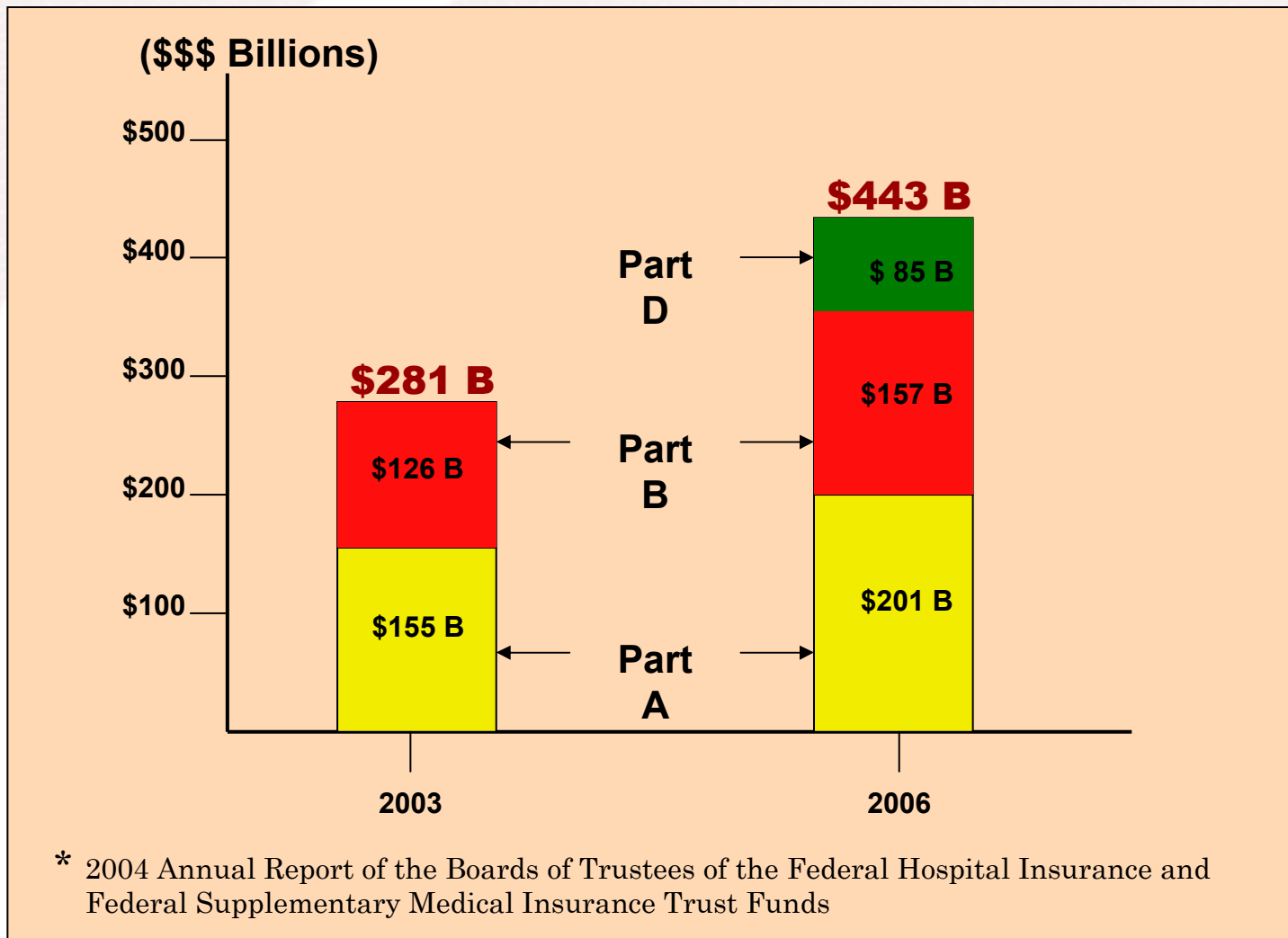
- M+C restructuring
- Regional PPOs
- Competitive-based program effective January 2006
- Limited cost contract renewals in 2008

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

MMA Highlights – Effective Dates

Enactment	2004	2005	2006	2007	2008	2010
	<ul style="list-style-type: none"> • M+C payment increase • Discount drug card program • Chronic Care Improvement Program • HSAs • Generic drug provisions • M+C renamed Medicare Advantage 	<ul style="list-style-type: none"> • M+C payment increases • Fee-for-Service contractor reform begins; starts phase-out of Prime Contract 	<ul style="list-style-type: none"> • Part D coverage begins (discount cards discontinued) • Medigap changes • New regional PPOs available; no new local PPOs until 2008 • Implementation of stabilization funds 	<ul style="list-style-type: none"> • \$10B Medicare Advantage Bonus 	<ul style="list-style-type: none"> • Limited cost contract renewals 	<ul style="list-style-type: none"> • Competition demonstration (brings in FFS Medicare)

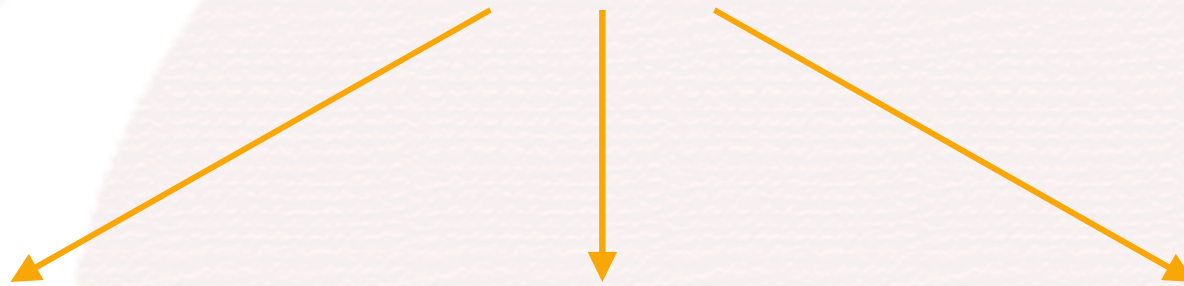
The Coming Medicare Market*



- Medicare will grow:
 - 2.6% of GDP in 2003
 - 3.4% of GDP in 2006
- Most of the growth (\$81.5B) in **Rx**
- 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

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**
- **Rx Plan required**
- **“Benchmark” Pricing**
- **Out-of-network coverage required**
- **Catastrophic limits**

SPECIALIZED PLANS

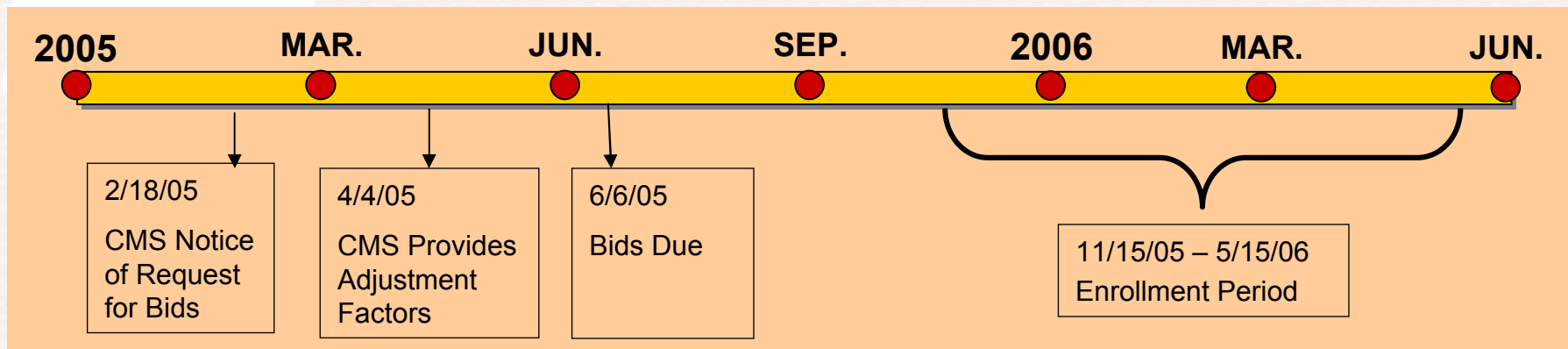
- **Special Needs Beneficiaries**
 - **Institutionalized**
 - **Medicaid**
 - **Chronic conditions**
- **Regs due 12/04**

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

Medicare Advantage – Regional plan bid process

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



Medicare Advantage – Risk sharing for 2006 - 2007

- Plans keep or pay between 97% and 103% of target
- Next $\pm 5\%$ 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

- 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

- 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

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

Provider compensation

(cont'd again)

- Don't fall for anti-fads
 - Why not do risk sharing with providers?
 - Can plan manage it?
 - o Provide timely usable reports
 - o Help providers manage utilization
 - Can providers afford it?
 - Is it just useful incentives? Or is it real sharing or downloading of economic risk?

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?

- 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

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

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

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