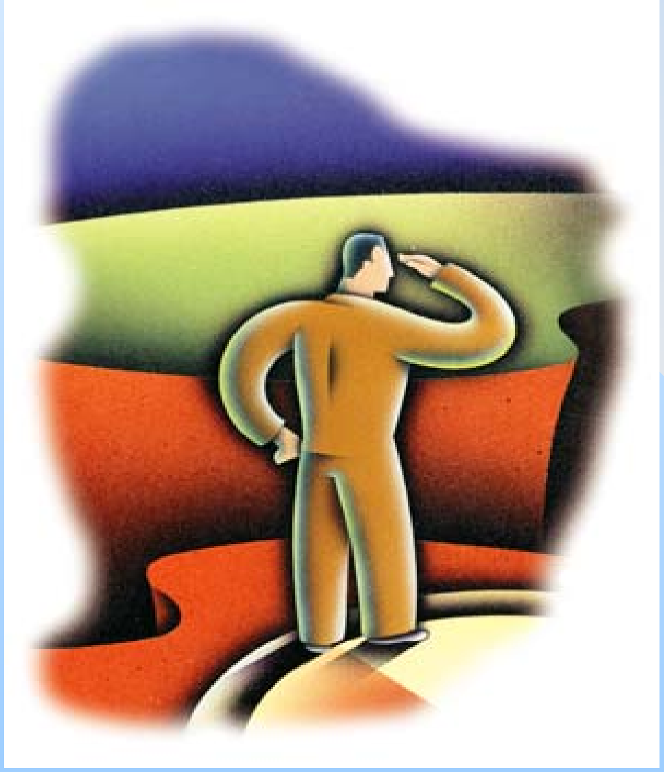
Medicare Modernization Act of 2003: *Product Development Strategies for Medicare Advantage*



John Gorman
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February 27, 2004

Today's Agenda

- The Argument for Adverse Selection in Part D
- Survival Tactics:
  - Product Design and Portfolio
  - Disease Management
- Product Options in Medicare Advantage
- Opportunity Segment Focus:
  - Retiree Groups
  - Dual Eligibles
  - Disease Management
- Product Strategy and Positioning
- Conclusions

Cut to the Chase!

- Medicare Advantage will expand in 2004.
- MMA will prompt increases in benefits from MA plans in 2004-2005.
- Broad participation in drug discount card program.
- Emergence of stand-alone drug benefits.
- Don’t expect significant strategic moves from PBMs.
- Basis for concern about adverse selection in Part D. Survival long-term contingent on product design, disease management.

The Argument for Adverse Selection in Part D

- Discount Rx cards and Part D are voluntary.
  - Older, lower-income beneficiaries disproportionately uninsured for drugs.
- Rx cards and Part D both provide better benefits to low-income beneficiaries.
- Direct relationship between income and health status in Medicare.
- Unfamiliarity with drug risk likely to result in high bids and high premiums in initial years of Part D.
  - High premiums result in adverse selection
- Disproportionate number of chronically ill, high drug utilizers will join first.

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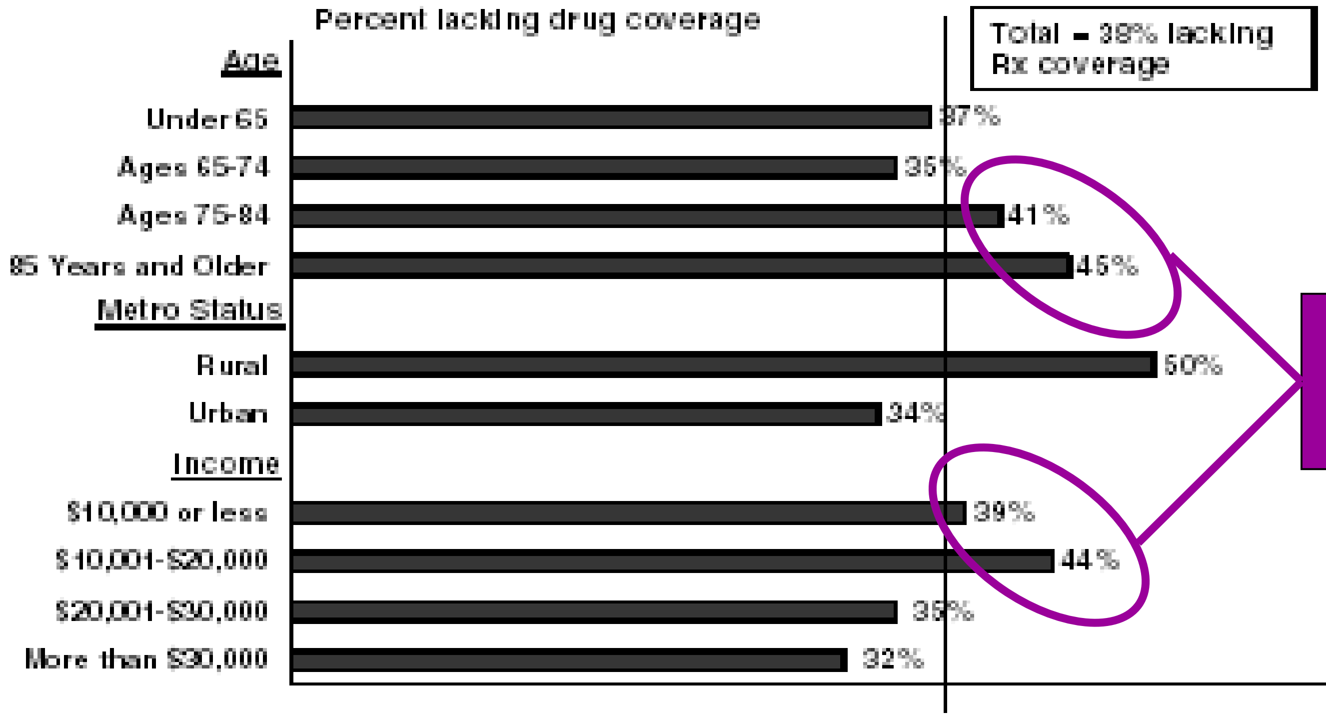
Prescription Drug Coverage For Medicare Beneficiaries

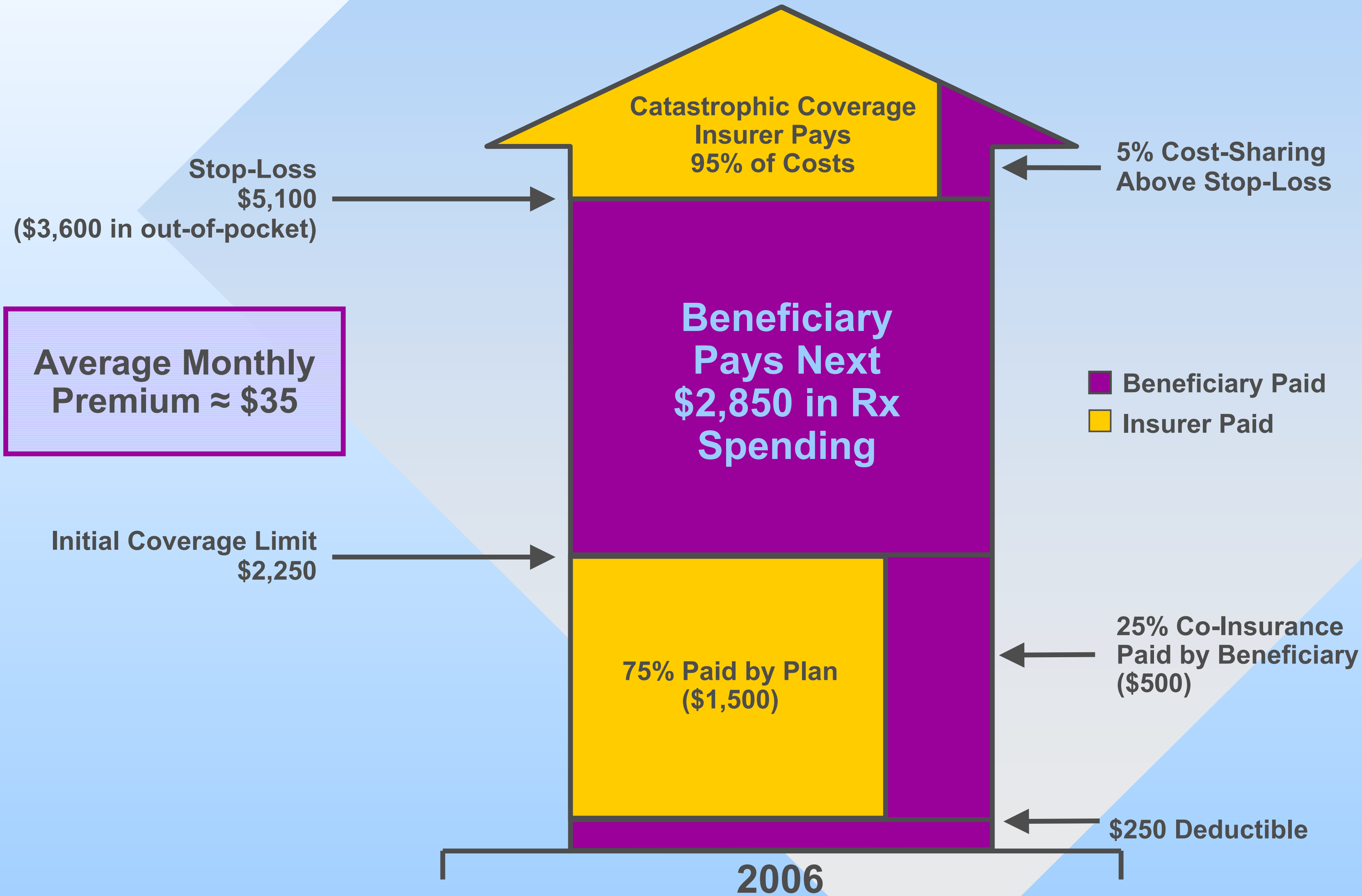
Percent of Beneficiaries Without Prescription Drug Coverage, by Beneficiary Characteristics, Fall 1999



Argues for Adverse Selection

Note: Analysis of non-institutionalized beneficiaries enrolled in Medicare for a full year.
SOURCE: Laschober, et al., *Health Affairs*, February 2002.

New Medicare Part D Benefit



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Medicare Part D Low-Income Subsidies

Subsidies	<100%[1]	<135%[2]	<150%[3]
Monthly Premiums	$0	$0	Subsidy phased out at 150% of FPL
Deductible ($250)	$0	$0	$50
Cost-sharing, Initial Benefit (<$2,250)	$1 generic $3 brand	$2 generic $5 brand	Patient pays 15%
Cost-sharing, Coverage Gap ("Donut Hole")	$1 generic $3 brand	$2 generic $5 brand	Patient pays 15%
Cost-sharing, Catastrophic Benefit (>$5,100)	$1 generic $3 brand	$2 generic $5 brand	$2 generic $5 brand

Notes:
1) Income must be less than $8,980 for individual/$12,120 for a couple. Must also be eligible for Medicaid
2) Income must be <$12,123/$16,362. Must have liquid assets <$6,000 for an individual/$9,000 for a couple
3) Income must be <$13,470/$18,180. Must have liquid assets <$10,000/$20,000

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Case Example: Average Beneficiary

Previous Drug Spending	$1,560
Negotiated Savings	($234)
New Drug Spending	$1,326
New Premium Costs	$420
New Out-of-Pocket Drug Spending	$519
Amount Covered by Plan	($807)
Annual Savings to Beneficiary	($621)

Assumptions

- No current Rx coverage
- Income = $24,000
- Takes 3 daily medications
- 2 generic, 1 brand

Notes: Assumes average brand drug retail cost of $90/month, generic drug cost of $40/month, average net negotiated discount of 15%

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Case Example: Low-Income Beneficiary

Previous Drug Spending	$3,120
Negotiated Savings	($468)
New Drug Spending	$2,652
New Premium Costs	$0
New Out-of-Pocket Drug Spending	$168
Amount Covered by Plan	($2,484)
Annual Savings to Beneficiary	($2,952)

Assumptions

- No current Rx coverage
- Income = $12,000
- Little savings, <$6,000
- Takes 4 daily medications
- 2 generic, 2 brand

Notes: Assumes average brand drug retail cost of $90/month, generic drug cost of $40/month, average net negotiated discount of 15%

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Case Example: High Cost Patient

Previous Drug Spending	$20,240
Negotiated Savings	($3,036)
New Drug Spending	$17,204
New Premium Costs	$420
New Out-of-Pocket Drug Spending	$4,205
Amount Covered by Plan	($12,999)
Annual Savings to Beneficiary	($15,615)

Assumptions

- No current Rx coverage
- Income = $36,000
- Takes 9 daily medications
- 4 generic, 4 brand, 1 biologic

Notes: Assumes average brand drug retail cost of $90/month, generic drug cost of $40/month, biologic cost of $5,000/year and average net negotiated discount of 15%

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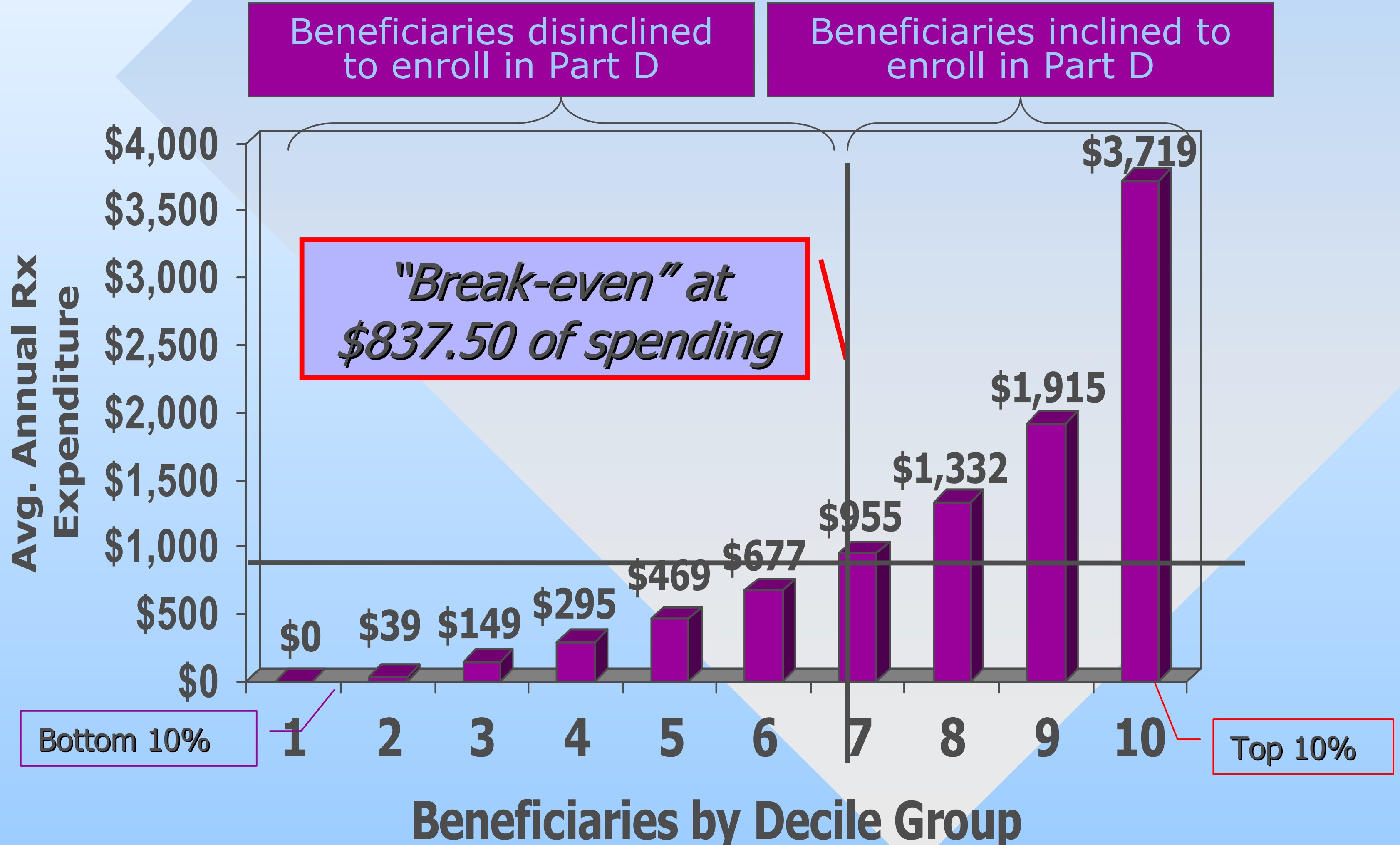
Beneficiary Break-Even Under Drug Benefit

Limited Benefit to More Than 2/3s of Beneficiaries – Potential for Adverse Selection



Potential for Adverse Selection in Part D

Comparison of Income and Medicare Expenditure Distribution in Elderly Population

Illustrates higher usage at lower income, lower usage at higher income

	Income	Income Distribution	Medicare Expenditures	Index
Medigap Buyers	$50,000+	6%	4%	67
	$25-50,000	21%	17%	81
MA HMO Members	$15-25,000	26%	21%	81
	$10-15,000	18%	19%	106
	$5-10,000	24%	34%	142
	$5,000<	4%	6%	150

Source: CMS

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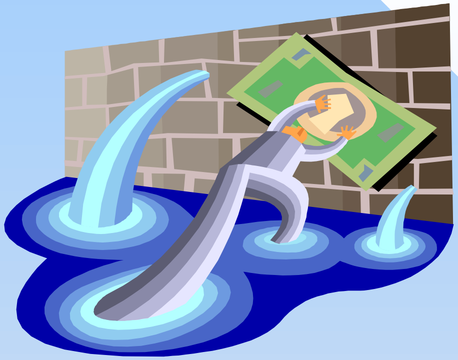
Reimbursement to MA Plans



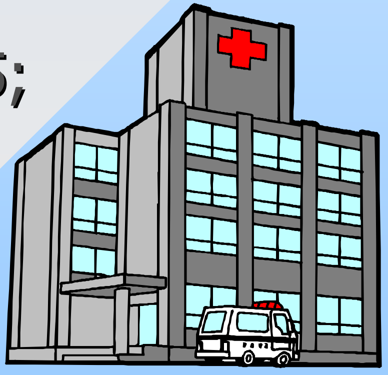
- In 2004, M+COs would be paid at the greater of:
  - 100% FFS
  - Blended rate of national and local (including VA/DOD)
  - Floor payment rate (2/3 of counties)
  - 2% or national per capita M+C growth percentage
- Rates increase by national per capita MA growth rate thereafter (min. 2%, est. 3.7%) – improves benchmark
- In 2006, competitive bidding begins with "blended benchmark"

MMA: Interim Payment Increases to MA Plans

- $500M increase in 2004, $800M increase in 2005
  - Revised ratebook includes average increase 10.6%
- New funds to be used for 3 approved purposes:
  - Benefit enhancements (Rx, vision, dental, etc.)
  - Reduction in beneficiary out of pocket costs
  - Increased reimbursements to providers to expand networks
- Reluctance to significantly expand Rx benefits due to adverse selection concerns

Notable Provider Provisions

- Significant expansions of cost-based reimbursement designations, especially rural.
- Hospital update set at market basket for FY 04; -0.4% in FY05-07 if hospital did not provide quality data to CMS.
- Physicians receive 1.5% increase in 2004 and 2005.
- 7-year freeze on lab payments.
- DME frozen 2004-2006.
- AWP –15% for most in 2004; ASP +6% in 2005; ASP + 6% or competitive bidding in 2006
- No copay for home health.



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MMA: Impact of Interim Payment Increases to MA Plans – Some Examples

State	County	2003 Total	Rescaling Factor	2003 Risk-Adjusted Rate	2004 Total	Rescaling Factor	2004 Risk-Adjusted Rate	Change 2003-2004
FL	DADE	$ 850.88	0.97	$ 825.77	$ 904.51	0.87	$ 788.25	-5%
FL	HILLSBOROUGH	$ 564.10	1.06	$ 599.95	$ 638.19	0.99	$ 634.53	6%
GA	COBB	$ 591.53	1.01	$ 599.95	$ 628.81	1.01	$ 634.53	6%
AL	MOBILE	$ 601.71	1.00	$ 599.95	$ 666.77	1.05	$ 697.43	16%
AL	MONTGOMERY	$ 564.10	1.06	$ 599.95	$ 613.89	1.03	$ 634.53	6%
SC	CHARLESTON	$ 564.10	1.06	$ 599.95	$ 619.38	1.02	$ 634.53	6%
AZ	PIMA	$ 564.10	1.06	$ 599.95	$ 613.89	1.03	$ 634.53	6%
CA	LOS ANGELES	$ 707.96	1.01	$ 715.76	$ 752.58	1.01	$ 758.57	6%
CO	DENVER	$ 572.90	1.05	$ 599.95	$ 613.89	1.05	$ 643.42	7%
IL	CHAMPAIGN	$ 510.38	1.06	$ 542.80	$ 555.42	1.03	$ 574.10	6%
IA	DES MOINES	$ 510.38	1.06	$ 542.80	$ 555.42	1.03	$ 574.10	6%
KS	WICHITA	$ 510.38	1.06	$ 542.80	$ 591.36	1.06	$ 628.77	16%
LA	ST TAMMANY	$ 717.89	0.95	$ 680.14	$ 831.04	0.94	$ 782.95	15%
MA	MIDDLESEX	$ 647.44	1.01	$ 653.56	$ 718.59	0.97	$ 698.00	7%
MI	KALAMAZOO	$ 564.10	1.06	$ 599.95	$ 613.89	1.03	$ 634.53	6%
NY	NEW YORK	$ 810.96	1.07	$ 868.59	$ 862.07	0.98	$ 844.15	-3%
PA	CHESTER	$ 593.31	1.02	$ 603.47	$ 659.65	0.96	$ 634.53	5%
TX	BEXAR	$ 564.10	1.06	$ 599.95	$ 654.10	1.10	$ 718.31	20%
WA	SPOKANE	$ 564.10	1.06	$ 599.95	$ 613.89	1.03	$ 634.53	6%

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Long-Term Survival Tactics

- Product Design
  - Increase likelihood of average selection into selected product
- Product Portfolio
  - Expand market share, balance risk across products by appealing to multiple income segments.
- Disease Management
  - More effectively manage costs of high-risk patients while reducing “hassle factors” for low-risk members

Beneficiary's Choice for Drug Coverage: 2006

County-Based HMO, grandfathered PPOs

"Fallback" Drug Plan (only if no risk plans)

Specialty MA Plans

Region-Based PPO

Region-Based Prescription Drug Plan (PDP)

Employer-Sponsored Rx Coverage w/subsidy

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Regional Plans (PPOs/PDPs)

- CMS will establish 10-50 MA Regions. Minimum size likely: a whole state.
- PPOs and Prescription Drug Plans (PDPs) can serve one or more regions.
- Beneficiary lock-in applies in 2006 onward
- Sweeteners to encourage plan participation:
  - Blended benchmark (allows bids to influence final payment rate)
  - Stabilization and network adequacy funds
  - Risk corridors for Parts A, B and D
  - PPOs licensed in one state in region waives out of other state licensure laws

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Regional PPOs and Fallback Plans

- Many PPOs will resort to consortia of leased or subcontracted networks.
- PPOs may contract with CMS on local basis
  - Local MA PPOs not required to offer standard Part D benefit (all other local plans are)
- CMS can contract for fallback plans if don't achieve 2 plans per region
  - Fallback plan must offer benefit, paid actual costs of drugs and management fees.
    - 1 fallback/region, 3 years
    - like carrier/FI contract

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Part D Subsidies

- Will cover approximately 75% of cost of providing standard drug benefit
- Direct subsidies and reinsurance:
  - Subsidies based on average expected cost of providing drug benefit (standardized bid amount minus premium)
  - Reinsurance for 80% of costs over catastrophic threshold (plan absorbs remaining 15%)

Drug Benefit: Notable Provisions

- MA plans and PDPs must offer at least one package that provides standard Part D coverage or actuarial equivalent
  - May not offer less coverage or impose greater cost-sharing than under standard package
- "Any willing pharmacist" – plan must reimburse any agreeing to reimbursement rate
- Prohibition on exclusive mail order
  - Community pharmacists may dispense 90-day supply

Drug Benefit: Notable Provisions

- "Incurred costs" include:
  - Deductible
  - Premiums
  - Cost-sharing payments
  - Purchases in the "donut hole"

- Do NOT include:
  - Costs paid by plan towards out of pocket threshold
  - purchase of drugs not covered under formulary
- Plans therefore lack incentive to offer more extensive coverage that would postpone triggering of catastrophic coverage – *CMS reinsures 80% of costs above $3,600*

Retiree Plans

- Employers to receive subsidy worth 28% of drug costs $250-5,000, tax-exempt, IF match or exceed standard coverage.
- Retiree Rx plans "must have maximum flexibility on plan design, formularies, and networks."
- Employers can provide premium subsidies and cost-sharing assistance for retirees enrolling in PDPs or integrated MCOs.
- Employers can negotiate preferential premiums from integrated plans.

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Employer Options for Retiree Health Costs

- Contract directly with CMS
- Self-insure
- Buy supplemental coverage
- Contract with local Medicare Advantage plans/PDPs
- Combination of above

Dual Eligibles

- Federal government assumes duals' Rx costs over 10-year period; states maintain 75% LOE
- Full dual-eligibles gain access to Medicare Part D in 2006
- State Medicaid programs can provide coverage for drugs not covered by Medicare and receive federal matching funds
- QMBs, SLMBs & QI-1s would be eligible for Part D and may be eligible for low income premium and cost sharing subsidies
- QI-1 program extended through September 2004
- Cost-sharing and premium assistance to 150% FPL with no gap in coverage
- Emphasis on LTC, home and community-based services

Upcoming Medicare Experiments

- Disease Management Demos:
  - Population-Based: FFS, Chronic Care Improvement Demonstration
    - Q1 2004 solicitation
    - $50-150 PMPM fees for DM services
      - Portion of fees at-risk for poor performance
    - Minimum 10,000 beneficiaries with targeted conditions in service area
    - Focus on CHF, diabetes, COPD (CMS may add others)
    - 90-day turnaround to submit application
    - Will be implemented nationally if success in 3 years

Opportunities for Health Plans and Insurers

- Medicare PPOs
  - Local before 12/05
  - Regional: Leased networks via "consortia"
  - Regional: Subcontracting via "consortia"
- County-based Medicare HMO
- Private Fee-for-Service (beware "deemed" network)
- PDP plan
- K&L "gap" insurance
- Health Savings Accounts (HSAs)
- Fallback plan (if pursue no MA option)

Medicare Product Options Spectrum

HMO

- Heavily managed
- Restrictive network
- Cost vs. Access

Private FFS

- Unmanaged
- "Deemed" network
- Value vs. Supp
- No Rx coverage

PPO

- Loosely managed
- Broad network
- Value vs. Supp
- ***Broadest appeal***

HSAs

- Unmanaged
- "Risk-segregating"
- No Rx coverage

Medigap/Select

- Unmanaged
- Access vs. Cost
- Can't sell to Part D
- Leaves $ on table
- Increasingly less attractive

Low-income beneficiaries — Market — High-income beneficiaries

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Product Decision Score Card (Market): An Example

Grades: Excellent (2), Good (1), Fair (-1), Poor (-2)

	PPO	HMO	PFFS	HSA	SUPPS	RX CARD	PART D
FINANCIAL							
Revenue/Cost	1	-1	1	0	0	2	-2
Premium Capacity	1	-2	-1	1	-1	-2	-2
Acquisition Cost	1	-1	1	1	-1	-1	-1
Admin Cost	1	1	1	1	1	-2	1
DEMOGRAPHICS							
Total Eligible	2	2	2	2	2	2	2
High Income Mix	2	0	2	2	2	2	2
Low Income Mix	0	2	0	0	0	1	1
Age Mix	1	-1	1	2	1	-1	-1

Product Decision Score Card (Market): An Example

Grades: Excellent (2), Good (1), Fair (-1), Poor (-2)

	PPO	HMO	PFFS	HSA	SUPPS	RX CARD	PART D
COMPETITION							
Mkt. Development	2	-2	1	2	-1	-1	1
Market Share	0	-1	0	0	1	1	0
Geo. Dist.	2	-2	2	2	-1	1	2
Price&Benefit	2	-1	1	1	-2	-1	-1
NETWORK							
Contract Model	1	-1	1	1	-2	1	1
# Doc/Spec.	2	2	-1	2	2	2	2
#Facility By Type	2	2	-1	2	2	2	2
Geo Access	2	2	-1	2	2	2	2
TOTAL POINTS	22	-1	9	21	5	8	9

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Product Decision Score Card (Core Competencies): An Example

Grades: Strength (S), Weakness (W), Unknown (U), N/A

	PPO	HMO	PFFS	HSA	SUPPS	RX CARD	PART D
CONTRACT							
Model	S	W	N/A	S	N/A	S	S
Risk Sharing	S	W	N/A	S	N/A	N/A	N/A
Access	S	S	N/A	S	N/A	S	S
MARKETING							
Acquisition Cost	S	S	U	U	W	S	S
Lead Cost	S	S	U	U	W	S	S
Close Ratio	S	S	U	U	W	U	U
Rapid Disenroll Rates	U	W	U	U	W	U	U
Disenrollment Rates	U	W	U	U	W	U	U

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Product Decision Score Card (Core Competencies): An Example

Grades: Strength (S), Weakness (W), Unknown (U), N/A

	PPO	HMO	PFFS	HSA	SUPPS	RX CARD	PART D
ADMINISTRATION							
Enrollment Process	S	S	S	S	S	S	S
Claim Pay	S	S	S	S	S	S	S
Receivables	S	S	S	S	S	S	S
Customer Service	W	W	S	S	S	S	W
Reconciliation	W	W	U	N/A	N/A	N/A	U
MEDICAL MANAGEMENT							
Admits	U	W	U	U	W	N/A	N/A
LOS	N/A	S	N/A	N/A	N/A	N/A	N/A
Disease Management	S	S	N/A	N/A	N/A	N/A	N/A
Readmission Rate	S	S	N/A	S	N/A	N/A	N/A

Product Decision Score Card (Core Competencies): An Example

Grades: Strength (S), Weakness (W), Unknown (U), N/A

	PPO	HMO	PFFS	HSA	SUPPS	RX CARD	PART D
COMPLIANCE							
Appeals/Grievances	S	S	S	N/A	N/A	S	S
Special Status Tracking	S	S	U	U	N/A	S	S
Market Integrity	S	S	S	S	S	S	S
Regulations Reporting	S	S	S	S	S	S	S
FINANCE							
Accounting	S	S	U	U	S	S	U
Budget Management	S	S	U	U	S	S	U
Allocations	S	S	U	U	S	N/A	U
Taxes	S	S	U	U	S	N/A	U

Conclusions

- Medicare Advantage will expand in 2004.
- Begin positioning now for 2006.
- Specter of adverse selection looms large:
  - Develop product portfolio designed to balance risk selection.
  - Improve disease management infrastructure to better manage costs.

How to Reach Us

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