

Plan Participation In Medicare+Choice

From 1991 to 1998 there was a steady increase in the number of organizations with Medicare risk contracts, with a greater than three-fold increase in the number of contractors in that time period.¹

Year (July data for Interstudy; December for Medicare)	Number of HMOs	Medicare Risk Contracts	Risk Contracts as % of HMOs	Non-Renewals	Non-Renewals as % of Total
1985	393	87	22%	3	3%
1986	595	149	25%	7	5%
1987	662	161	24%	29	18%
1988	643	154	24%	34	22%
1989	590	131	22%	38	29%
1990	556	96	17%	14	15%
1991	559	93	17%	12	13%
1992	560	96	17%	8	8%
1993	555	110	20%	4	4%
1994	543	148	27%	1	1%
1995	562	181	32%	0	0%
1996	630	241	38%	2	1%
1997	651	307	47%	8	3%
1998	652	346	53%	43	12%
1999		303		41	14%

At the beginning of 1999, for the first time since the end of the 1980s, the number of Medicare managed care risk contractors declined from the previous year. At the end of 1998, 45 contracts were terminated. There were 16 new contracts signed with effective dates in 1999, resulting in a net decline of 29 contracts between 1998 and 1999.

In 2000, there will also be a decline in the number of Medicare+Choice contractors, with 41 Medicare+Choice plans not renewing their contracts. There are 12 new coordinated care plan (CCP) contracts pending, resulting in a net change of 29 fewer contracts in 2000.

From 1990 through 1997, on average only six organizations left the risk program each year. However, in the late 1980s, there were large numbers of non-renewals, mirroring a decline in the number of HMOs operating in the United States.

¹Note that one organization can have multiple Medicare contracts; so that the percentage of HMOs in the Nation with risk contracts is a number to be used with caution. However, the trend over the years is clear: more HMOs participate in Medicare. Changes in the numbers of HMOs can also be due to mergers and acquisitions, some of which result from poorer-performing HMOs being bought out by stronger HMOs.

Payment Rates for Non-Renewing Plans

Beneficiaries residing in low-payment counties were disproportionately affected by non-renewals at the end of 1999. Three-quarters of enrollees affected by non-renewals live in areas in which the 2000 payment rate will be less than \$550, while nationally 50% of M+C enrollees reside in such counties.

Large increases in payment rates from 1999 to 2000 in low-payment areas were not sufficient to retain M+C contractors. For areas with payment rates in the \$450-500 range in which the payment increases for 2000 will exceed 10%, 11.1% of beneficiaries were affected by disenrollments compared to 5.1% of beneficiaries affected by non-renewals nationwide.

Beneficiary Access to Plans

Beneficiary access to an M+C plan in their area declined between 1999 and 2000, from the 1999 level of 72% to a 2000 level of 67%. Several States saw declines in the percentage of beneficiaries with access to M+C plans of 15 or more percentage points: Louisiana, Maryland, West Virginia and New Hampshire. (New plans with pending applications or new service area expansions increase access by about 1.5% nationwide, including "abandoned" that have new plans entering the county (listed as "replaced" in the table below), and counties that had not previously had any M+C plan. The States mentioned as having significant declines in availability of plans are generally not benefitting from new entrants in the market.)

Rural areas have been particularly affected by plan withdrawals: 16% of rural M+C enrollees have been affected by withdrawals for 1999 (including service area reductions), yet only 5% of M+C enrollees nationally have been affected.

The table below shows that in some counties new contractors are replacing departing M+C plans in cases in which the departing plan was the only M+C plan available in the county (counties that would otherwise be "orphaned" or abandoned counties). The counties for which there will be new M+C contractors have payment rates that are 16% *lower* than counties for which no M+C contracts are pending, but the very lowest payment counties in the "replaced" group tended not to offer drug coverage and charged a higher premium.

Count	Category (1999 Non-Renewal Status and Whether the Departing Plan Offered Drug Coverage in the County)	Number of Beneficiaries In Affected Counties	Average Member Premium	1999 Payment Rate	1999 Payment Plus Premium	% of Revenue from Premium	Payment Increase, 1999 to 2000
14	orphans replaced	168058	\$ 16.79	\$ 426.80	\$ 443.59	3.8%	6.5%
97	orphans unreplaced	1085374	\$ 33.40	\$ 443.03	\$ 476.43	7.0%	6.1%
29	orphans; no drugs; unreplaced	532826	\$ 27.00	\$ 428.10	\$ 455.10	5.9%	6.7%
68	orphans; drugs; unreplaced	552548	\$ 36.13	\$ 449.39	\$ 485.52	7.4%	5.9%
7	orphans replaced; drugs	122059	\$ 14.29	\$ 452.31	\$ 466.60	3.1%	5.2%

7 orphans replaced; no drugs	45997	\$ 19.29	\$ 401.29	\$ 420.58	4.6%	7.8%
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[THE FOLLOWING NEEDS TO BE UPDATED BASED ON INFORMATION ABOUT PENDING PLANS.] There are not significant changes in the proportion of beneficiaries with multiple M+C options available. Among beneficiaries with at least one M+C option in their area in 2000, about 18% will have one or two options available (about the same proportion as 1999), and 82% will have three or more options available. There will be 229 counties in which beneficiaries will have a choice of six or more plans, up from 212 in 1999, with an additional 350,000 beneficiaries included in the group with six or more options.

Premiums and Benefit Costs

In 1999, 19% of counties had zero premium plans. In 2000, only 12% of counties will have zero premium plans. There are 180 counties that had a \$0 premium product in 1999 that will no longer have zero premium plans in 2000. There are also 8 counties that did not have a \$0 premium plan in 1999 but will for 2000.

While in 1999, a majority of plans charged \$20 or less per month as the premium for the basic plan, in the year 2000, nearly half of plans will have premiums of \$40 or more per month.

For 2000, half of the plans in rural areas will have premiums of \$60 or more per month for the basic benefit package. In 1999, half of plans offered in rural areas had premiums of \$40 or less per month.

Overall in the US, the average monthly premium in M+C basic plans across all States (weighted by the beneficiary population) will double, going from \$18 to \$35. The difference in premiums between rural areas and urban areas will not be as great as in the past: in 1999, weighted average premiums in rural areas were nearly twice as high as urban area premiums (\$29 versus \$16.50). In 2000, rural premiums are converging with urban levels; rural premiums will only be about 20% higher than urban premiums for basic benefit plans (\$42 versus \$35).

Although premiums have risen, and fewer plans are participating, the average reported monthly value of non-Medicare benefits included in basic benefit packages has declined only slightly, from \$52.30 in 1999, to \$51.04 in the year 2000. Non-renewing plans offered higher levels of non-covered benefits, as shown below.

In addition to increasing premiums in 2000, plans will be relying on copayments to produce more revenue in 2000 [I assume numbers will show this], and the average cost to the plan for the drug benefit they will be offering will decline.

(MONTHLY)	All Plans, 1999	Non-Renewing Plans	All Plans, Yr 2000
Average Premium for Basic Package	[need fill-in]	\$22.00	

Weighted Average Premium			
Median Premium			
Average Copay Revenue		\$25.00	
Average Value of Drug Benefit		\$40.00	
Average Value of Other Benefits	\$52.00	\$59.00	\$51.00

Drugs in the Basic Benefit Package

The percentage of plans offering drugs (over a smaller base of available plans) remained about the same, declining slightly from 77% to 75%. However, this is the first year in the history of the program (? check) that there has been a decline in the percentage of plans including drugs in the basic package.

Premium Costs for Drug Coverage

What beneficiaries will have to pay for the drug benefit will increase significantly in 2000, and the level of coverage declined.

While in 1999 over half of plans offering drugs in their basic package charged no premium (zero premium plans), in 2000 only about one-fourth of plans offering drugs will be zero-premium plans.

In 1999 an additional one fourth of plans offering drugs in the basic package had monthly premiums of less than \$40, and therefore three-quarters of plans had drug coverage for less than a \$40 per month premium. In 2000, nearly half of all plans will have premiums of over \$40 for basic packages that include drug coverage.

In rural areas in 1999, fewer than 10% of plans offering drugs in the basic package had premiums of \$80 or more. In 2000, over one-third of rural plans offering drugs will have a premium of \$80 or more.

Limits on the Level of Drug Coverage

In 2000, among plans with limits on drug coverage, more plans will provide unlimited generic coverage but limited brand coverage than in 1999.

In 1999, the majority of plans (74%) with prescription drug limits imposed limits on both generic and brand drugs, while 26% provided unlimited generic coverage but limited brand coverage.

In 2000, 55% of plans with limits on prescription drug coverage provided unlimited generic coverage while limiting brand coverage and 45% limited both generic and brand coverage. **[DOES THIS MEAN THERE ARE NO PLANS PROVIDING UNLIMITED GENERIC AND BRAND, AS THE PLANS IN BOTH MIAMI-DADE AND LOS ANGELES OFFERED IN 1999?]**

Copayments for Drug Coverage

While about 72% of plans had copayments for generic drugs of \$10 or less in 1999, the percent will decline to 52% in the year 2000. More plans will set copayments for generic drugs in the \$10 to \$15—the percent with generic copays in this range will almost double, going from 23% to 44%.

Copayments for brand name drugs will continue to fall predominately within the the \$15 to \$25 and up range (stable at 89% of plans between 1999 and 2000).

Use of Formularies

The use of formularies among M+C plans will increase by 10% between 1999 and 2000. While in 1999, 78% of plans indicated they were using formularies, for 2000 the percent of plans indicating that they will be using formularies is 85%.

Other Benefits

Between 1999 and 2000 there will be slight declines in the level of coverage for other additional benefits not covered under Medicare, such as dental coverage, vision coverage and hearing aids. There is an 8% increase in the number of plans not offering dental benefits, and a 3% decline in the number of plans not offering vision benefits.

Parallels in the Private Sector

In the last two to three years, managed care organizations in the private sector have faced higher costs for providing care—in particular, higher drug costs—and declining profitability. This has resulted in the need to scale back expansion into new markets and new products, the need to increase premiums at substantially higher levels than in the mid-1990s, and the need to restrict benefits or otherwise attempt to control utilization costs, particularly for drugs.

Over the last two years, the Federal Employees Health Benefits Program, which covers 9 million people, has seen the same kinds of changes that the M+C program has experienced. At the end of 1998, about 20% of participating HMOs withdrew from the FEHB program. At the end of 1999, it is expected that about 13% of plans will withdraw from FEHBP. Premiums in FEHBP increased in by slightly over 10% for 1999 and by 8.5% for 1998.

Another large sponsor of employment-based health insurance, the California Public Employees Retirement System (CalPERS), which covers over 1 million people, agreed to an average rate of HMO premium increases for 1/1/99 of 7.3%. For 1/1/2000, CalPERS has granted an increase to its HMOs of over 9.7%.

Chris -

debunking the myths -

increasing rate of enrollment 1995-9

2.7 to 6.2 increases 98-99 8.27
1995 1999

for 2002

no projection of enrollment

According to a January, 1999 Towers-Perrin press release, large employers experienced a 7% increase in average health insurance premiums for active workers in 1999, owing to "unusually sharp increases in prescription drug costs and a health care market that continues to experience rising demand for services from an aging population." One finding in the survey was that rate increases for HMO products in 1999 equalled or exceeded the increases for traditional indemnity plans.

Because of concern over drug costs, many managed care plans are opting for a three-tiered copayment structure to control drug costs for their commercial as well as Medicare products (variation in copayments based on generic, brand, and off-formulary drugs). According to a study by Scott Levin, a pharmaceutical consulting company in Newtown, Pa., 50% of managed care plans now have these three-tiered compared to 36% in 1998. (Source: "EMPLOYERS SCRUTINIZE PRESCRIPTION DRUG COSTS," August 9, 1999, Business Insurance via NewsEdge Corporation.)

The rate of increase in the cost of covering drugs may be moderating. A recent report from IMS indicates that in the first quarter of 1999, prescription costs rose at a rate that was 4.2% higher than the first quarter of 1998. The rise was attributed to increasing demand for brand-name drugs and increases in the cost of generic drugs. However, the increase for the first quarter of 1999 is only .3% higher than the rate of increase experienced in the last quarter of 1998. (Source: "IMS HEALTH Reports First Quarter U.S. Prescription Drug Prices Up 4.2 Percent; Annual Price Change Flat Over Fourth Quarter '98," July 16, 1999, London, BW HealthWire via NewsEdge Corporation.)

story that Chris wants out of this report is prob of benefit deterioration; plans pulled out b/c of competition; similar access to MC plans, but benefits are decreasing; plans that pulled out have high rates. no matter what, prob w/ access to MC → prob w/ drugs & preventive care → equity issue.

this report ~~says~~ provides info justifying rate increase; decline in choice contractors; more plans offering drug benefits.

↓
set us up to be the solution; → draft in am → sit on it.

Qb

Jeanne Lambrew
08/16/99 08:05:28 AM

Record Type: Record

To: Pharbage@Hcfa.gov @ inet, Deborah R. Adler/OPD/EOP@EOP

cc:

Subject: M+C report

Hello,

Well, things didn't turn out quite as planned; I have not gotten feedback on the attached document. Hopefully, Chris will weigh in directly later.

The document pulls the facts that I found the most interesting. There are some notes about additional analysis that I would like to see if possible. Additionally, I'd like more on the drug limits - the same breaks by eligibles, and a state by state table showing percent of beneficiaries eligible for: no mc / drug option; eligible for at least one unlimited plan and eligible for limited drug plan only. Since we collapsed the data for unlimited brand only with the unlimited brand and generics, that should be done as well (if you want to show the separate tables, you can show them as well, but we have to show the table that shows up in the drug report).

If there is time, I would also like to see if we could do a correlation analysis between counties where FEHBP plan withdrew and the M+C over the last several years. This will take data from OPM and time, so it should only be done if we delay this for whatever reason (although I think we should set the analysis up regardless because it is interesting).

Finally, in terms of the structure / content of the summary, I think that you should pull the private trends section into the plan participation section, since we do not have data on the benefit changes in the private section. It also can be part of this section (since it is not really about M+C).

Also, you should tone down/eliminate references to high drug costs causing the large premium increases / problems.

On the withdrawal section, the points made here seemed quite different than those made in the testimony and Mike's statement - I thought that the data suggest that payment does not appear to be causal. If so, this needs to be changed.

On the benefits section - clearly, we need more on drugs. The words that were in the testimony were good, so you can probably use those plus the new facts.

Finally, you might want to add a conclusion section that does the qualitative assessment that was in the testimony plus reference the President's plan.

That's it for now - sorry for the delay and thanks for your patience.

PS -- Deborah, can you make sure that CHRIS got the fax (I sent other things yesterday) and that he reviews this and the HHS 5-pages today? Thanks

DRAFT: Highlights of the Medicare + Choice in 2000 Report

Managed Care Remains an Important and Growing Part of Medicare

- A growing number of Medicare beneficiaries have chosen to enroll in managed care. Enrollment in managed care doubled in the last four years (from 3.4 million in 1995 to 6.9 million in 1998). Although the rate of enrollment growth has slowed somewhat in recent years, it still increased by nearly 8 percent in 1999. [can we show this by state, rural? This is not new, but it helps put the withdrawals in context].
 - The number of plans participating in Medicare has declined, although these changes are typical of what is happening in the private sector. In 2000, there will be a decline in the number of Medicare+Choice contractors with 50 plans (11 percent) not renewing their contracts. This is larger than in previous years; on average only 6 plans left the program in each year between 1990 and 1997. Yet, it is similar to what has occurred in the private sector. In the last 2 to 3 years, premiums and the volatility of the private sector has increased, resulting in scaling back in expansions for managed care plans. For example, about 13 percent of plans withdrew from the Federal Employees' Health Benefit Program in 1999, despite average premium increases of 10 percent.
 - Most plans withdrawing from Medicare would have received high rates or rate increases. Half of the beneficiaries affected by projected withdrawals live in counties where the payment rate will be \$500 or more. [what is the weighted average payment rate? How many plans are above / below it? This should help put in context the question of whether low-cost areas were disproportionately affected] Only about 20 percent of beneficiaries affected by these withdrawals will have no other managed care choices. And, even in the low-cost areas, rates will increase by more than 10 percent. This suggests that inadequate payment rates were not the sole reason for withdrawals.
- ### Access to Managed Care Will Decline
- Access to Medicare managed care will decline in 2000. In 1999, 30 percent of beneficiaries - 12 million -- lacked access to managed care but in 2000, 32 percent or nearly 13 million will have no access. Another 2.3 million will have access to only one plan option.
 - ° This is particularly pronounced in rural areas. Only 1 in 5 rural beneficiaries - 21 percent - will have access to one or managed care plans in 2000, down from 23 percent in 1999. Only 14 percent or 1.3 million of all rural Medicare beneficiaries will have a choice of managed care plans.
 - ° Some states will see even greater restrictions on access. The proportion of beneficiaries with access to managed care will drop by at least 15 percent in Louisiana, Maryland, New Hampshire and West Virginia. [can we get a state by state table?]
 - Plans with no competition typically have higher premiums and low benefit. About 52 percent of beneficiaries with access to only one plan will pay \$40 or more per month to join that plan, compared to 18 percent overall. [Would like to know whether we can get proportion of people in counties with only one plan who have access to drugs compared to overall and the comparison of the drug generosity]

Premiums and Cost Sharing Are Rising

- Premiums for managed care have grown rapidly. The average monthly premium for Medicare managed care plans will double in 2000, from \$18 to \$35. The proportion of plan with premiums less than \$40 per month has decreased from 89 percent in 1997 to 55 percent in 2000. In 2000, 180 counties in 26 states will no longer have managed care plans with no premiums.
- ° Premiums vary dramatically from state to state - from \$12 per month in Texas to \$121 per month in Minnesota.
- ° Although prices are typically lower in rural areas, premiums in rural areas are higher than those in urban areas in 22 of the 28 states with plans in rural areas.

Benefits Will Deteriorate

- In 2000, the proportion of plans offering extra benefit will decline slightly. While the proportion of plans offering extra benefits like prescription drugs and vision services has increased in recent years, the projections for 2000 suggest that this trend has reversed - the proportions of plans offering prescription drugs, vision or dental services in 2000 are lower than those of 1999 (prescription drugs will decline from 77 to 75 percent; vision services from 94 to 91 percent; and dental services from 52 to 48 percent of plans).
- Most prescription drug benefits are limited and those limits will lower in 2000. In 2000, over 85 percent of plans' drug benefits will be limited, down from 93 percent in 1999. However, limits for plans that use them will drop. The proportion of plans with annual spending limits of \$1,000 or less will increase from 57 to 60 percent. More dramatically, the proportion of plans with limits of \$500 or less will increase by nearly 50 percent - from 19 to 27 percent.
- Although a slightly higher percent of rural plans offer unlimited prescription drug coverage (16 percent), they tend to have lower limits. In 2000, 32 plans will offer prescription drugs to Medicare beneficiaries. About 63 percent will limit this coverage to \$1,000 or less - higher than the national average. Only about 1.4 million or 15 percent of rural beneficiaries will have access to these plans.

DRAFT: HIGHLIGHTS OF THE MEDICARE+CHOICE IN 2000 REPORT

MANAGED CARE REMAINS AN IMPORTANT AND GROWING PART OF MEDICARE

- **A growing number of Medicare beneficiaries have chosen to enroll in managed care.** Enrollment in managed care doubled in the last four years (from 3.4 million in 1995 to 6.9 million in 1998). Although the rate of enrollment growth has slowed somewhat in recent years, it still increased by nearly 8 percent in 1999. *[can we show this by state, rural? This is not new, but it helps put the withdrawals in context]*
- **The number of plans participating in Medicare has declined, although these changes are typical of what is happening in the private sector.** In 2000, there will be a decline in the number of Medicare+Choice contractors with 50 plans (11 percent) not renewing their contracts. This is larger than in previous years; on average only 6 plans left the program in each year between 1990 and 1997. Yet, it is similar to what has occurred in the private sector. In the last 2 to 3 years, premiums and the volatility of the private sector has increased, resulting in scaling back in expansions for managed care plans. For example, about 13 percent of plans withdrew from the Federal Employees' Health Benefit Program in 1999, despite average premium increases of 10 percent.
- **Most plans withdrawing from Medicare would have received high rates or rate increases.** Half of the beneficiaries affected by projected withdrawals live in counties where the payment rate will be \$500 or more. *[what is the weighted average payment rate? How many plans are above / below it? This should help put in context the question of whether low-cost areas were disproportionately affected]* Only about 20 percent of beneficiaries affected by these withdrawals will have no other managed care choices. And, even in the low-cost areas, rates will increase by more than 10 percent. This suggests that inadequate payment rates were not the sole reason for withdrawals.

ACCESS TO MANAGED CARE WILL DECLINE

- **Access to Medicare managed care will decline in 2000.** In 1999, 30 percent of beneficiaries - 12 million -- lacked access to managed care but in 2000, 32 percent or nearly 13 million will have no access. Another 2.3 million will have access to only one plan option.
- **This is particularly pronounced in rural areas.** Only 1 in 5 rural beneficiaries - 21 percent -- will have access to one or managed care plans in 2000, down from 23 percent in 1999. Only 14 percent or 1.3 million of all rural Medicare beneficiaries will have a choice of managed care plans.
- **Some states will see even greater restrictions on access.** The proportion of beneficiaries with access to managed care will drop by at least 15 percent in Louisiana, Maryland, New Hampshire and West Virginia. *[can we get a state by state table?]*

- **Plans with no competition typically have higher premiums and low benefit.** About 52 percent of beneficiaries with access to only one plan will pay \$40 or more per month to join that plan, compared to 18 percent overall. *[Would like to know whether we can get proportion of people in counties with only one plan who have access to drugs compared to overall and the comparison of the drug generosity]*

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- **Premiums vary dramatically from state to state.** Premiums vary dramatically from state to state - from \$12 per month in Texas to \$121 per month in Minnesota.
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BENEFITS WILL DETERIORATE

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- **Although a slightly higher percent of rural plans offer unlimited prescription drug coverage (16 percent), they tend to have lower limits.** In 2000, 32 plans will offer prescription drugs to Medicare beneficiaries. About 63 percent will limit this coverage to \$1,000 or less - higher than the national average. Only about 1.4 million or 15 percent of rural beneficiaries will have access to these plans.

Medicare + Choice Premium and Rx Benefit Analyses

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 - E. Information by number of Medicare Eligibles

Note: The following pages contain preliminary information based on an analyses of the AGC/BIF data for Medicare + Choice organizations. Analyses is based on an overview of Medicare + Choice organizations only and does not reflect other managed care prepaid arrangements (e.g. section 1876 cost contracts, Health Care Prepayment Organizations, and other arrangements). Information is based on data received as of 8/1/99 and is subject to change.

Very Kratt

Plan Participation in Medicare+Choice

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At the beginning of 1999, for the first time since the end of the 1980s, the number of Medicare managed care risk contractors declined from the previous year. At the end of 1998, 43 organizations left the program. @XX new organizations began contracting in 1999, resulting in a net change between 1998 and 1999 of XX organizations with M+C contracts.

In 2000, there will also be a decline in the number of Medicare+Choice contractors, with 41 Medicare+Choice plans not renewing their contracts. There are XX new contracts pending, resulting in a net change of XX fewer (?) contracts in 2000.

From 1990 through 1997, on average only six organizations left the risk program each year.

Payment Rates for Non-Renewing Plans

Beneficiaries residing in low-payment counties were disproportionately affected by non-renewals

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①

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While in 1999, a majority of plans charged \$20 or less per month as the premium for the basic plan, in the year 2000, nearly half of plans will have premiums of \$40 or more per month.

For 2000, half of the plans in **rural areas** will have premiums of \$60 or more per month for the basic benefit package. In 1999, half of plans offered in rural areas had premiums of \$40 or less per month.

Overall in the US, the average monthly premium in M+C basic plans across all States (weighted by the beneficiary population) will double, going from \$18 to \$35. The difference in premiums between **rural areas** and urban areas will not be as great as in the past: in 1999, weighted average premiums in rural areas were nearly twice as high as urban area premiums (\$29 versus \$16.50). In 2000, rural

premiums are converging with urban levels; rural premiums will only be about 20% higher than urban premiums for basic benefit plans (\$42 versus \$35).

Although premiums have risen, and fewer plans are participating, the average reported monthly value of non-Medicare benefits included in basic benefit packages has declined only slightly, from \$52.30 in 1999, to \$51.04 in the year 2000. Non-renewing plans offered higher levels of non-covered benefits, as shown below.

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Median Premium			
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Average Value of Drug Benefit		\$40.00	
Average Value of Other Benefits	\$52.00	\$59.00	\$51.00

Drugs In the Basic Benefit Package

The percentage of plans offering drugs (over a smaller base of available plans) remained about the same, declining slightly from 77% to 75%. However, this is the first year in the history of the program (? check) that there has been a decline in the percentage of plans including drugs in the basic package.

Premium Costs for Drug Coverage

What beneficiaries will have to pay for the drug benefit will increase significantly in 2000, and the level of coverage declined.

While in 1999 over half of plans offering drugs in their basic package charged no premium (zero premium plans), in 2000 only about one-fourth of plans offering drugs will be zero-premium plans.

In 1999 an additional one fourth of plans offering drugs in the basic package had monthly premiums of less than \$40, and therefore three-quarters of plans had drug coverage for less than a \$40 per month premium. In 2000, nearly half of all plans will have premiums of over \$40 for basic packages that include drug coverage.

In rural areas in 1999, fewer than 10% of plans offering drugs in the basic package had premiums of \$80 or more. In 2000, over one-third of rural plans offering drugs will have a premium of \$80 or more.

Limits on the Level of Drug Coverage

In 2000, among plans with limits on drug coverage, more plans will provide unlimited generic coverage but limited brand coverage than in 1999.

In 1999, the majority of plans (74%) with prescription drug limits imposed limits on both generic and brand drugs, while 26% provided unlimited generic coverage but limited brand coverage.

In 2000, 55% of plans with limits on prescription drug coverage provided unlimited generic coverage while limiting brand coverage and 45% limited both generic and brand coverage. **[DOES THIS MEAN THERE ARE NO PLANS PROVIDING UNLIMITED GENERIC AND BRAND, AS THE PLANS IN BOTH MIAMI-DADE AND LOS ANGELES OFFERED IN 1999?]**

Copayments for Drug Coverage

While about 72% of plans had copayments for generic drugs of \$10 or less in 1999, the percent will decline to 52% in the year 2000. More plans will set copayments for generic drugs in the \$10 to \$15—the percent with generic copays in this range will almost double, going from 23% to 44%.

Copayments for brand name drugs will continue to fall predominately within the the \$15 to \$25 and up range (stable at 89% of plans between 1999 and 2000).

Use of Formularies

The use of formularies among M+C plans will increase by 10% between 1999 and 2000. While in 1999, 78% of plans indicated they were using formularies, for 2000 the percent of plans indicating that they will be using formularies is 85%.

Other Benefits

Between 1999 and 2000 there will be slight declines in the level of coverage for other additional benefits not covered under Medicare, such as dental coverage, vision coverage and hearing aids. There is an 8% increase in the number of plans not offering dental benefits, and a 3% decline in the number of plans not offering vision benefits.

4

Parallels in the Private Sector

In the last two to three years, managed care organizations in the private sector have faced higher costs for providing care—in particular, higher drug costs—and declining profitability. This has resulted in the need to scale back expansion into new markets and new products, the need to increase premiums at substantially higher levels than in the mid-1990s, and the need to restrict benefits or otherwise attempt to control utilization costs, particularly for drugs.

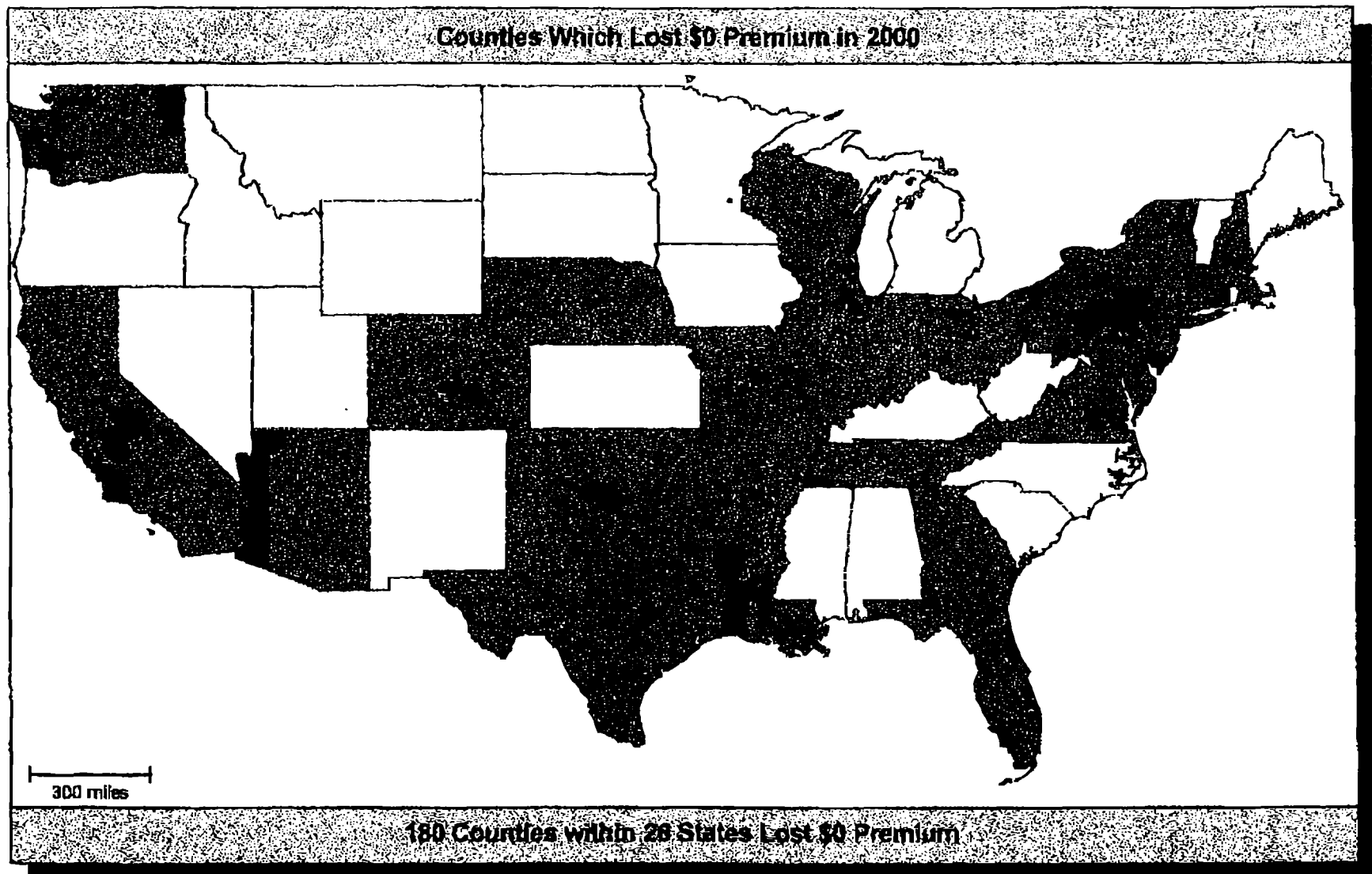
The Federal Employees Health Benefits Program over the last two years has seen the same kinds of changes that the M+C program has experienced. At the end of 1998, about 20% of participating HMOs withdrew from the FEHB program. At the end of 1999, it is expected that about 13% of plans will withdraw from FEHBP. Premiums in FEHBP have also increased in the 10% range or higher in each of the last two years. [WILL CHECK NOS.]

Another large sponsor of employment-based health insurance, the California Public Employees Retirement System (CalPERS), has agreed to average rate increases of over 10% per year in each of the last two years. [WILL CHECK NOS.]

According to a January, 1999 Towers-Perrin press release, large employers experienced a 7% increase in average health insurance premiums for active workers in 1999, owing to "unusually sharp increases in prescription drug costs and a health care market that continues to experience rising demand for services from an aging population." One startling finding in the survey was that rate increases for HMO products in 1999 equalled or exceeded the increases for traditional indemnity plans.



Counties Which Lost \$0 Premium in 2000



■ Counties with \$0 Premium in 1999 but not in 2000

180 Counties within 26 states lost \$0 premium

Medicare + Choice
Weighted Average Premium
By State (weighted by eligibles)

State

	1999	Total	2000
AL	\$ -	\$ -	\$ -
AR	\$ 20.56	\$ 19.62	\$ 20.24
AZ	\$ 12.58	\$ 45.48	\$ 17.20
CA	\$ 31.35	\$ 11.26	\$ 27.38
CO	\$ 18.44	\$ 33.07	\$ 19.16
CT	\$ 27.33	\$ 65.67	\$ 28.51
DC	\$ -	\$ -	\$ -
DE	\$ 30.00	\$ -	\$ 30.00
FL	\$ 38.34	\$ 6.91	\$ 49.34
GA	\$ 5.50	\$ -	\$ 5.20
HI	\$ 68.60	\$ 68.60	\$ 68.60
IA	\$ -	\$ -	\$ -
ID	\$ 35.00	\$ -	\$ 35.00
IL	\$ 12.46	\$ 3.23	\$ 12.23
IN	\$ 36.25	\$ 50.00	\$ 36.52
KS	\$ 28.74	\$ -	\$ 28.74
KY	\$ 21.35	\$ -	\$ 21.35
LA	\$ -	\$ 1.37	\$ -
MA	\$ 15.00	\$ 2.73	\$ -
MD	\$ 8.03	\$ 75.00	\$ 14.30
ME	\$ 52.71	\$ 62.43	\$ 54.12
MI	\$ 19.46	\$ 60.00	\$ 20.27
MN	\$ 119.93	\$ 128.90	\$ 120.25
MO	\$ 16.53	\$ 27.37	\$ 16.90
MS	\$ -	\$ -	\$ -
MT	\$ -	\$ -	\$ -
NC	\$ 26.98	\$ 37.23	\$ 28.24
NE	\$ -	\$ -	\$ -
NH	\$ 12.05	\$ -	\$ 10.80
NJ	\$ -	\$ 22.21	\$ -
NM	\$ 14.02	\$ 22.27	\$ 15.48
NV	\$ 16.79	\$ 45.03	\$ 17.72
NY	\$ 19.51	\$ 26.02	\$ 19.83
OH	\$ 12.61	\$ 24.55	\$ 13.92
OK	\$ 13.29	\$ 13.82	\$ 13.48
OR	\$ 48.96	\$ 62.65	\$ 51.85
PA	\$ 21.07	\$ 27.02	\$ 21.85
RI	\$ 9.56	\$ -	\$ 9.56
SC	\$ 45.00	\$ -	\$ 45.00
TN	\$ 14.92	\$ 22.42	\$ 16.56
TX	\$ 3.75	\$ 13.70	\$ 5.23
VA	\$ 24.35	\$ 30.53	\$ 24.60
WA	\$ 26.00	\$ 40.99	\$ 28.42
WI	\$ 15.05	\$ 15.00	\$ 15.05
WV	\$ 54.62	\$ 38.31	\$ 48.28
US Total	\$ 16.51	\$ 29.02	\$ 17.47

10.95

5.99

1.75

2.58

22.21

21.56

24.8

20.30

12.45

80.27

Medicare + Choice

Premium Ranges for Counties with Access to Only 1 Plan

(analyses by # of Counties)

	1999						2000					
	#	%	#	%	#	%	#	%	#	%	#	%
1) Premium Range (all plans)												
\$0	25	22.9%	48	41.4%	73	32.4%	16	23.2%	35	35.0%	51	30.2%
\$0.01 - \$19.99	-	0.0%	1	0.9%	1	0.4%	-	0.0%	-	0.0%	-	0.0%
\$20.00 - \$39.99	16	14.7%	20	17.2%	36	18.0%	11	15.8%	17	17.0%	28	16.6%
\$40.00 - \$59.99	31	28.4%	20	17.2%	51	22.7%	21	30.4%	23	23.0%	44	26.0%
\$60.00 - \$79.99	12	11.0%	21	18.1%	33	14.7%	7	10.1%	12	12.0%	19	11.2%
\$80.00 - \$99.99	-	0.0%	3	2.6%	3	1.3%	4	5.8%	12	12.0%	16	9.5%
Not Available	25		3	2.6%	28	12.4%	10	14.5%	1	1.0%	11	6.5%
	109	77.1%	116	100.0%	225	100.0%	69	100%	100	100%	169	100%
2) Premium Range (plans w/ Rx)												
\$0	17	38.5%	40	51.3%	57	47.1%	8	30.8%	32	47.1%	40	42.6%
\$0.01 - \$19.99	-	0.0%	1	1.3%	1	0.8%	-	0.0%	-	0.0%	-	0.0%
\$20.00 - \$39.99	9	20.9%	11	14.1%	20	16.5%	7	26.8%	13	19.1%	20	21.3%
\$40.00 - \$59.99	10	23.3%	7	9.0%	17	14.0%	4	15.4%	7	10.3%	11	11.7%
\$60.00 - \$79.99	7	16.3%	17	21.8%	24	19.8%	4	15.4%	8	11.8%	12	12.8%
\$80.00 - \$99.99	-	0.0%	2	2.6%	2	1.7%	3	11.5%	8	11.8%	11	11.7%
	43	100.0%	78	100.0%	121	100.0%	28	100.0%	68	100.0%	94	100.0%

Medicare + Choice
Distribution of Plans
1999

Urban Counties Rural Total Eligibles

	Urban		Counties		Rural		Total		Urban		Rural		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
No M+C plans available	352	39.0%	1987	86.2%	2339	72.9%	4,788,818	15.8%	7,235,295	77.5%	12,024,113	30.3%		
1 or more plans available	551	61.0%	319	13.8%	870	27.1%	25,596,295	84.2%	2,099,737	22.5%	27,696,032	69.7%		
1	94	17.1%	131	41.1%	225	25.9%	1,996,036	7.8%	811,985	38.7%	2,808,021	10.1%		
2	76	13.8%	105	32.9%	181	20.8%	1,392,614	5.4%	613,907	29.2%	2,006,521	7.2%		
3	78	14.2%	46	14.4%	124	14.3%	1,928,395	7.5%	322,722	15.4%	2,251,117	8.1%		
4	64	11.6%	10	3.1%	74	8.5%	2,251,737	8.8%	68,623	3.3%	2,320,360	8.4%		
5	47	8.5%	14	4.4%	61	7.0%	2,328,862	9.1%	123,587	5.9%	2,452,449	8.9%		
6+	190	34.5%	13	4.1%	203	23.3%	15,698,651	61.3%	158,913	7.6%	15,857,564	57.3%		

Counties R T 2000 U R Eligibles T

	Urban		Counties		Rural		Total		Urban		Rural		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
No plans available	385	42.6%	2025	87.8%	2410	75.1%	5,454,550	18.0%	7,412,558	79.4%	12,867,108	32.4%		
1 or more plans available	518	57.4%	281	12.2%	789	24.9%	24,930,563	82.0%	1,941,440	20.8%	26,872,003	67.7%		
1	67	12.2%	102	32.0%	169	19.4%	1,692,011	6.6%	638,525	30.4%	2,330,536	8.4%		
2	88	16.0%	74	23.2%	162	18.6%	1,507,724	5.9%	604,029	28.8%	2,111,753	7.6%		
3	66	12.0%	69	21.6%	135	15.5%	1,653,954	6.5%	376,206	17.9%	2,030,160	7.3%		
4	55	10.0%	16	5.0%	71	8.2%	2,282,772	9.0%	89,718	4.3%	2,382,490	8.6%		
5	40	7.3%	2	0.6%	42	4.8%	1,699,983	6.6%	12,745	0.6%	1,712,728	6.2%		
6+	200	36.3%	18	5.6%	218	25.1%	16,084,119	62.8%	220,217	10.5%	16,304,336	58.9%		

Medicare + Choice
Premium Ranges for Beneficiaries
with Access to Only 1 Plan
(analyses by Medicare Eligibles)

1) Premium Range (all plans)	1999											
	1998				1999				2000			
	#	%	#	%	#	%	#	%	#	%	#	%
\$0	531,329	29.2%	271,833	37.7%	803,162	31.6%	424,587	28.8%	174,956	28.1%	599,553	28.4%
\$0.01 - \$19.99	-	0.0%	17,614	2.4%	17,614	0.7%	-	0.0%	-	0.0%	-	0.0%
\$20.00 - \$39.99	371,153	20.4%	98,131	13.3%	467,284	18.4%	305,868	20.6%	104,798	16.8%	410,662	19.5%
\$40.00 - \$59.99	581,222	31.9%	135,440	18.8%	716,662	28.2%	536,604	36.1%	146,425	23.5%	683,029	32.4%
\$60.00 - \$79.99	338,448	18.6%	160,647	22.3%	489,095	19.8%	138,463	9.3%	81,774	13.1%	220,237	10.4%
\$80.00 - \$99.99	-	0.0%	39,742	5.5%	39,742	1.6%	79,763	5.4%	115,669	18.5%	195,432	9.3%
	1,822,152	100.0%	721,407	100.0%	2,543,559	100.0%	1,485,283	100.0%	623,620	100.0%	2,108,913	100.0%
2) Premium Range (plans w/ Rx)												
\$0	322,595	40.2%	201,275	44.1%	523,870	41.6%	189,581	35.3%	152,603	36.8%	342,194	36.0%
\$0.01 - \$19.99	-	0.0%	17,614	3.9%	17,614	1.4%	-	0.0%	-	0.0%	-	0.0%
\$20.00 - \$39.99	169,992	21.2%	52,805	11.6%	222,897	17.7%	155,768	29.0%	87,387	21.1%	243,155	25.6%
\$40.00 - \$59.99	170,176	21.2%	59,084	12.9%	229,270	18.2%	88,686	12.8%	65,779	15.8%	134,465	14.1%
\$60.00 - \$79.99	140,141	17.5%	106,474	23.3%	246,615	19.6%	58,885	11.1%	39,723	9.6%	99,408	10.5%
\$80.00 - \$99.99	-	0.0%	19,174	4.2%	19,174	1.5%	63,581	11.8%	67,879	16.4%	131,460	13.6%
	802,804	100.0%	458,536	100.0%	1,259,440	100.0%	537,311	100.0%	413,371	100.0%	850,682	100.0%

MEDICARE MANAGED CARE (AS OF JUNE 1, 199X)

AUG-13-1999 19:10

HCFA 0A

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	2000	1999	1998	1997	1996	1995						
CONTRACT SUMMARY	# of Contracts¹	Enrollees²	# of Contracts	Enrollees	# of Contracts	Enrollees	# of Contracts	Enrollees	# of Contracts	Enrollees		
M+C/RISK	262	7	303	6,182,892	346	5,710,560	283	4,700,386	218	3,836,912	184	2,874,095
COBT	38	7	47	763,658	34	725,758	36	199,959	34	191,212	30	180,889
OTHER DEMOS	36	7	37	185,666	28	122,845	19	58,132	6	21,536	3	17,802
HCPPs	15	7	15	125,843	43	338,182	48	406,011	51	469,089	56	548,078
	350	7	402	8,988,048	452	6,281,435	386	6,365,488	308	4,311,753	253	3,422,064
M+C/RISK PREMIUMS												
Range:	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)
\$0	242	30.5	204	48.9	232	69.5	190	67.4	173	84.7	77	50.7
\$ 0.01 - \$18.98	39	4.9	41	8.6	16	4.5	17	6	7	3.7	12	7.9
\$20.00 - \$38.98	156	19.7	130	29.9	43	12.9	43	15.3	38	11.7	28	18.4
\$40.00 - \$59.99	130	16.4	89	14.3	23	6.9	20	7.1	24	12.6	16	10.5
\$60.00 - \$79.99	60	10.1	40	8.4	18	5.4	10	3.6	8	4.2	13	8.5
Above \$80.00	146	18.4	10	2.9	1	0.3	2	0.7	2	1.1	6	4
	791		622		332		282		190		152	
M+C/RISK BENEFITS³	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)
PREVENTIVE ⁴	NA	NA	NA	NA	750	98.7 / 89.8 / 94	624	98.8 / 88.3 / 96.7	397	97.4 / 86.3 / 25.3	317	98.7 / 86.8 / 25
Rx	598	75	481	77	225	67.4	184	68.8	118	62.1	73	48
VISION ⁵	721	91	515	94	280	83.2 / 0.6	303	91.5 / 16	178	87.9 / 5.8	144	69.5 / 5.3
HEARING ¹	NA	NA	NA	NA	243	72.2 / 0.6	249	77.7 / 10.6	147	73.7 / 3.7	118	73.7 / 4
DENTAL	382	48	323	52	124	37.1	113	40.1	73	38.4	53	34.9

¹ Does not reflect anticipated new contracts or service area expansions.

² Projected enrollees not projected.

³ Includes: Routine Physicals, Immunizations & Health Ed.

⁴ Includes: Eye Exams & Lenses

⁵ Includes: 9 Risk Demos

⁶ Included in Base option package

PART 1 - DATA ON YR 2000 NONRENEWALS ONLY

MTC
Summary Information on
Service Area Reduction and Nonrenewals

A. 2000 HCFA Payment Distribution	Benefit Plans *		Affected Enrollees		Counties	
	#	%	#	%	#	%
up to \$449	N/A	N/A	39,002	11.9%	75	22.7%
\$450 - \$499	N/A	N/A	124,343	38.1%	115	34.8%
\$500 - \$549	N/A	N/A	88,572	27.1%	72	21.8%
\$550 - \$599	N/A	N/A	51,382	15.7%	41	12.4%
\$600 +	N/A	N/A	23,286	7.1%	27	8.2%
Total	N/A	N/A	326,585	100.0%	330	100.0%
B. MSA vs. non-MSA						
MSA	94	80.3%	289,010	88.5%	232	70.3%
non-MSA	23	19.7%	37,575	11.5%	98	29.7%
Total	117	100.0%	326,585	100.0%	330	100.0%
C. 1999 Premium Distribution						
\$0	79	67.5%	232,172	71.1%	N/A	N/A
\$0.01 - \$19.99	4	3.4%	8,876	2.7%	N/A	N/A
\$20.00 - \$39.99	11	9.4%	22,540	6.9%	N/A	N/A
\$40.00 - \$59.99	14	12.0%	42,584	13.0%	N/A	N/A
\$60.00 - \$79.99	7	6.0%	18,211	5.6%	N/A	N/A
\$80.00 - \$99.99	2	1.7%	2,202	0.7%	N/A	N/A
\$100.00 - \$149.99	-	0.0%	-	0.0%	N/A	N/A
\$150 +	-	0.0%	-	0.0%	N/A	N/A
Total	117	100.0%	326,585	100.0%	N/A	N/A
D. Rx included in base plan						
Yes	87	74.4%	263,806	80.8%	245	74.2%
No	30	25.6%	62,779	19.2%	85	25.8%
Total	117	100.0%	326,585	100.0%	330	100.0%
E. Other Information						
(PMPM basis)						
Average Premium	\$22.00					
Weighted Average Premium	pending					
Premium Median	\$0.00					
Average Copay	\$25.00					
Average Value of Rx Benefit	\$40.00					
Average Value of Non-Medicare Benefits	\$59.00					

* Based on 2000 nonrenewal data (99 H#s)

DATE:

8/19/99

U.S. DEPARTMENT OF HEALTH AND HUMAN
SERVICESROOM 405H, HUMPHREY BUILDING
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OFFICE: _____

ROOM: _____

PHONE: _____

FAX: _____

As promised, this is what hctm prepared for
Des/Mike/lski mky on M+C pull-outs.

It makes the pt that payment rates are
not the only reason. Chart shows pullouts from countries w/
high rate increases

(INCLUDING COVER): _____

REMARKS: _____

Maryland Medicare+Choice (M+C) Contracting

Maryland Medicare Managed Care -- History

In 1986, HealthCare Corporation of the Mid-Atlantic, later known as Free State Health Plan, became the first managed care organization (MCO) to offer a Medicare managed care plan in Maryland. From 1994 to 1998, Maryland's Medicare managed care penetration rates mirrored the steady growth of the rest of the country. In 1998, over 95,000 Medicare beneficiaries were enrolled in managed care. Eight MCOs offered plans to Medicare beneficiaries in Maryland counties and every county had one or more managed care choices. However, the growth in the number of managed care options in Maryland reversed in 1998 when four of MCOs made the business decision to discontinue their contracts.

Nonrenewals for 1999-2000

Free State Health, the only MCO providing coverage in all counties, has notified HCFA that they will no longer operate in 17 of Maryland's 24 counties effective January 1st. The MCO will only to remain in the 7 Baltimore-Washington Corridor counties. Currently, Free State is the only managed care option in 11 rural counties (9 on the Eastern Shore and 2 in Western Maryland.) As a result of this withdrawal, almost 15,000 beneficiaries will have to find a new source of health coverage. Over 12,000 of the 15,000 will not have access to an MCO and will have to return to Original Medicare. (Please see attached table on nonrenewals.)

Explanation for Withdrawals

Earlier this year, Bill Jews, CEO of Free State Health Plan, met with the Administrator and me to discuss his organization's withdrawal from the Medicare program. He confirmed that he had not withdrawn from a number of counties last year against his better business judgement, partly because he knew that the withdrawals of four other M+C plans from Maryland left Free State as the only MCO available to many beneficiaries. He had hoped some way could be found for an exception for his plan to receive additional funding for the coming year. We were not able to justify special treatment for Free State Health.

In our discussion, he did not discuss the full scope of his pull-out from Maryland. However, he did explain that he felt pressured to make difficult business decision based on the following considerations:

- **Low Payment Level** -- For the most part, Free State left counties where the payment rate was below the national average payment rate. (However, it is worth noting that Free State withdrew from two counties with relatively high payment rates--over \$550.)
- **Adverse Selection** -- Based on the absence of other plans to choose from in many counties, there was concern that persons who expected to have high health care costs would enroll in Free State for the drug benefit.
- **Weak Provider Network** -- Free State had difficulty maintaining adequate provider networks in rural areas. Indeed, HCFA staff attended a meeting recently in which physicians on the Eastern Shore were seeking Congressional and HCFA assistance to resolve payment disputes between Free State and the doctors.

The withdrawal from the counties in Maryland counties is not unique. It was replicated in other places such as Virginia and Louisiana where a high proportion of the beneficiaries affected were left without another MCO. In addition, many MCOs withdrew from the Medicare for reasons related to adverse selection and weak provider networks.

1999 Payment Rates and MCO Participation

It is true that there is a wide variation in payment rates and MCO penetration in Maryland. Payment rates in the Eastern and Western shore counties are significantly below that of the Baltimore Washington Corridor counties.

- **Eastern Shore Rural** counties have the lowest reimbursement rates (average \$431/ PMPM) and have no M+C options remaining.
- **Western and Southern Rural** counties have the reimbursement rates higher than the Eastern Shore (average \$498/PMPM.) 2 of the 8 counties in this area have no M+C options. Of the 6 remaining counties, 2 have a single option, and 4 have at least 2 M+C plans each.
- **Baltimore-Washington Corridor** counties have the highest reimbursement rates (average \$581/PMPM.) These counties have 4 M+C options, the most available.

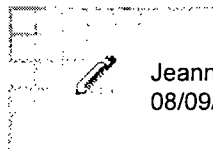
Medicare+Choice Enrollees Affected By Non-Renewals and Service Area Reductions

County	Plan Name	Medicare Beneficiaries in County	Affected Enrollees in County*	M+C Plans Remaining	1999 Rate	2000 Rate	99-00 Growth	Rural/ MSA
MARYLAND								
Allegany	FREE STATE HEALTH PLAN	15,615	808	0	\$574.23	\$585.71	2.0%	MSA
Calvert	FREE STATE HEALTH PLAN	7,243	776	0	\$495.45	\$517.03	4.4%	MSA
Caroline	FREE STATE HEALTH PLAN	4,631	889	0	\$416.87	\$448.08	7.5%	Rural
Carroll	FREE STATE HEALTH PLAN	19,722	1,920	2	\$500.93	\$519.96	3.8%	MSA
Cecil	FREE STATE HEALTH PLAN	10,051	724	0	\$532.84	\$548.76	3.0%	MSA
Cecil	UNITED HEALTHCARE OF THE MID-ATLA	10,051	664	0	\$532.84	\$548.76	3.0%	MSA
Charles	FREE STATE HEALTH PLAN	9,989	151	3	\$587.79	\$599.55	2.0%	MSA
Dorchester	FREE STATE HEALTH PLAN	5,815	1,112	0	\$455.06	\$478.16	5.1%	Rural
Frederick	FREE STATE HEALTH PLAN	19,388	505	1	\$441.48	\$477.87	8.2%	MSA
Garrett	FREE STATE HEALTH PLAN	4,577	340	0	\$476.26	\$493.83	3.7%	Rural
Kent	FREE STATE HEALTH PLAN	4,555	748	0	\$460.96	\$483.27	4.8%	Rural
Queen Annes	FREE STATE HEALTH PLAN	4,784	732	0	\$442.27	\$468.85	6.0%	MSA
Saint Marys	FREE STATE HEALTH PLAN	8,214	458	0	\$516.85	\$527.19	2.0%	Rural
Somerset	FREE STATE HEALTH PLAN	3,998	496	0	\$379.84	\$413.12	8.8%	Rural
Talbot	FREE STATE HEALTH PLAN	7,228	1,307	0	\$407.34	\$440.65	8.2%	Rural
Washington	FREE STATE HEALTH PLAN	20,425	1,122	0	\$396.70	\$439.26	10.7%	MSA
Wicomico	FREE STATE HEALTH PLAN	11,973	1,587	0	\$397.14	\$433.53	9.2%	Rural
Worcester	FREE STATE HEALTH PLAN	9,857	1,182	0	\$384.33	\$423.58	10.2%	Rural
Total Affected Enrollees			15,521					
Total Enrollees With No Other M+C Plan			12,945					

NOTES: Data as of July 15, based on information HCFA received from Medicare+Choice plans.

MSA=Metropolitan Statistical Area

*A "-" in column indicates that 10 or fewer enrollees were affected.



Jeanne Lambrew
08/09/99 05:21:18 PM

Record Type: Record

To: Peter Harbage <PHarbage@hcfa.gov>

cc:

Subject: managed care withdrawal report 

Hello,

I did catch up with Chris today and here's our thoughts.

Overall: We would like the major message of the report to be the inability to rely on managed care to provide a decent prescription drug benefit and, secondarily, that not all beneficiaries have access to affordable managed care. The volatility of managed care is not the main theme since we cannot totally address it with our proposal; to that end, any correlation analysis that can be done with the FEHBP plan withdrawals would be great.

Specifics: To the extent possible, we would like to see trends 1998 through 2000 -- 1997 if possible -- for the following.

Overall plan participation: Changes over time, patterns of withdrawals. Any correlations with (a) FEHBP changes; (b) general managed care penetration; (c) payment rates.

Access to plans by beneficiaries: Benes with access to no plans, one plan, two or more plans. Breaks by state, urban rural.

Prescription drug benefit: Proportion of plans, beneficiaries with access to plans with drugs. Nature of drug benefit (breaks by caps); number of plans with quarterly limits on drug spending; premium (probably weighted average) for plans offering drugs; correlation between payment rates and drug benefit (either offers/doesn't offer or generosity of benefit); proportion / nature of drug benefit in counties with one plan option.

Cost sharing / other supplemental benefits: Not sure what we can do, but similar analysis to drug benefit analysis.

I think that what would be most useful to us is to take a look at the data on Wednesday or Thursday if possible, we'll give you feedback, and help guide the executive summary -- then we'll try to be hands off.

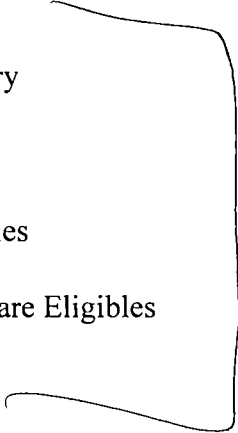
In terms of timing, we agree that ASAP is best. Is next week an option?

Thanks, Jeanne

Nichol / Nicolaus
212 663 4283

Medicare + Choice Premium and Rx Benefit Analyses

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- 

Note: The following pages contain preliminary information based on an analyses of the ACR/BIF data for Medicare + Choice organizations. Analyses is based on an overview of Medicare + Choice organizations only and does not reflect other managed care prepaid contracts (e.g. section 1876 cost contracts, Health Care Prepayment Organizations, and other demonstration projects. Information is based on data received as of 8/1/99 and is subject to change.

**MEDICARE MANAGED CARE
(AS OF JUNE 1, 199X)**

	2000		1999		1998		1997		1996		1995	
CONTRACT SUMMARY	# of Contracts	Enrollees	# of Contracts	Enrollees	# of Contracts	Enrollees	# of Contracts	Enrollees	# of Contracts	Enrollees	# of Contracts	Enrollees
M+C/RISK	?	?	303	6,192,892	346	5,710,550	283	4,700,386	218	3,635,912	164	2,674,095
COST	?	?	47	358,658	34	225,758	36	199,959	34	191,212	30	180,989
OTHER DEMOS	37	185,656	37	185,656	29	122,945	19	59,132	6	21,536	3	17,902
HCPPs	15	125,843	15	125,843	43	339,182	48	406,011	51	463,093	56	549,078
	52	311,499	402	6,863,049	452	6,398,435	386	5,365,488	309	4,311,753	253	3,422,064
M+C/RISK PREMIUMS												
Range:	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)
\$0	242	30.5	304	48.9	232	69.5	190	67.4	123	64.7	77	50.7
\$ 0.01 - \$19.99	39	4.9	41	6.6	15	4.5	17	6	7	3.7	12	7.9
\$ 20.00 - \$ 39.99	156	19.7	130	20.9	43	12.9	43	15.3	26	11.7	28	18.4
\$ 40.00 - \$59.99	130	16.4	89	14.3	23	6.9	20	7.1	24	12.6	16	10.5
\$ 60.00 - \$79.99	80	10.1	40	6.4	18	5.4	10	3.6	8	4.2	13	8.5
Above \$ 80.00	146	18.4	18	2.9	1	0.3	2	0.7	2	1.1	6	4
	793		622		332		282		190		152	
M+C/ RISK BENEFITS*	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)
PREVENTIVE ¹	NA	NA	NA	NA	750	96.7 / 89.8 / 38	624	96.8 / 88.3 / 36.2	397	97.4 / 86.3 / 25.3	317	96.7 / 86.8 / 25
Rx	598	75	481	77 ✓	225	67.4 ✓	194	68.8 ✓	118	62.1 ✓	73	48 ✓
VISION ²	721	91	585	94	280	83.2 / 0.6	303	91.5 / 16	178	87.9 / 9.8	144	89.5 / 5.3
HEARING ³	NA	NA	NA	NA	243	72.2 / 0.6	249	77.7 / 10.6	147	73.7 / 3.7	118	73.7 / 4
DENTAL	382	48	323	52	124	37.1	113	40.1	73	38.4	53	34.9

* - (IN BASIC OPTION PACKAGE)

1 - Includes: Routine Physicals, Immunizations & Health Ed.

2 - Includes: Eye Exams & Lenses

3 - Includes: Ear Exams & Hearing Aids

** - Includes: 9 Risk Demos

Important: The following data is based on a preliminary analyses of the ACR/BIF database. Information is subject to change.

Medicare+Choice Premium and Benefit Analyses, By Number of Counties

	1999 National Data						2000 National Data						99 - 00
	URBAN		RURAL		TOTAL		URBAN		RURAL		TOTAL		% Change
1A) Distribution of M+C Plan Premiums (Average Premium Range)	#	%	#	%	#	%	#	%	#	%	#	%	
\$0	93	17%	72	23%	165	19%	46	9%	47	17%	93	12%	-44%
\$ 0.01 - \$19.99	223	41%	86	27%	309	36%	82	16%	39	14%	121	15%	-61%
\$20.00 - \$39.99	133	24%	91	29%	224	26%	177	34%	77	27%	254	32%	13%
\$40.00 - \$59.99	72	13%	41	13%	113	13%	107	21%	55	20%	162	20%	43%
\$60.00 - \$79.99	17	3%	24	8%	41	5%	45	9%	33	12%	78	10%	90%
\$80.00 - \$99.99	0	0%	3	1%	3	0%	42	8%	27	10%	69	9%	2200%
\$100 - \$149.99	11	2%	2	1%	13	1%	17	3%	3	1%	20	3%	54%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
Missing Data					2						2		0%
	549	100%	319	100%	870	100%	516	100%	281	100%	799	100%	-8%
1B) M+C Plan Premiums (Minimum Premium Range)													
\$0	399	73%	213	67%	612	70%	315	61%	133	47%	448	56%	-27%
\$ 0.01 - \$19.99	14	3%	4	1%	18	2%	27	5%	20	7%	47	6%	161%
\$20.00 - \$39.99	61	11%	48	15%	109	13%	88	17%	51	18%	139	17%	28%
\$40.00 - \$59.99	47	9%	28	9%	75	9%	55	11%	44	16%	99	12%	32%
\$60.00 - \$79.99	12	2%	21	7%	33	4%	18	3%	19	7%	37	5%	12%
\$80.00 - \$99.99	1	0%	4	1%	5	1%	5	1%	14	5%	19	2%	280%
\$100 - \$149.99	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
Not available	17	3%	1	0%	18	2%	10	2%	0	0%	10	1%	-44%
	551	100%	319	100%	870	100%	518	100%	281	100%	799	100%	-8%
2) M+C Plan Premiums (plans w/ Rx)													
\$0	81	17%	64	35%	145	22%	35	8%	42	20%	77	12%	-47%
\$ 0.01 - \$19.99	217	46%	0%	0%	217	33%	78	18%	29	14%	107	16%	-51%
\$20.00 - \$39.99	123	26%	69	38%	192	29%	157	36%	64	31%	221	34%	15%
\$40.00 - \$59.99	28	6%	26	14%	54	8%	78	18%	22	11%	100	15%	85%
\$60.00 - \$79.99	11	2%	18	10%	29	4%	42	10%	28	13%	70	11%	141%
\$80.00 - \$99.99	0	0%	2	1%	2	0%	40	9%	22	11%	62	10%	3000%
\$100 - \$149.99	11	2%	2	1%	13	2%	10	2%	2	1%	12	2%	-8%

Important: The following data is based on a preliminary analyses of the ACR/BIF database. Information is subject to change.

Medicare+Choice Premium and Benefit Analyses, By Number of Counties

	1999 National Data						2000 National Data						99 - 00
	URBAN		RURAL		TOTAL		URBAN		RURAL		TOTAL		% Change
above \$150	0 471	0% 100%	0 181	0% 100%	0 652	0% 100%	0 440	0% 100%	0 209	0% 100%	0 649	0% 100%	0% 0%
3A) Rx Copayments (per script) (Average Co-Pay, By County, \$)													
<u>Generic</u>													
\$0	39	8%	21	8%	60	8%	0	0%	0	0%	0	0%	-100%
\$0.01-\$4.99	40	9%	42	17%	82	11%	6	1%	1	1%	7	1%	-91%
\$5.00-\$9.99	328	70%	127	50%	455	63%	257	60%	99	50%	356	57%	-22%
\$10.00-\$14.99	52	11%	59	23%	111	15%	158	37%	100	50%	258	41%	132%
\$15.00-\$24.99	7	2%	5	2%	12	2%	4	1%	0	0%	4	1%	-67%
\$25 and up	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	466	100%	254	100%	720	###	425	100%	200	100%	625	100%	-13%
<u>Brand</u>													
\$0	9	2%	7	3%	16	2%	0	0%	0	0%	0	0%	-100%
\$0.01-\$4.99	0	0%	2	1%	2	0%	0	0%	0	0%	0	0%	-100%
\$5.00-\$9.99	51	11%	26	11%	77	11%	16	4%	11	6%	27	4%	-65%
\$10.00-\$14.99	155	34%	100	43%	255	37%	70	17%	49	25%	119	19%	-53%
\$15.00-\$24.99	236	51%	72	31%	308	45%	301	71%	126	64%	427	69%	39%
\$25 and up	8	2%	23	10%	31	4%	35	8%	11	6%	46	7%	48%
	459	100%	230	100%	689	###	422	100%	197	100%	619	100%	-10%
3B) Rx Copayments (per script) (Minimum Co-Pay, By County, \$)													
<u>Generic</u>													
\$0	39	8%	21	8%	60	8%	19	4%	1	1%	20	3%	-67%
\$0.01-\$4.99	40	9%	42	17%	82	11%	10	2%	0	0%	10	2%	-88%
\$5.00-\$9.99	328	70%	127	50%	455	63%	267	63%	101	51%	368	59%	-19%
\$10.00-\$14.99	52	11%	59	23%	111	15%	127	30%	98	49%	225	36%	103%
\$15.00-\$24.99	7	2%	5	2%	12	2%	2	0%	0	0%	2	0%	-83%
\$25 and up	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	466	100%	254	100%	720	100%	425	100%	200	100%	625	100%	-13%
<u>Brand</u>													
\$0	36	8%	21	9%	57	8%	14	3%	1	1%	15	2%	-74%

Important: The following data is based on a preliminary analyses of the ACR/BIF database. Information is subject to change.

Medicare+Choice Premium and Benefit Analyses, By Number of Counties

	1999 National Data						2000 National Data						99 - 00
	URBAN		RURAL		TOTAL		URBAN		RURAL		TOTAL		% Change
\$0.01-\$4.99	0	0%	0	0%	0	0%	3	1%	0	0%	3	0%	0%
\$5.00-\$9.99	95	21%	27	12%	122	18%	18	4%	13	7%	31	5%	-75%
\$10.00-\$14.99	168	37%	90	39%	258	37%	106	25%	57	29%	163	26%	-37%
\$15.00-\$24.99	152	33%	69	30%	221	32%	257	61%	115	58%	372	60%	68%
\$25 and up	8	2%	23	10%	31	4%	24	6%	11	6%	35	6%	13%
	459	100%	230	100%	689	100%	422	100%	197	100%	619	100%	-10%
4A) Rx Coinsurance (by %) (Average Co-Pay, By County, %)													
Generic													
Under Five %	46	100%	12	100%	58	100%	34	100%	14	100%	48	100%	-17%
	46	###	12	###	58	###	34	###	14	100%	48	###	-17%
Brand													
Under Five %	52	100%	12	100%	64	100%	52	61%	14	100%	66	67%	3%
Twenty-five and Up	0	0%	0	0%	0	0%	33	39%	0	0%	33	33%	0%
	52	###	12	###	64	###	85	###	14	100%	99	###	55%
4B) Rx Coinsurance (by %) (Minimum Co-Pay, By County, %)													
Generic													
Under Five %	46	100%	12	100%	58	100%	34	100%	14	100%	48	100%	-17%
	46	###	12	###	58	###	34	###	14	100%	48	###	-17%
Brand													
Under Five %	52	100%	12	100%	64	100%	53	62%	14	100%	67	68%	5%
Twenty-five and up	0	0%	0	0%	0	0%	32	38%	0	0%	32	32%	0%
	52	###	12	###	64	###	85	###	14	100%	99	###	55%
5) Dental Benefit													
Yes	382	70%	161	50%	543	63%	331	64%	125	44%	456	57%	-16%
No	167	30%	158	50%	325	37%	185	36%	156	56%	341	43%	5%
	549	###	319	###	868	###	516	###	281	100%	797	###	-8%

Important: The following data is based on a preliminary analyses of the ACR/BIF database. Information is subject to change.

Medicare+Choice Premium and Benefit Analyses, By Number of Counties

	1999 National Data						2000 National Data						99 - 00
	URBAN		RURAL		TOTAL		URBAN		RURAL		TOTAL		% Change
6) Vision Benefit													
Medicare Coverage Only	9	7%	15	16%	24	11%	8	5%	9	12%	17	7%	-29%
Additional Benefit	540	406%	304	334%	844	377%	508	287%	272	353%	780	307%	-8%
	549	###	319	###	868	###	516	###	281	365%	797	###	-8%

Important: The following information is based on a preliminary analyses of the ACR/BIF database. Information is subject to change

Medicare+Choice Premium and Benefit Analyses, By # of Medicare Eligibles

	1999 National Data						2000 National Data						% Change
	URBAN		RURAL		TOTAL		URBAN		RURAL		TOTAL		
1A) M+C Plan Premiums (Average Premium Range)													
\$0	3,855,164	15%	365,824	17%	4,220,988	15%	1,781,725	7%	232,194	12%	2,013,919	7%	-52%
\$ 0.01 - \$19.99	14,491,477	57%	586,159	28%	15,077,636	54%	6,610,159	27%	266,383	14%	6,876,542	26%	-54%
\$20.00 - \$39.99	4,998,372	20%	586,657	28%	5,585,029	20%	7,841,536	31%	456,881	24%	8,298,417	31%	49%
\$40.00 - \$59.99	1,375,156	5%	334,047	16%	1,709,203	6%	4,363,633	18%	394,506	20%	4,758,139	18%	178%
\$60.00 - \$79.99	567,109	2%	194,663	9%	761,772	3%	2,312,236	9%	368,354	19%	2,680,590	10%	252%
\$80.00 - \$99.99	0	0%	39,742	2%	39,742	0%	1,417,499	6%	203,160	10%	1,620,659	6%	3978%
\$100 - \$149.99	309,017	1%	11,611	1%	320,628	1%	603,775	2%	19,962	1%	623,737	2%	95%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	
	25,596,295	100%	2,118,703	100%	27,714,998	100%	24,930,563	100%	1,941,440	100%	26,872,003	100%	-3%
1B) M+C Plan Premiums (Minimum Premium Range)													
\$0	20,341,768	79%	1,331,493	63%	21,673,261	78%	19,422,463	78%	784,702	40%	20,207,165	75%	-7%
\$ 0.01 - \$19.99	377,001	1%	46,752	2%	423,753	2%	836,321	3%	213,475	11%	1,049,796	4%	148%
\$20.00 - \$39.99	1,192,150	5%	296,954	14%	1,489,104	5%	2,122,571	9%	352,954	18%	2,475,525	9%	66%
\$40.00 - \$59.99	1,071,638	4%	224,769	11%	1,296,407	5%	1,377,563	6%	333,463	17%	1,711,026	6%	32%
\$60.00 - \$79.99	338,448	1%	160,647	8%	499,095	2%	364,369	1%	133,437	7%	497,806	2%	0%
\$80.00 - \$99.99	3,393	0%	46,733	2%	50,126	0%	83,156	0%	123,409	6%	206,565	1%	312%
\$100 - \$149.99	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
Not available	2,271,897	9%	11,355	1%	2,283,252	8%	724,120	3%	0	0%	724,120	3%	-68%
	25,596,295	100%	2,118,703	100%	27,714,998	100%	24,930,563	100%	1,941,440	100%	26,872,003	100%	-3%
2) M+C Plan Premiums (plans w/ Rx)													
\$0	3,409,485	14%	295,266	18%	3,704,751	14%	1,363,961	6%	206,778	14%	1,570,739	6%	-58%
\$ 0.01 - \$19.99	14,391,871	60%	545,303	32%	14,937,174	58%	6,563,141	28%	204,096	14%	6,767,237	27%	-55%
\$20.00 - \$39.99	4,669,979	20%	455,926	27%	5,125,905	20%	7,386,503	32%	363,731	25%	7,750,234	31%	51%
\$40.00 - \$59.99	792,055	3%	233,783	14%	1,025,838	4%	3,726,218	16%	177,569	12%	3,903,787	16%	281%
\$60.00 - \$79.99	347,421	1%	122,525	7%	469,946	2%	2,233,458	10%	318,855	22%	2,552,313	10%	443%
\$80.00 - \$99.99	0	0%	19,174	1%	19,174	0%	1,397,924	6%	148,379	10%	1,546,303	6%	7965%
\$100 - \$149.99	309,017	1%	11,611	1%	320,628	1%	529,049	2%	15,342	1%	544,391	2%	70%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	23,919,828	100%	1,683,588	100%	25,603,416	100%	23,200,254	100%	1,434,750	100%	24,635,004	100%	-4%
3A) Rx Copayments (per script) (Average Co-Pay, By County, \$)													
Generic													
\$0	1,209,300	5%	34,631	2%	1,243,931	5%	0	0%	0	0%	0	0%	-100%
\$0.01-\$4.99	3,458,347	15%	225,475	14%	3,683,822	15%	798,350	4%	11,738	1%	810,088	3%	-78%
\$5.00-\$9.99	16,948,449	72%	848,389	53%	17,796,838	71%	16,408,831	72%	638,304	47%	17,047,135	71%	-4%
\$10.00-\$14.99	1,567,607	7%	461,919	29%	2,029,526	8%	5,482,219	24%	703,565	52%	6,185,784	26%	205%
\$15.00-\$24.99	211,393	1%	38,392	2%	249,785	1%	28,627	0%	0	0%	28,627	0%	-89%
\$25 and up	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	23,395,096	100%	1,608,806	100%	25,003,902	100%	22,718,027	100%	1,353,607	100%	24,071,634	100%	-4%
Brand													
\$0	1,214,074	5%	56,879	4%	1,270,953	5%	0	0%	0	0%	0	0%	-100%

No Ben

Important: The following information is based on a preliminary analyses of the ACR/BIF database. Information is subject to change

Medicare+Choice Premium and Benefit Analyses, By # of Medicare Eligibles

	1999 National Data						2000 National Data						% Change
	URBAN		RURAL		TOTAL		URBAN		RURAL		TOTAL		
\$0.01-\$4.99	0	0%	9,357	1%	9,357	0%	0	0%	0	0%	0	0%	-100%
\$5.00-\$9.99	2,104,366	9%	182,913	12%	2,287,279	9%	871,992	4%	86,399	7%	958,391	4%	-58%
\$10.00-\$14.99	10,052,829	43%	610,663	41%	10,663,492	43%	4,267,243	19%	263,225	20%	4,530,468	19%	-58%
\$15.00-\$24.99	9,779,832	42%	519,720	35%	10,299,552	42%	16,496,878	73%	871,358	67%	17,368,236	73%	69%
\$25 and up	170,224	1%	103,694	7%	273,918	1%	944,382	4%	87,919	7%	1,032,301	4%	277%
	23,321,325	100%	1,483,226	100%	24,804,551	100%	22,580,495	100%	1,308,901	100%	23,889,396	100%	-4%
3B) Rx Copayments (per script)													
(Minimum Co-Pay, By County, \$)													
Generic													
\$0	4,592,990	20%	116,133	7%	4,709,123	19%	3,793,298	17%	11,738	1%	3,805,036	16%	-19%
\$0.01-\$4.99	3,040,592	13%	200,049	12%	3,240,641	13%	942,726	4%	0	0%	942,726	4%	-71%
\$5.00-\$9.99	14,474,089	62%	832,198	52%	15,306,287	61%	13,669,116	60%	660,949	49%	14,330,065	60%	-6%
\$10.00-\$14.99	1,076,032	5%	422,034	26%	1,498,066	6%	4,299,031	19%	680,920	50%	4,979,951	21%	232%
\$15.00-\$24.99	211,393	1%	38,392	2%	249,785	1%	13,856	0%	0	0%	13,856	0%	-94%
\$25 and up	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	23,395,096	100%	1,608,806	100%	25,003,902	100%	22,718,027	100%	1,353,607	100%	24,071,634	100%	-4%
Brand													
\$0	3,305,144	14%	116,133	8%	3,421,277	14%	1,993,732	9%	11,738	1%	2,005,470	8%	-41%
\$0.01-\$4.99	0	0%	0	0%	0	0%	239,524	1%	0	0%	239,524	1%	0%
\$5.00-\$9.99	6,847,514	29%	194,173	13%	7,041,687	28%	1,851,344	8%	96,701	7%	1,948,045	8%	-72%
\$10.00-\$14.99	8,187,894	35%	566,502	38%	8,754,396	35%	6,322,988	28%	285,099	22%	6,608,087	28%	-25%
\$15.00-\$24.99	4,810,549	21%	502,724	34%	5,313,273	21%	11,726,996	52%	827,444	63%	12,554,440	53%	136%
\$25 and up	170,224	1%	103,694	7%	273,918	1%	445,911	2%	87,919	7%	533,830	2%	95%
	23,321,325	100%	1,483,226	100%	24,804,551	100%	22,580,495	100%	1,308,901	100%	23,889,396	100%	-4%
4A) Rx Coinsurance (%)													
(Average Co-Pay, By County, %)													
Generic													
Under Five %	1,647,682	100%	116,452	100%	1,764,134	100%	1,404,965	100%	124,813	100%	1,529,778	100%	-13%
	1,647,682	100%	116,452	100%	1,764,134	100%	1,404,965	100%	124,813	100%	1,529,778	100%	(0)
Brand													
Under Five %	1,874,268	100%	116,452	100%	1,990,720	100%	2,456,224	41%	124,813	100%	2,581,037	42%	30%
Twenty-five and Up	0	0%	0	0%	0	0%	3,565,353	59%	0	0%	3,565,353	58%	0%
	1,874,268	100%	116,452	100%	1,990,720	100%	6,021,577	100%	124,813	100%	6,146,390	100%	209%
4B) Rx Coinsurance (%)													
(Minimum Co-Pay, By County, %)													
Generic													
Under Five %	1,647,682	100%	116,452	100%	1,764,134	100%	1,404,965	100%	124,813	100%	1,529,778	100%	-13%
	1,647,682	100%	116,452	100%	1,764,134	100%	1,404,965	100%	124,813	100%	1,529,778	100%	(0)
Brand													
Under Five %	1,874,268	100%	116,452	100%	1,990,720	100%	2,506,526	42%	124,813	100%	2,631,339	43%	32%
Twenty-five and up	0	0%	0	0%	0	0%	3,515,051	58%	0	0%	3,515,051	57%	0%
	1,874,268	100%	116,452	100%	1,990,720	100%	6,021,577	100%	124,813	100%	6,146,390	100%	209%

Important: The following information is based on a preliminary analyses of the ACR/BIF database. Information is subject to change

**Medicare+Choice
Premium and Benefit Analyses, By # of Medicare Eligibles**

		1999 National Data						2000 National Data						% Change
		URBAN		RURAL		TOTAL		URBAN		RURAL		TOTAL		
5) Dental Benefit	Yes	21,721,135	85%	1,073,724	51%	22,794,859	82%	20,786,990	83%	780,070	40%	21,567,060	80%	-5%
	No	3,875,160	15%	1,044,979	49%	4,920,139	18%	4,143,573	17%	1,161,370	60%	5,304,943	20%	8%
		25,596,295	100%	2,118,703	100%	27,714,998	100%	24,930,563	100%	1,941,440	100%	26,872,003	100%	3%
6) Vision Benefit	Medicare Coverage Only	133,654	1%	88,301	4%	221,955	1%	207,586	1%	98,765	5%	306,351	1%	38%
	Additional Benefit	25,462,641	99%	2,030,402	96%	27,493,043	99%	24,722,977	99%	1,842,675	95%	26,565,652	99%	-3%
		25,596,295	100%	2,118,703	100%	27,714,998	100%	24,930,563	100%	1,941,440	100%	26,872,003	100%	3%

Medicare + Choice Premium and Rx Benefit Analyses

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1. General Summary (1995 - 2000)
2. Nonrenewal Information (Premiums and Benefits - 1999 data)
3. Changes in the Medicare+Choice Industry
 - A. Information by number of Plans
 - B. Information by number of Counties
 - C. Information by number of Medicare

Note: The following pages contain preliminary information based on an analyses of the ACR/BIF data for Medicare+Choice organizations. Analyses is based on an overview of Medicare+Choice organizations only and does not reflect other managed care prepaid contracts (including 1876 contracts, Health Care Prepayment Organizations, and other demonstration contracts). Information is based on data received as of 8/1/99 and is subject to change.

**MEDICARE MANAGED CARE
(AS OF JUNE 1, 199X)**

CONTRACT SUMMARY

MCORISK
OOST
OTHER DEMOS
HOPPs

# of Contracts	Enrollment	# of Contracts	Enrollment	# of Contracts	Enrollment	# of Contracts	Enrollment	# of Contracts	Enrollment	# of Contracts	Enrollment
262	7	303	8,182,882	349	8,710,550	269	4,708,388	216	3,835,842	164	2,674,086
58	7	47	368,058	34	225,758	38	190,058	34	184,252	30	180,888
35	186,858	37	185,858	29	122,848	19	88,132	6	21,538	3	17,802
15	125,843	15	125,843	43	338,182	48	408,011	51	483,088	58	548,078
388	311,888	602	6,883,848	482	8,381,435	388	5,388,488	289	4,311,783	253	3,472,884

Range	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)
\$0	242	30.5	304	48.8	232	88.5	190	67.4	123	84.7	77	50.7
\$001-\$18.99	39	4.9	41	8.8	15	4.5	17	6	7	3.7	12	7.9
\$20.00-\$38.88	158	19.7	130	20.9	43	12.9	43	15.3	25	11.7	28	18.4
\$40.00-\$58.99	130	18.4	89	14.3	23	6.9	20	7.1	24	12.6	18	10.5
\$60.00-\$78.99	80	10.1	40	8.4	18	5.4	10	3.6	8	4.2	13	8.5
Above \$80.00	146	18.4	18	2.9	1	0.3	2	0.7	2	1.1	8	4
	798		622		382		282		189		252	

# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)
NA	NA	NA	NA	750	16.7/18.8/38	824	86.8/18.3/38.2	387	97.4/85.3/25.3	317	86.7/85.8/25
PREVENTIVE ¹				225	87.4	194	68.8	118	62.5	73	48
Rx	598	75	481	77		280	83.2/10.6	178	67.9/5.8	144	89.5/15.3
VISION ²	721	91	585	94		243	72.2/10.6	147	73.7/3.7	158	73.7/4
HEARING ³	NA	NA	NA	NA		113	40.1	73	38.4	63	34.8
DENTAL	382	48	329	52							

MCORISK BENEFITS

PREVENTIVE¹
Rx
VISION²
HEARING³
DENTAL

* - (IN BASIC OPTION PACKAGE)

1 - Includes: Routine Physicals, Immunizations & Health Ed.

2 - Includes: Eye Exams & Lenses

3 - Includes: Ear Exams & Hearing Aids

- Includes: 8 Risk Demos

Carlos to write narrative

A. 2000 HCFA Payment Distribution	Benefit Plans *		Affected Enrollees		Counties	
	#	%	#	%	#	%
up to \$449	N/A	N/A	39,002	11.9%	75	22.7%
\$450 - \$499	N/A	N/A	124,343	38.1%	115	34.8%
\$500 - \$549	N/A	N/A	88,572	27.1%	72	21.8%
\$550 - \$599	N/A	N/A	51,382	15.7%	41	12.4%
\$600 +	N/A	N/A	23,286	7.1%	27	8.2%
Total	N/A	N/A	326,585	100.0%	330	100.0%
B. MSA vs. non-MSA						
MSA	94	80.3%	289,010	88.5%	232	70.3%
non-MSA	23	19.7%	37,575	11.5%	98	29.7%
Total	117	100.0%	326,585	100.0%	330	100.0%
C. 1999 Premium Distribution						
\$0	79	67.5%	232,172	71.1%	N/A	N/A
\$0.01 - \$19.99	4	3.4%	8,876	2.7%	N/A	N/A
\$20.00 - \$39.99	11	9.4%	22,540	6.9%	N/A	N/A
\$40.00 - \$59.99	14	12.0%	42,584	13.0%	N/A	N/A
\$60.00 - \$79.99	7	6.0%	18,211	5.6%	N/A	N/A
\$80.00 - \$99.99	2	1.7%	2,202	0.7%	N/A	N/A
\$100.00 - \$149.99	-	0.0%	-	0.0%	N/A	N/A
\$150 +	-	0.0%	-	0.0%	N/A	N/A
Total	117	100.0%	326,585	100.0%	N/A	N/A
D. Rx included in base plan						
Yes	87	74.4%	263,806	80.8%	245	74.2%
No	30	25.6%	62,779	19.2%	85	25.8%
Total	117	100.0%	326,585	100.0%	330	100.0%
E. Other Information (PMPM basis)						
Average Premium			\$22.00			
Weighted Average Premium			pending			
Premium Median			? \$0			
Average Copay			\$25.00			
Average Value of Rx Benefit			\$40.00			
Average Value of Non-Medicare Benefits			\$59.00			

* Based on 2000 nonrenewal data (99 HHA)

Brief analysis
CHPP/HPP/DPFE

M+C SAR/NR Summary - August 11, 1999 6:30PM

more than
half of plans
have 0
there are non renewals

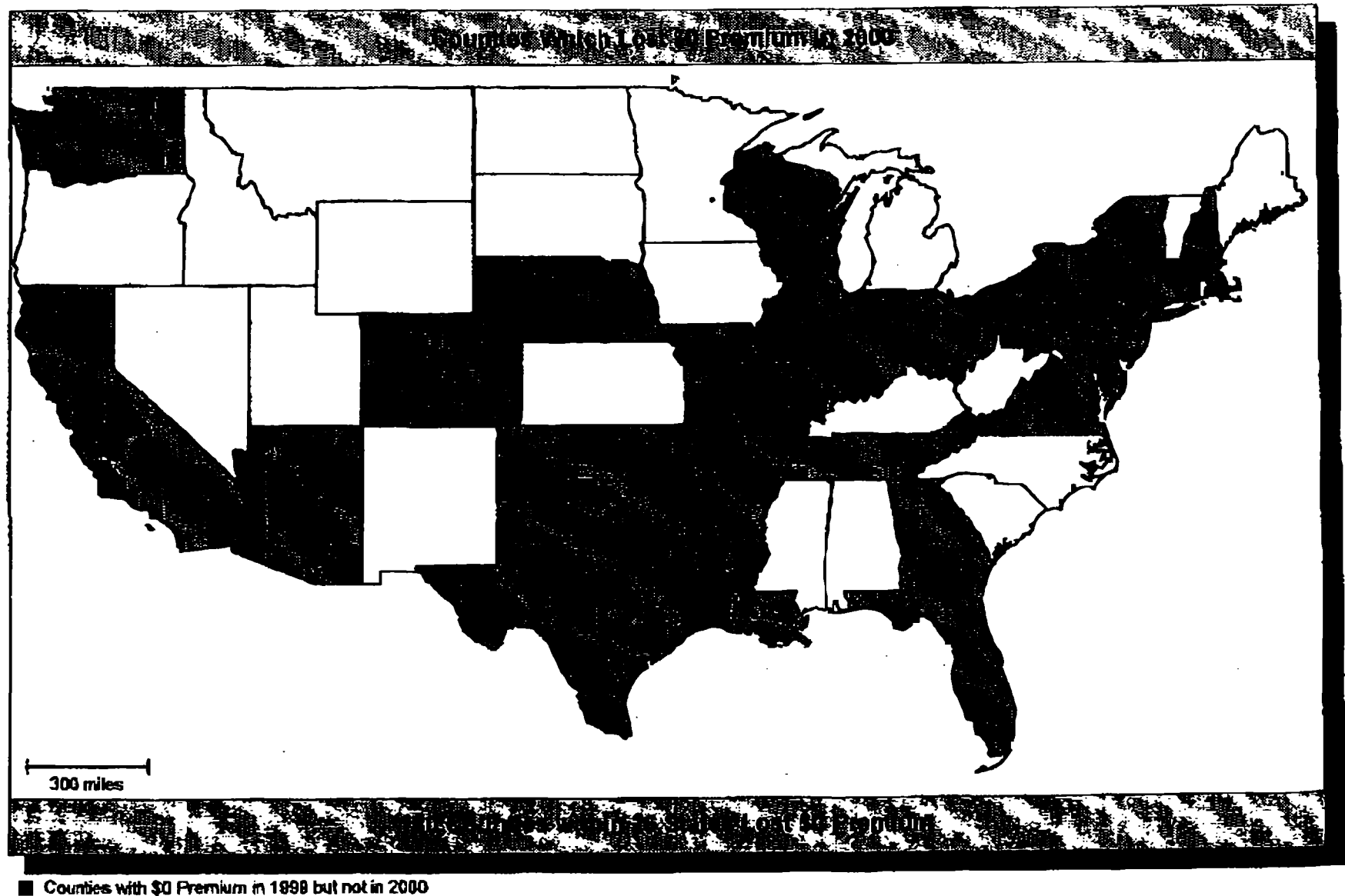
in their package
Nat'l average is \$52

Medicare + Choice Distribution of Plans

No plans available	2123	69.5%	10,602,795	27.3%	2379	74.1%	12,562,124	31.9%
1 or more plans available	932	30.5%	28,207,062	72.7%	831	25.9%	26,876,987	68.1%
1	257	27.6%	3,002,679	10.6%	190	22.9%	2,413,897	9.0%
2	199	21.4%	2,118,191	7.5%	167	20.1%	2,294,945	8.5%
3	105	11.3%	2,062,608	7.3%	127	15.3%	1,958,209	7.3%
4	102	10.9%	2,464,509	8.7%	74	8.9%	1,700,052	6.3%
5	57	6.1%	2,291,720	8.1%	44	5.3%	1,884,938	7.0%
6+	212	22.7%	16,267,355	57.7%	229	27.6%	16,624,946	61.9%

**Medicare + Choice
Weighted Average Premium
By State**

AL	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
AR	\$ 20.56	\$ 19.62	\$ 20.24	\$ 44.50	\$ 34.07	\$ 40.95
AZ	\$ 12.58	\$ 45.48	\$ 17.20	\$ 15.67	\$ 60.08	\$ 20.73
CA	\$ 10.95	\$ 31.35	\$ 11.28	\$ 21.56	\$ 27.38	\$ 21.62
CO	\$ 18.44	\$ 33.07	\$ 19.18	\$ 35.06	\$ 75.15	\$ 37.03
CT	\$ 27.33	\$ 65.67	\$ 28.51	\$ 78.61	\$ -	\$ 78.61
DC	\$ -	\$ -	\$ -	\$ 17.60	\$ -	\$ 17.60
DE	\$ 30.00	\$ -	\$ 30.00	\$ 53.79	\$ 81.00	\$ 61.29
FL	\$ 5.98	\$ 38.34	\$ 6.91	\$ 24.80	\$ 49.34	\$ 25.54
GA	\$ 5.50	\$ -	\$ 5.20	\$ 26.03	\$ -	\$ 26.03
HI	\$ 68.60	\$ 68.60	\$ 68.60	\$ 47.87	\$ 60.53	\$ 51.28
IA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
ID	\$ 35.00	\$ -	\$ 35.00	\$ 35.00	\$ -	\$ 35.00
IL	\$ 12.48	\$ 3.23	\$ 12.23	\$ 39.07	\$ 12.05	\$ 38.41
IN	\$ 38.25	\$ 50.00	\$ 36.52	\$ 43.48	\$ 50.00	\$ 43.61
KS	\$ 28.74	\$ -	\$ 28.74	\$ 31.43	\$ -	\$ 31.43
KY	\$ 21.35	\$ -	\$ 21.35	\$ 48.83	\$ -	\$ 48.83
LA	\$ 1.75	\$ -	\$ 1.37	\$ 20.30	\$ 15.06	\$ 19.56
MA	\$ 2.58	\$ 15.00	\$ 2.73	\$ 12.45	\$ 12.50	\$ 12.45
MD	\$ 8.03	\$ 75.00	\$ 14.30	\$ 15.91	\$ -	\$ 15.91
ME	\$ 52.71	\$ 62.43	\$ 54.12	\$ 47.00	\$ 47.00	\$ 47.00
MI	\$ 19.46	\$ 60.00	\$ 20.27	\$ 25.98	\$ 82.50	\$ 27.10
MN	\$ 119.93	\$ 128.90	\$ 120.25	\$ 122.28	\$ 99.99	\$ 121.48
MO	\$ 16.53	\$ 27.37	\$ 16.90	\$ 29.48	\$ 50.77	\$ 30.22
MS	\$ -	\$ -	\$ -	N/A	N/A	N/A
MT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
NC	\$ 26.98	\$ 37.23	\$ 28.24	\$ 33.44	\$ 41.39	\$ 34.41
NE	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
NH	\$ 12.05	\$ -	\$ 10.80	\$ 40.00	\$ -	\$ 40.00
NJ	\$ 22.21	\$ -	\$ 22.21	\$ 80.27	\$ -	\$ 80.27
NM	\$ 14.02	\$ 22.27	\$ 15.48	\$ 17.42	\$ 32.14	\$ 20.02
NV	\$ 16.79	\$ 45.03	\$ 17.72	\$ 15.31	\$ 27.28	\$ 15.71
NY	\$ 19.51	\$ 26.02	\$ 19.83	\$ 48.90	\$ 42.87	\$ 46.72
OH	\$ 12.61	\$ 24.55	\$ 13.92	\$ 33.91	\$ 40.74	\$ 34.71
OK	\$ 13.29	\$ 13.82	\$ 13.48	\$ 23.62	\$ 5.52	\$ 17.32
OR	\$ 48.96	\$ 62.65	\$ 51.85	\$ 63.43	\$ 65.14	\$ 63.78
PA	\$ 21.07	\$ 27.02	\$ 21.85	\$ 55.82	\$ 56.21	\$ 55.87
RI	\$ 9.56	\$ -	\$ 9.56	\$ 39.08	\$ -	\$ 39.08
SC	\$ 45.00	\$ -	\$ 45.00	N/A	N/A	N/A
TN	\$ 14.92	\$ 22.42	\$ 16.66	\$ 14.35	\$ 19.17	\$ 15.63
TX	\$ 3.75	\$ 13.70	\$ 5.23	\$ 8.33	\$ 33.02	\$ 11.88
VA	\$ 24.35	\$ 30.53	\$ 24.60	\$ 29.77	\$ 32.59	\$ 29.95
WA	\$ 26.00	\$ 40.99	\$ 28.42	\$ 43.00	\$ 76.48	\$ 47.58
WI	\$ 15.05	\$ 15.00	\$ 15.05	\$ 35.05	\$ 51.97	\$ 37.52
WV	\$ 54.62	\$ 38.31	\$ 48.28	\$ 32.39	\$ 44.00	\$ 39.25
US Total	\$ 16.61	\$ 29.02	\$ 17.47	\$ 34.91	\$ 42.21	\$ 35.44



Research+Choice
Premium and Benefit Analysis, By Plan

1) Distribution of M+C Plan Premiums (all plans)													
\$0	293	51.7%	11	20.0%	304	48.9%	235	31.8%	7	12.7%	242	30.5%	-20%
\$ 0.01 - \$19.99	37	6.5%	4	7.3%	41	6.6%	37	5.0%	2	3.6%	39	4.9%	-5%
\$20.00 - \$39.99	117	20.6%	13	23.6%	130	20.9%	146	19.8%	10	18.2%	156	19.7%	20%
\$40.00 - \$59.99	79	13.9%	10	18.2%	89	14.3%	120	16.3%	10	18.2%	130	16.4%	46%
\$60.00 - \$79.99	27	4.8%	13	23.6%	40	6.4%	71	9.6%	9	16.4%	80	10.1%	100%
\$80.00 - \$99.99	9	1.6%	4	7.3%	13	2.1%	50	6.8%	11	20.0%	61	7.7%	369%
\$100 - \$149.99	2	0.4%	0	0.0%	2	0.3%	58	7.9%	4	7.3%	62	7.8%	3000%
above \$150	3	0.5%	0	0.0%	3	0.5%	21	2.8%	2	3.6%	23	2.9%	667%
	567	100.0%	55	100.0%		100.0%	738	100.0%	55	100.0%		100.0%	
2) Distribution of M+C Plan Premiums (plans w/ Rx)													
\$0	239	53.1%	4	14.3%	243	50.8%	172	30.5%	3	9.1%	175	29.3%	-28%
\$ 0.01 - \$19.99	31	6.9%	1	3.6%	32	6.7%	29	5.1%	1	3.0%	30	5.0%	-6%
\$20.00 - \$39.99	90	20.0%	8	28.6%	98	20.5%	113	20.0%	7	21.2%	120	20.1%	22%
\$40.00 - \$59.99	57	12.7%	4	14.3%	61	12.8%	84	14.9%	5	15.2%	89	14.9%	46%
\$60.00 - \$79.99	22	4.9%	9	32.1%	31	6.5%	49	8.7%	3	9.1%	52	8.7%	68%
\$80.00 - \$99.99	6	1.3%	2	7.1%	8	1.7%	41	7.3%	8	24.2%	49	8.2%	513%
\$100 - \$149.99	2	0.4%	0	0.0%	2	0.4%	56	9.9%	4	12.1%	60	10.1%	2900%
above \$150	3	0.7%	0	0.0%	3	0.6%	20	3.5%	2	6.1%	22	3.7%	633%
	450	100.0%	28	100.0%		100.0%	564	100.0%	33	100.0%		100.0%	
3) Annual Limit on Rx Benefits													
Unlimited (Brand and Generic)	33	7.4%	1	4.0%		7.2%	76	13.5%	5	15.6%		13.7%	
<u>Distribution of Annual Limits</u> (Unlimited Generic, Limited Brand)													
Up to \$500	10	2.2%	0	0.0%	10	2.1%	78	13.9%	4	12.5%	82	13.8%	720%
\$501 - \$799	8	1.8%	2	8.0%	10	2.1%	17	3.0%	2	6.3%	19	3.2%	90%
\$800 - \$999	3	0.7%	0	0.0%	3	0.6%	3	0.5%	0	0.0%	3	0.5%	0%
\$1,000	16	3.6%	1	4.0%	17	3.6%	58	10.3%	2	6.3%	60	10.1%	253%
\$1,001 - \$2,000	49	11.0%	1	4.0%	50	10.5%	92	16.4%	7	21.9%	99	16.7%	98%
\$2,001 - \$2,500	18	4.0%	0	0.0%	18	3.8%	10	1.8%	0	0.0%	10	1.7%	-44%
Over \$2,500	7	1.6%	0	0.0%	7	1.5%	7	1.2%	0	0.0%	7	1.2%	0%
	111	24.9%	4	16.0%		24.5%	265	47.2%	15	46.9%		47.2%	
<u>Distribution of Annual Limits</u> (Limited Generic, Limited Brand)													
Up to \$500	77	17.3%	3	12.0%	80	17.0%	79	14.1%	2	6.3%	81	13.7%	1%
\$501 - \$799	37	8.3%	4	16.0%	41	8.7%	34	6.1%	4	12.5%	38	6.4%	-7%
\$800 - \$999	26	5.8%	3	12.0%	29	6.2%	11	2.0%	0	0.0%	11	1.9%	-62%
\$1,000	74	16.6%	6	24.0%	80	17.0%	53	9.4%	6	18.8%	59	9.9%	-26%
\$1,001 - \$2,000	74	16.6%	4	16.0%	78	16.6%	38	6.8%	0	0.0%	38	6.4%	-51%
\$2,001 - \$2,500	5	1.1%	0	0.0%	5	1.1%	3	0.5%	0	0.0%	3	0.5%	-40%
Over \$2,500	8	1.8%	0	0.0%	8	1.7%	2	0.4%	0	0.0%	2	0.3%	-75%
	301	67.6%	20	80.0%		68.3%	220	39.2%	12	37.5%		39.1%	
Grand Total	445	100.0%	25	100.0%		100.0%	561	100.0%	32	100.0%		100.0%	

Medicare Choice
Premium and Benefit Analysis, by Plan

4) Distribution of Rx Copayments (per script)													
Generic													
\$0	8	2.0%	0	0.0%	8	1.9%	8	1.7%	0	0.0%	8	1.6%	0%
\$0.01-\$4.99	21	5.2%	2	8.3%	23	5.4%	5	1.1%	0	0.0%	5	1.0%	-78%
\$5.00-\$9.99	263	65.3%	15	62.5%	278	65.1%	236	50.5%	10	37.0%	246	49.8%	-12%
\$10.00-\$14.99	95	23.6%	5	20.8%	100	23.4%	203	43.5%	15	55.6%	218	44.1%	118%
\$15.00-\$24.99	16	4.0%	2	8.3%	18	4.2%	15	3.2%	2	7.4%	17	3.4%	-6%
\$25 and up	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0%
	403	100.0%	24	100.0%		100.0%	467	100.0%	27	100.0%		100.0%	
Brand													
\$0	5	1.0%	0	0.0%	5	1.0%	5	1.1%	0	0.0%	5	1.0%	0%
\$0.01-\$4.99	3	0.6%	0	0.0%	3	0.6%	3	0.6%	0	0.0%	3	0.6%	0%
\$5.00-\$9.99	6	1.3%	0	0.0%	6	1.2%	6	1.3%	0	0.0%	6	1.2%	0%
\$10.00-\$14.99	37	7.7%	2	10.0%	39	7.8%	34	7.3%	4	14.8%	38	7.7%	-3%
\$15.00-\$24.99	312	65.0%	9	45.0%	321	64.2%	303	64.9%	19	70.4%	322	65.2%	0%
\$25 and up	117	24.4%	9	45.0%	126	25.2%	116	24.8%	4	14.8%	120	24.3%	-5%
	480	100.0%	20	100.0%		100.0%	467	100.0%	27	100.0%		100.0%	
5) Rx Formulary													
Total using Formulary	356	78.6%	18	64.3%	374	77.8%	482	85.3%	26	78.8%	508	84.9%	36%
Of these above, may have diff. copayments	49	13.8%	3	16.7%	52	13.9%	271	56.2%	16	61.5%	287	56.5%	452%
No formulary indicated	92	21.4%	10	35.7%	107	22.2%	83	14.7%	7	21.2%	90	15.1%	-16%
	453	100.0%	28	100.0%		100.0%	565	100.0%	33	100.0%		100.0%	
6) Dental Benefit													
Yes	302	53.3%	21	38.2%	323	51.9%	362	49.1%	20	36.4%	382	48.2%	18%
No	265	46.7%	34	61.8%	299	48.1%	376	50.9%	35	63.6%	411	51.8%	37%
	567	100.0%	55	100.0%		100.0%	738	100.0%	55	100.0%		100.0%	
7) Vision Benefit													
Medicare Coverage Only	30	5.3%	7	12.7%	37	5.9%	68	9.2%	4	7.3%	72	9.1%	95%
Additional Benefit	537	94.7%	48	87.3%	585	94.1%	670	90.8%	51	92.7%	721	90.9%	23%
	567	100.0%	55	100.0%		100.0%	738	100.0%	55	100.0%		100.0%	

Medicare+Choice
Premium and Benefit Analyses, By Number of Counties

	1	2	3	4	5	6	7	8	9	10	11	12	13
1A) Distribution of M+C Plan Premiums (Avg. Premium Range)													
\$0	93	17%	72	23%	165	19%	46	9%	47	17%	93	12%	-44%
\$ 0.01 - \$19.99	223	41%	86	27%	309	36%	82	16%	39	14%	121	15%	-61%
\$20.00 - \$39.99	133	24%	91	29%	224	26%	177	34%	77	27%	254	32%	13%
\$40.00 - \$59.99	72	13%	41	13%	113	13%	107	21%	55	20%	162	20%	43%
\$60.00 - \$79.99	17	3%	24	8%	41	5%	45	9%	33	12%	78	10%	90%
\$80.00 - \$99.99	0	0%	3	1%	3	0%	42	8%	27	10%	69	9%	2200%
\$100 - \$149.99	11	2%	2	1%	13	1%	17	3%	3	1%	20	3%	54%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
Missing Data					2						2		0%
Not available	549	100%	319	100%		100%	516	100%	281	100%		100%	
1B) M+C Plan Premiums (Min. Premium Range)													
\$0	399	73%	213	57%	612	70%	315	61%	133	47%	448	56%	-27%
\$ 0.01 - \$19.99	14	3%	4	1%	18	2%	27	5%	20	7%	47	6%	161%
\$20.00 - \$39.99	61	11%	48	15%	109	13%	88	17%	51	18%	139	17%	28%
\$40.00 - \$59.99	47	9%	28	9%	75	9%	55	11%	44	16%	99	12%	32%
\$60.00 - \$79.99	12	2%	21	7%	33	4%	18	3%	19	7%	37	5%	12%
\$80.00 - \$99.99	1	0%	4	1%	5	1%	5	1%	14	5%	19	2%	280%
\$100 - \$149.99	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
Not available	17	3%	1	0%	18	2%	10	2%	0	0%	10	1%	-44%
	551	100%	329	100%		100%	518	100%	281	100%		100%	
2) M+C Plan Premiums (plans w/ Rx) (Avg. Premium Range)													
\$0	81	17%	64	24%	145	19%	35	8%	43	20%	78	12%	-46%
\$ 0.01 - \$19.99	217	44%	81	31%	298	40%	78	18%	29	14%	107	16%	-64%
\$20.00 - \$39.99	123	25%	69	26%	192	26%	157	36%	64	30%	221	34%	15%
\$40.00 - \$59.99	45	9%	26	10%	71	9%	78	18%	22	10%	100	15%	41%
\$60.00 - \$79.99	11	2%	18	7%	29	4%	42	10%	28	13%	70	11%	141%
\$80.00 - \$99.99	0	0%	2	1%	2	0%	40	9%	22	10%	62	10%	3000%
\$100 - \$149.99	11	2%	2	1%	13	2%	10	2%	2	1%	12	2%	-8%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	488	100%	262	100%		100%	440	100%	210	100%		100%	
3A) Rx Copayments (per script) (Average Co-Pay, By County, \$)													
Generic													
\$0	39	8%	21	8%	60	8%	0	0%	0	0%	0	0%	-100%
\$0.01-\$4.99	40	9%	42	17%	82	11%	6	1%	1	1%	7	1%	-91%
\$5.00-\$9.99	328	70%	127	50%	455	63%	257	60%	99	50%	356	57%	-22%
\$10.00-\$14.99	52	11%	59	23%	111	15%	158	37%	100	50%	258	41%	132%
\$15.00-\$24.99	7	2%	5	2%	12	2%	4	1%	0	0%	4	1%	-67%
\$25 and up	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	466	100%	254	100%		100%	425	100%	200	100%		100%	

Medicare+Choice
Premium and Benefit Analysis, By Number of Counties

Brand	9	2%	7	3%	16	2%	0	0%	0	0%	0	0%	-100%
\$0	0	0%	2	1%	2	0%	0	0%	0	0%	0	0%	-100%
\$0.01-\$4.99	51	11%	24	11%	77	11%	16	4%	11	6%	27	4%	-65%
\$5.00-\$9.99	155	34%	100	43%	255	37%	70	17%	49	25%	119	19%	-53%
\$10.00-\$14.99	236	51%	72	31%	308	45%	301	71%	126	64%	427	69%	39%
\$15.00-\$24.99	8	2%	23	10%	31	4%	35	8%	11	5%	46	7%	48%
\$25 and up	459	100%	230	100%		100%	422	100%	197	100%		100%	
3B) Rx Copayments (per script)													
(Minimum Co-Pay, By County, \$)													
Generic													
\$0	39	8%	21	8%	60	8%	19	4%	1	1%	20	3%	-67%
\$0.01-\$4.99	40	9%	42	17%	82	11%	10	2%	0	0%	10	2%	-89%
\$5.00-\$9.99	328	70%	127	50%	455	63%	267	63%	101	51%	364	59%	-19%
\$10.00-\$14.99	52	11%	59	23%	111	15%	127	30%	98	49%	225	36%	103%
\$15.00-\$24.99	7	2%	5	2%	12	2%	2	0%	0	0%	2	0%	-83%
\$25 and up	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	486	100%	254	100%		100%	425	100%	200	100%		100%	
Brand													
\$0	36	8%	21	9%	57	8%	14	3%	1	1%	15	2%	-74%
\$0.01-\$4.99	0	0%	0	0%	0	0%	3	1%	0	0%	3	0%	0%
\$5.00-\$9.99	95	21%	27	12%	122	18%	18	4%	13	7%	31	5%	-75%
\$10.00-\$14.99	168	37%	90	39%	258	37%	106	25%	57	29%	163	26%	-37%
\$15.00-\$24.99	152	33%	69	30%	221	32%	257	61%	115	58%	372	60%	68%
\$25 and up	8	2%	23	10%	31	4%	24	6%	11	6%	35	6%	13%
	459	100%	230	100%		100%	422	100%	197	100%		100%	
4A) Rx Coinsurance (by %)													
(Average Co-Pay, By County, %)													
Generic													
Under Five %	46	100%	12	100%	58	100%	34	100%	14	100%	48	100%	-17%
	46	100%	12	100%		100%	34	100%	14	100%		100%	
Brand													
Under Five %	52	100%	12	100%	64	100%	52	61%	14	100%	66	67%	3%
Twenty-five and Up	0	0%	0	0%	0	0%	33	39%	0	0%	33	33%	0%
	52	100%	12	100%		100%	85	100%	14	100%		100%	
4B) Rx Coinsurance (by %)													
(Minimum Co-Pay, By County, %)													
Generic													
Under Five %	46	100%	12	100%	58	100%	34	100%	14	100%	48	100%	-17%
	46	100%	12	100%		100%	34	100%	14	100%		100%	
Brand													
Under Five %	52	100%	12	100%	64	100%	53	62%	14	100%	67	68%	5%
Twenty-five and up	0	0%	0	0%	0	0%	32	38%	0	0%	33	32%	0%
	52	100%	12	100%		100%	85	100%	14	100%		100%	

Medicare+Choice
Premium and Benefit Analyses, By Number of Counties

	1	2	3	4	5	6	7	8	9	10	11	12	13
5) Dental Benefit													
Yes	382	70%	161	50%	543	63%	331	64%	125	44%	456	57%	-16%
No	167	30%	158	50%	325	37%	185	36%	156	56%	341	43%	5%
	549	100%	319	100%		100%	516	100%	281	100%		100%	
6) Vision Benefit													
Medicare Coverage Only	9	7%	15	16%	24	11%	8	5%	9	12%	17	7%	-28%
Additional Benefit	540	406%	304	234%	644	277%	508	287%	272	253%	780	307%	-8%
	549	413%	319	351%		388%	516	292%	281	365%		314%	

Medicare+Choice

Premium and Benefit Analyses, By # of Medicare Eligibles

1A) M+C Plan Premiums													
(Average Premium Range)													
\$0	3,555,164	15%	365,824	17%	4,220,988	15%	1,781,725	7%	232,194	12%	2,013,919	7%	-52%
\$ 0.01 - \$19.99	14,491,477	57%	586,159	28%	15,077,636	54%	6,610,159	27%	266,383	14%	6,876,542	26%	-54%
\$20.00 - \$39.99	4,998,372	20%	586,657	28%	5,585,029	20%	7,841,536	31%	456,881	24%	8,298,417	31%	49%
\$40.00 - \$59.99	1,375,156	5%	334,047	16%	1,709,203	6%	4,363,633	18%	394,506	20%	4,758,139	18%	178%
\$60.00 - \$79.99	567,109	2%	194,663	9%	761,772	3%	2,312,236	9%	368,354	19%	2,680,590	10%	252%
\$80.00 - \$99.99	0	0%	39,742	2%	39,742	0%	1,417,499	6%	203,160	10%	1,620,659	6%	3978%
\$100 - \$149.99	309,017	1%	11,611	1%	320,628	1%	603,775	2%	19,962	1%	623,737	2%	95%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	
	25,586,295	100%	2,118,763	100%		100%	24,930,563	100%	1,941,440	100%		100%	
1B) M+C Plan Premiums													
(Minimum Premium Range)													
\$0	20,341,768	79%	1,331,493	63%	21,673,261	78%	19,422,463	78%	784,702	40%	20,207,165	75%	-7%
\$ 0.01 - \$19.99	377,001	1%	46,752	2%	423,753	2%	836,321	3%	213,475	11%	1,049,796	4%	148%
\$20.00 - \$39.99	1,192,150	5%	296,954	14%	1,489,104	5%	2,122,571	9%	352,954	18%	2,475,525	9%	66%
\$40.00 - \$59.99	1,071,638	4%	224,769	11%	1,296,407	5%	1,377,563	6%	333,463	17%	1,711,026	6%	32%
\$60.00 - \$79.99	338,448	1%	160,647	8%	499,095	2%	364,369	1%	133,437	7%	497,806	2%	0%
\$80.00 - \$99.99	3,393	0%	46,733	2%	50,126	0%	83,156	0%	123,409	6%	206,565	1%	312%
\$100 - \$149.99	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	
Not available	2,271,897	9%	11,355	1%	2,283,252	8%	724,120	3%	0	0%	724,120	3%	-68%
	25,586,295	100%	2,118,763	100%		100%	24,930,563	100%	1,941,440	100%		100%	
2) M+C Plan Premiums (plans w/ Rx)													
\$0	3,409,485	14%	295,266	18%	3,704,751	14%	1,363,961	6%	206,778	14%	1,570,739	6%	-58%
\$ 0.01 - \$19.99	14,391,871	60%	545,303	32%	14,937,174	58%	6,563,141	28%	204,096	14%	6,767,237	27%	-55%
\$20.00 - \$39.99	4,669,979	20%	455,926	27%	5,125,905	20%	7,386,503	32%	363,731	25%	7,750,234	31%	51%
\$40.00 - \$59.99	792,055	3%	233,783	14%	1,025,838	4%	3,726,218	16%	177,569	12%	3,903,787	16%	281%
\$60.00 - \$79.99	347,421	1%	122,525	7%	469,946	2%	2,233,458	10%	318,855	22%	2,552,313	10%	443%
\$80.00 - \$99.99	0	0%	19,174	1%	19,174	0%	1,397,924	6%	148,379	10%	1,546,303	6%	7965%
\$100 - \$149.99	309,017	1%	11,611	1%	320,628	1%	529,049	2%	15,342	1%	544,391	2%	70%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	
	23,910,826	100%	1,683,588	100%		100%	23,200,154	100%	1,434,750	100%		100%	
3A) Rx Copayments (per script)													
(Average Co-Pay, By County, \$)													
Generic													
\$0	1,209,300	5%	34,631	2%	1,243,931	5%	0	0%	0	0%	0	0%	-100%
\$0.01-\$4.99	3,456,347	15%	225,475	14%	3,683,822	15%	798,350	4%	11,738	1%	810,088	3%	-78%
\$5.00-\$9.99	16,948,449	72%	848,389	53%	17,796,838	71%	16,408,831	72%	638,304	47%	17,047,135	71%	-4%
\$10.00-\$14.99	1,567,607	7%	461,919	29%	2,029,526	8%	5,482,219	24%	703,565	52%	6,185,784	26%	205%
\$15.00-\$24.99	211,393	1%	38,392	2%	249,785	1%	28,627	0%	0	0%	28,627	0%	-89%
\$25 and up	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	
	23,385,096	100%	1,608,806	100%		100%	22,718,027	100%	1,353,607	100%		100%	
Brand													

Medicare+Choice
Premium and Benefit Analyses, By # of Medicare Eligibles

\$0	1,214,074	5%	56,879	4%	1,270,953	5%	0	0%	0	0%	0	0%	-100%
\$0.01-\$4.99	0	0%	9,357	1%	9,357	0%	0	0%	0	0%	0	0%	-100%
\$5.00-\$9.99	2,104,366	9%	182,913	12%	2,287,279	9%	871,992	4%	86,399	7%	958,391	4%	-58%
\$10.00-\$14.99	10,052,829	43%	610,663	41%	10,663,492	43%	4,267,243	19%	263,225	20%	4,530,468	19%	-58%
\$15.00-\$24.99	9,779,832	42%	519,720	35%	10,299,552	42%	16,496,878	73%	871,358	67%	17,368,236	73%	69%
\$25 and up	170,224	1%	103,694	7%	273,918	1%	944,382	4%	87,919	7%	1,032,301	4%	277%
	23,321,325	100%	1,483,226	100%		100%	22,580,495	100%	1,308,801	100%		100%	
Rx Copayments (per script)													
(Minimum Co-Pay, By County, %)													
Generic													
\$0	4,592,990	20%	116,133	7%	4,709,123	19%	3,793,298	17%	11,738	1%	3,805,036	16%	-19%
\$0.01-\$4.99	3,040,592	13%	200,049	12%	3,240,641	13%	942,726	4%	0	0%	942,726	4%	-71%
\$5.00-\$9.99	14,474,089	62%	832,198	52%	15,306,287	61%	13,669,116	60%	660,949	49%	14,330,065	60%	-8%
\$10.00-\$14.99	1,076,032	5%	422,034	26%	1,498,066	6%	4,299,031	19%	680,920	50%	4,979,951	21%	232%
\$15.00-\$24.99	211,393	1%	38,392	2%	249,785	1%	13,856	0%	0	0%	13,856	0%	-94%
\$25 and up	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	23,395,096	100%	1,488,868	100%		100%	22,718,027	100%	1,353,807	100%		100%	
Brand													
\$0	3,305,144	14%	116,133	8%	3,421,277	14%	1,993,732	9%	11,738	1%	2,005,470	8%	-41%
\$0.01-\$4.99	0	0%	0	0%	0	0%	239,524	1%	0	0%	239,524	1%	0%
\$5.00-\$9.99	6,847,514	29%	194,173	13%	7,041,687	28%	1,851,344	8%	96,701	7%	1,948,045	8%	-72%
\$10.00-\$14.99	8,187,894	35%	566,502	38%	8,754,396	35%	6,322,988	28%	285,099	22%	6,608,087	28%	-25%
\$15.00-\$24.99	4,810,549	21%	502,724	34%	5,313,273	21%	11,726,996	52%	827,444	63%	12,554,440	53%	136%
\$25 and up	170,224	1%	103,694	7%	273,918	1%	445,911	2%	87,919	7%	533,830	2%	95%
	23,321,325	100%	1,483,226	100%		100%	22,580,495	100%	1,308,801	100%		100%	
4A) Rx Coinsurance (%)													
(Average Co-Pay, By County, %)													
Generic													
Under Five %	1,647,682	100%	116,452	100%	1,764,134	100%	1,404,965	100%	124,813	100%	1,529,778	100%	-13%
	1,647,682	100%	116,452	100%		100%	1,404,965	100%	124,813	100%		100%	(0)
Brand													
Under Five %	1,874,268	100%	116,452	100%	1,990,720	100%	2,458,224	41%	124,813	100%	2,581,037	42%	30%
Twenty-five and Up	0	0%	0	0%	0	0%	3,565,353	58%	0	0%	3,565,353	58%	0%
	1,874,268	100%	116,452	100%		100%	6,021,577	100%	124,813	100%		100%	
Rx Coinsurance (%)													
(Minimum Co-Pay, By County, %)													
Generic													
Under Five %	1,647,682	100%	116,452	100%	1,764,134	100%	1,404,965	100%	124,813	100%	1,529,778	100%	-13%
	1,647,682	100%	116,452	100%		100%	1,404,965	100%	124,813	100%		100%	(0)
Brand													
Under Five %	1,874,268	100%	116,452	100%	1,990,720	100%	2,506,526	42%	124,813	100%	2,631,339	43%	32%
Twenty-five and up	0	0%	0	0%	0	0%	3,515,051	58%	0	0%	3,515,051	57%	0%

Medicare Choice
Premium and Benefit Analysis, By # of Medicare Eligibles

	1,174,268	100%	110,452	100%		100%	8,021,577	100%	124,813	100%		100%	
5) Dental Benefit													
Yes	21,721,135	85%	1,073,724	51%	22,794,859	82%	20,786,990	83%	780,070	40%	21,567,060	80%	-5%
No	3,875,160	15%	1,044,979	49%	4,920,139	18%	4,143,573	17%	1,161,370	60%	5,304,943	20%	8%
	25,596,295	100%	2,118,703	100%		100%	24,930,563	100%	1,941,440	100%		100%	
8) Vision Benefit													
Medicare Coverage Only	133,654	1%	88,301	4%	221,955	1%	207,586	1%	98,765	5%	306,351	1%	38%
Additional Benefit	25,462,641	99%	2,030,402	96%	27,493,043	99%	24,722,977	99%	1,842,675	95%	26,565,652	99%	-3%
	25,596,295	100%	2,118,703	100%		100%	24,930,563	100%	1,941,440	100%		100%	

1) Distribution of M+C Plan Premiums (all plans)													
\$0	293	51.7%	11	20.0%	304	48.9%	235	31.8%	7	12.7%	242	30.5%	-20%
\$ 0.01 - \$19.99	37	6.5%	4	7.3%	41	6.6%	37	5.0%	2	3.6%	39	4.9%	-5%
\$20.00 - \$39.99	117	20.6%	13	23.6%	130	20.9%	146	19.8%	10	18.2%	156	19.7%	20%
\$40.00 - \$59.99	79	13.9%	10	18.2%	89	14.3%	120	16.3%	10	18.2%	130	16.4%	46%
\$60.00 - \$79.99	27	4.8%	13	23.6%	40	6.4%	71	9.6%	9	16.4%	80	10.1%	100%
\$80.00 - \$99.99	9	1.6%	4	7.3%	13	2.1%	50	6.8%	11	20.0%	61	7.7%	369%
\$100 - \$149.99	2	0.4%	0	0.0%	2	0.3%	58	7.9%	4	7.3%	62	7.8%	3000%
above \$150	3	0.5%	0	0.0%	3	0.5%	21	2.8%	2	3.6%	23	2.9%	667%
	567	100.0%	55	100.0%		100.0%	738	100.0%	55	100.0%		100.0%	
2) Distribution of M+C Plan Premiums (plans w/ Rx)													
\$0	239	53.1%	4	14.3%	243	50.8%	172	30.5%	3	9.1%	175	29.3%	-28%
\$ 0.01 - \$19.99	31	6.9%	1	3.6%	32	6.7%	29	5.1%	1	3.0%	30	5.0%	-6%
\$20.00 - \$39.99	90	20.0%	8	28.6%	98	20.5%	113	20.0%	7	21.2%	120	20.1%	22%
\$40.00 - \$59.99	57	12.7%	4	14.3%	61	12.8%	84	14.9%	5	15.2%	89	14.9%	46%
\$60.00 - \$79.99	22	4.9%	9	32.1%	31	6.5%	49	8.7%	3	9.1%	52	8.7%	68%
\$80.00 - \$99.99	6	1.3%	2	7.1%	8	1.7%	41	7.3%	8	24.2%	49	8.2%	513%
\$100 - \$149.99	2	0.4%	0	0.0%	2	0.4%	56	9.9%	4	12.1%	60	10.1%	2900%
above \$150	3	0.7%	0	0.0%	3	0.6%	20	3.5%	2	6.1%	22	3.7%	633%
	450	100.0%	28	100.0%		100.0%	564	100.0%	33	100.0%		100.0%	
3) Annual Limit on Rx Benefits													
Unlimited (Brand and Generic)	33	7.4%	1	4.0%		7.2%	76	13.5%	5	15.6%		13.7%	
Distribution of Annual Limits (Unlimited Generic, Limited Brand)													
Up to \$500	10	2.2%	0	0.0%	10	2.1%	78	13.9%	4	12.5%	82	13.8%	720%
\$501 - \$799	8	1.8%	2	8.0%	10	2.1%	17	3.0%	2	6.3%	19	3.2%	90%
\$800 - \$999	3	0.7%	0	0.0%	3	0.6%	3	0.5%	0	0.0%	3	0.5%	0%
\$1,000	16	3.6%	1	4.0%	17	3.6%	58	10.3%	2	6.3%	60	10.1%	253%
\$1,001 - \$2,000	49	11.0%	1	4.0%	50	10.6%	92	16.4%	7	21.9%	99	16.7%	98%
\$2,001 - \$2,500	18	4.0%	0	0.0%	18	3.8%	10	1.8%	0	0.0%	10	1.7%	-44%
Over \$2,500	7	1.6%	0	0.0%	7	1.5%	7	1.2%	0	0.0%	7	1.2%	0%
	111	24.9%	4	16.0%		24.5%	265	47.2%	15	46.9%		47.2%	
Distribution of Annual Limits (Limited Generic, Limited Brand)													
Up to \$500	77	17.3%	3	12.0%	80	17.0%	79	14.1%	2	6.3%	81	13.7%	1%
\$501 - \$799	37	8.3%	4	16.0%	41	8.7%	34	6.1%	4	12.5%	38	6.4%	-7%
\$800 - \$999	26	5.8%	3	12.0%	29	6.2%	11	2.0%	0	0.0%	11	1.9%	-62%
\$1,000	74	16.6%	6	24.0%	80	17.0%	53	9.4%	6	18.8%	59	9.9%	-26%
\$1,001 - \$2,000	74	16.6%	4	16.0%	78	16.6%	38	6.8%	0	0.0%	38	6.4%	-51%
\$2,001 - \$2,500	5	1.1%	0	0.0%	5	1.1%	3	0.5%	0	0.0%	3	0.5%	-40%
Over \$2,500	8	1.8%	0	0.0%	8	1.7%	2	0.4%	0	0.0%	2	0.3%	-75%
	301	67.6%	20	80.0%		68.3%	220	39.2%	12	37.5%		39.1%	
Grand Total	445	100.0%	25	100.0%		100.0%	561	100.0%	32	100.0%		100.0%	

**Medicare+Choice
Premium and Benefit Analysis, By Plan**

4) Distribution of Rx Copayments (per script)													
Generic													
\$0	8	2.0%	0	0.0%	8	1.9%	8	1.7%	0	0.0%	8	1.6%	0%
\$0.01-\$4.99	21	5.2%	2	8.3%	23	5.4%	5	1.1%	0	0.0%	5	1.0%	-78%
\$5.00-\$9.99	263	65.3%	15	62.5%	278	65.1%	236	50.5%	10	37.0%	246	49.8%	-12%
\$10.00-\$14.99	95	23.6%	5	20.8%	100	23.4%	203	43.5%	15	55.6%	218	44.1%	118%
\$15.00-\$24.99	16	4.0%	2	8.3%	18	4.2%	15	3.2%	2	7.4%	17	3.4%	-6%
\$25 and up	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0%
	403	100.0%	24	100.0%		100.0%	467	100.0%	27	100.0%		100.0%	
Brand													
\$0	5	1.0%	0	0.0%	5	1.0%	5	1.1%	0	0.0%	5	1.0%	0%
\$0.01-\$4.99	3	0.6%	0	0.0%	3	0.6%	3	0.6%	0	0.0%	3	0.6%	0%
\$5.00-\$9.99	6	1.3%	0	0.0%	6	1.2%	6	1.3%	0	0.0%	6	1.2%	0%
\$10.00-\$14.99	37	7.7%	2	10.0%	39	7.8%	34	7.3%	4	14.8%	38	7.7%	-3%
\$15.00-\$24.99	312	65.0%	9	45.0%	321	64.2%	303	64.9%	19	70.4%	322	65.2%	0%
\$25 and up	117	24.4%	9	45.0%	126	25.2%	116	24.8%	4	14.8%	120	24.3%	-5%
	480	100.0%	20	100.0%		100.0%	467	100.0%	27	100.0%		100.0%	
5) Rx Formulary													
Total using Formulary	356	78.6%	18	64.3%	374	77.8%	482	85.3%	26	78.6%	508	84.9%	36%
Of those above, may have diff. copayments	49	13.8%	3	16.7%	52	13.9%	271	56.2%	16	61.5%	287	56.5%	452%
No formulary indicated	97	21.4%	10	35.7%	107	22.2%	83	14.7%	7	21.2%	90	15.1%	-16%
	453	100.0%	28	100.0%		100.0%	565	100.0%	33	100.0%		100.0%	
6) Dental Benefit													
Yes	302	53.3%	21	38.2%	323	51.9%	362	49.1%	20	36.4%	382	48.2%	18%
No	265	46.7%	34	61.8%	299	48.1%	376	50.9%	35	63.6%	411	51.8%	37%
	567	100.0%	55	100.0%		100.0%	738	100.0%	55	100.0%		100.0%	
7) Vision Benefit													
Medicare Coverage Only	30	5.3%	7	12.7%	37	5.9%	68	9.2%	4	7.3%	72	9.1%	95%
Additional Benefit	537	94.7%	48	87.3%	585	94.1%	670	90.8%	51	92.7%	721	90.9%	23%
	567	100.0%	55	100.0%		100.0%	738	100.0%	55	100.0%		100.0%	

Medicare+Choice
Premium and Benefit Analyses, By Number of Counties

	1	2	3	4	5	6	7	8	9	10	11	12	13
1A) Distribution of M+C Plan Premiums (Avg. Premium Range)													
\$0	93	17%	72	23%	165	19%	46	9%	47	17%	93	12%	-44%
\$ 0.01 - \$19.99	223	41%	86	27%	309	35%	82	16%	39	14%	121	15%	-61%
\$20.00 - \$39.99	133	24%	91	29%	224	26%	177	34%	77	27%	254	32%	13%
\$40.00 - \$59.99	72	13%	41	13%	113	13%	107	21%	55	20%	162	20%	43%
\$60.00 - \$79.99	17	3%	24	8%	41	5%	45	9%	33	12%	78	10%	90%
\$80.00 - \$99.99	0	0%	3	1%	3	0%	42	8%	27	10%	59	9%	2200%
\$100 - \$149.99	11	2%	2	1%	13	1%	17	3%	3	1%	20	3%	54%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
Missing Data					2						2		0%
Not available	548	100%	318	100%		100%	516	100%	281	100%		100%	
1B) M+C Plan Premiums (Min. Premium Range)													
\$0	399	73%	213	67%	612	70%	315	61%	133	47%	448	56%	-27%
\$ 0.01 - \$19.99	14	3%	4	1%	18	2%	27	5%	20	7%	47	6%	161%
\$20.00 - \$39.99	61	11%	48	15%	109	13%	88	17%	51	18%	139	17%	28%
\$40.00 - \$59.99	47	9%	28	9%	75	9%	55	11%	44	16%	99	12%	32%
\$60.00 - \$79.99	12	2%	21	7%	33	4%	18	3%	19	7%	37	5%	12%
\$80.00 - \$99.99	1	0%	4	1%	5	1%	5	1%	14	5%	19	2%	280%
\$100 - \$149.99	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
Not available	12	3%	1	0%	18	2%	10	2%	0	0%	10	1%	-44%
	551	100%	318	100%		100%	618	100%	281	100%		100%	
2) M+C Plan Premiums (plans w/ Rx) (Avg. Premium Range)													
\$0	81	17%	64	24%	145	19%	35	8%	43	20%	78	12%	-46%
\$ 0.01 - \$19.99	217	44%	81	31%	298	40%	78	18%	29	14%	107	16%	-64%
\$20.00 - \$39.99	123	25%	69	26%	192	26%	157	36%	64	30%	221	34%	15%
\$40.00 - \$59.99	45	9%	26	10%	71	9%	78	18%	22	10%	100	15%	41%
\$60.00 - \$79.99	11	2%	18	7%	29	4%	42	10%	28	13%	70	11%	141%
\$80.00 - \$99.99	0	0%	2	1%	2	0%	40	9%	22	10%	62	10%	3000%
\$100 - \$149.99	11	2%	2	1%	13	2%	10	2%	2	1%	12	2%	-8%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	488	100%	262	100%		100%	440	100%	210	100%		100%	
3A) Rx Copayments (per script) (Average Co-Pay, By County, \$)													
<u>Generic</u>													
\$0	39	8%	21	8%	60	8%	0	0%	0	0%	0	0%	-100%
\$0.01-\$4.99	40	9%	42	17%	82	11%	6	1%	1	1%	7	1%	-91%
\$5.00-\$9.99	328	70%	127	50%	455	63%	257	60%	99	50%	356	57%	-22%
\$10.00-\$14.99	52	11%	59	23%	111	15%	158	37%	100	50%	258	41%	132%
\$15.00-\$24.99	7	2%	5	2%	12	2%	4	1%	0	0%	4	1%	-67%
\$25 and up	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	466	100%	254	100%		100%	425	100%	209	100%		100%	

Medicare+Choice
Premium and Benefit Analysis, By Number of Counties

Brand	9	2%	7	3%	16	2%	0	0%	0	0%	0	0%	-100%
\$0	0	0%	2	1%	2	0%	0	0%	0	0%	0	0%	-100%
\$0.01-\$4.99	51	11%	26	11%	77	11%	16	4%	11	6%	27	4%	-65%
\$5.00-\$9.99	155	34%	100	43%	255	37%	70	17%	49	25%	119	19%	-53%
\$10.00-\$14.99	236	51%	72	31%	308	45%	301	71%	126	64%	427	69%	39%
\$15.00-\$24.99	8	2%	23	10%	31	4%	35	8%	11	5%	46	7%	48%
\$25 and up	459	100%	230	100%		100%	422	100%	197	100%		100%	
3B) Rx Copayments (per script)													
(Minimum Co-Pay, By County, \$)													
Generic													
\$0	39	8%	21	8%	60	8%	19	4%	1	1%	20	3%	-67%
\$0.01-\$4.99	40	9%	42	17%	82	11%	10	2%	0	0%	10	2%	-89%
\$5.00-\$9.99	328	70%	127	50%	455	63%	267	63%	101	51%	368	59%	-19%
\$10.00-\$14.99	52	11%	59	23%	111	15%	127	30%	98	49%	225	36%	103%
\$15.00-\$24.99	7	2%	5	2%	12	2%	2	0%	0	0%	2	0%	-83%
\$25 and up	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	466	100%	254	100%		100%	425	100%	200	100%		100%	
Brand													
\$0	36	8%	21	9%	57	8%	14	3%	1	1%	15	2%	-74%
\$0.01-\$4.99	0	0%	0	0%	0	0%	3	1%	0	0%	3	0%	0%
\$5.00-\$9.99	95	21%	27	12%	122	18%	18	4%	13	7%	31	5%	-75%
\$10.00-\$14.99	168	37%	90	39%	258	37%	106	25%	57	29%	163	26%	-37%
\$15.00-\$24.99	152	33%	69	30%	221	32%	257	61%	115	58%	372	60%	68%
\$25 and up	8	2%	23	10%	31	4%	24	6%	11	6%	35	6%	13%
	459	100%	230	100%		100%	422	100%	197	100%		100%	
4A) Rx Coinsurance (by %)													
(Average Co-Pay, By County, %)													
Generic													
Under Five %	46	100%	12	100%	58	100%	34	100%	14	100%	48	100%	-17%
	46	100%	12	100%		100%	34	100%	14	100%		100%	
Brand													
Under Five %	52	100%	12	100%	64	100%	52	61%	14	100%	66	67%	3%
Twenty-five and Up	0	0%	0	0%	0	0%	23	29%	0	0%	23	23%	0%
	52	100%	12	100%		100%	85	100%	14	100%		100%	
4B) Rx Coinsurance (by %)													
(Minimum Co-Pay, By County, %)													
Generic													
Under Five %	46	100%	12	100%	58	100%	34	100%	14	100%	48	100%	-17%
	46	100%	12	100%		100%	34	100%	14	100%		100%	
Brand													
Under Five %	52	100%	12	100%	64	100%	53	62%	14	100%	67	68%	5%
Twenty-five and up	0	0%	0	0%	0	0%	22	28%	0	0%	22	22%	0%
	52	100%	12	100%		100%	85	100%	14	100%		100%	

Medicare+Choice
Premium and Benefit Analyses, By Number of Counties

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
5) Dental Benefit													
Yes	382	70%	161	50%	543	63%	331	64%	125	44%	456	57%	-16%
No	167	30%	158	50%	325	37%	185	36%	156	56%	341	43%	5%
	549	100%	319	100%		100%	516	100%	281	100%		100%	
6) Vision Benefit													
Medicare Coverage Only	9	7%	15	16%	24	11%	8	5%	9	12%	17	7%	-28%
Additional Benefit	540	106%	304	334%	644	377%	508	287%	272	353%	780	307%	-8%
	549	413%	319	351%		388%	516	292%	281	365%		314%	

Medicare+Choice

Premium and Benefit Analyses, By # of Medicare Eligibles

1A) M+C Plan Premiums													
(Average Premium Range)													
\$0	3,855,164	15%	365,824	17%	4,220,988	15%	1,781,725	7%	232,194	12%	2,013,919	7%	-52%
\$0.01 - \$19.99	14,491,477	57%	586,159	28%	15,077,636	54%	6,610,159	27%	266,383	14%	6,876,542	26%	-54%
\$20.00 - \$39.99	4,998,372	20%	586,637	28%	5,585,029	20%	7,841,536	31%	456,881	24%	8,298,417	31%	49%
\$40.00 - \$59.99	1,375,156	5%	334,047	16%	1,709,203	6%	4,363,633	18%	394,506	20%	4,758,139	18%	178%
\$60.00 - \$79.99	567,109	2%	194,663	9%	761,772	3%	2,312,236	9%	368,354	19%	2,680,590	10%	252%
\$80.00 - \$99.99	0	0%	39,742	2%	39,742	0%	1,417,499	6%	203,160	10%	1,620,659	6%	3978%
\$100 - \$149.99	309,017	1%	11,611	1%	320,628	1%	603,775	2%	19,962	1%	623,737	2%	95%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	
	25,586,285	100%	2,118,703	100%		100%	24,970,563	100%	1,941,440	100%		100%	
1B) M+C Plan Premiums													
(Minimum Premium Range)													
\$0	20,341,768	78%	1,331,493	63%	21,673,261	78%	19,422,463	78%	784,702	40%	20,207,165	75%	-7%
\$0.01 - \$19.99	377,001	1%	46,752	2%	423,753	2%	836,321	3%	213,475	11%	1,049,796	4%	148%
\$20.00 - \$39.99	1,192,150	5%	296,954	14%	1,489,104	5%	2,122,571	9%	352,954	18%	2,475,525	9%	66%
\$40.00 - \$59.99	1,071,638	4%	224,769	11%	1,296,407	5%	1,377,563	6%	333,463	17%	1,711,026	6%	32%
\$60.00 - \$79.99	338,448	1%	160,647	8%	499,095	2%	364,369	1%	133,437	7%	497,806	2%	0%
\$80.00 - \$99.99	3,393	0%	46,733	2%	50,126	0%	83,156	0%	123,409	6%	206,565	1%	312%
\$100 - \$149.99	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
Not available	2,271,897	9%	11,355	1%	2,283,252	8%	724,120	3%	0	0%	724,120	3%	-68%
	25,586,285	100%	2,118,703	100%		100%	24,970,563	100%	1,941,440	100%		100%	
2) M+C Plan Premiums (plans w/ Rx)													
\$0	3,409,485	14%	295,266	18%	3,704,751	14%	1,363,961	6%	206,778	14%	1,570,739	6%	-58%
\$0.01 - \$19.99	14,391,871	60%	545,303	32%	14,937,174	58%	6,563,141	28%	204,096	14%	6,767,237	27%	-55%
\$20.00 - \$39.99	4,669,979	20%	455,926	27%	5,125,905	20%	7,386,503	32%	363,731	25%	7,750,234	31%	51%
\$40.00 - \$59.99	792,055	3%	233,783	14%	1,025,838	4%	3,726,218	16%	177,569	12%	3,903,787	16%	281%
\$60.00 - \$79.99	347,421	1%	122,525	7%	469,946	2%	2,233,458	10%	318,855	22%	2,552,313	10%	443%
\$80.00 - \$99.99	0	0%	19,174	1%	19,174	0%	1,397,924	6%	148,379	10%	1,546,303	6%	7965%
\$100 - \$149.99	309,017	1%	11,611	1%	320,628	1%	529,049	2%	15,342	1%	544,391	2%	70%
above \$150	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	23,910,828	100%	1,883,588	100%		100%	23,280,254	100%	1,434,750	100%		100%	
3A) Rx Copayments (per script)													
(Average Co-Pay, By County, \$)													
Generic													
\$0	1,209,300	5%	34,631	2%	1,243,931	5%	0	0%	0	0%	0	0%	-100%
\$0.01-\$4.99	3,456,347	15%	225,475	14%	3,683,822	15%	798,350	4%	11,738	1%	810,088	3%	-78%
\$5.00-\$9.99	16,948,449	72%	849,389	53%	17,796,838	71%	16,408,831	72%	638,304	47%	17,047,135	71%	-4%
\$10.00-\$14.99	1,567,607	7%	461,919	29%	2,029,526	8%	5,482,219	24%	703,565	52%	6,185,784	26%	205%
\$15.00-\$24.99	211,393	1%	38,392	2%	249,785	1%	28,627	0%	0	0%	28,627	0%	-89%
\$25 and up	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	23,385,096	100%	1,608,806	100%		100%	22,718,027	100%	1,353,807	100%		100%	
Brand													

Medicare+Choice
Premium and Benefit Analyses, By # of Medicare Eligibles

\$0	1,214,074	5%	56,879	4%	1,270,953	5%	0	0%	0	0%	0	0%	-100%
\$0.01-\$4.99	0	0%	9,357	1%	9,357	0%	0	0%	0	0%	0	0%	-100%
\$5.00-\$9.99	2,104,366	9%	182,913	12%	2,287,279	9%	871,992	4%	86,399	7%	958,391	4%	-58%
\$10.00-\$14.99	10,052,829	43%	610,663	41%	10,663,492	43%	4,267,243	19%	263,225	20%	4,530,468	19%	-58%
\$15.00-\$24.99	9,779,832	42%	519,720	35%	10,299,552	42%	16,496,878	73%	871,358	67%	17,368,236	73%	69%
\$25 and up	170,224	1%	103,694	7%	273,918	1%	944,382	4%	87,919	7%	1,032,301	4%	277%
	23,321,325	100%	1,483,226	100%		100%	22,580,495	100%	1,308,801	100%		100%	
3B) Rx Copayments (per script)													
[(Minimum Co-Pay, By County, %)]													
Generic													
\$0	4,592,890	20%	116,133	7%	4,709,123	19%	3,793,298	17%	11,738	1%	3,805,036	16%	-19%
\$0.01-\$4.99	3,040,592	13%	200,049	12%	3,240,641	13%	942,726	4%	0	0%	942,726	4%	-71%
\$5.00-\$9.99	14,474,089	62%	832,198	52%	15,306,287	61%	13,669,116	60%	660,949	49%	14,330,065	60%	-8%
\$10.00-\$14.99	1,076,032	5%	422,034	26%	1,498,066	6%	4,299,031	19%	680,920	50%	4,979,951	21%	232%
\$15.00-\$24.99	211,393	1%	38,392	2%	249,785	1%	13,856	0%	0	0%	13,856	0%	-94%
\$25 and up	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0%
	23,395,896	100%	1,408,808	100%		100%	22,788,027	100%	1,353,607	100%		100%	
Brand													
\$0	3,305,144	14%	116,133	8%	3,421,277	14%	1,993,732	9%	11,738	1%	2,005,470	8%	-41%
\$0.01-\$4.99	0	0%	0	0%	0	0%	239,524	1%	0	0%	239,524	1%	0%
\$5.00-\$9.99	6,847,514	29%	194,173	13%	7,041,687	28%	1,851,344	8%	96,701	7%	1,948,045	8%	-72%
\$10.00-\$14.99	8,187,894	35%	566,502	38%	8,754,396	35%	6,322,988	28%	285,099	22%	6,608,087	28%	-25%
\$15.00-\$24.99	4,810,549	21%	502,724	34%	5,313,273	21%	11,726,996	52%	827,444	63%	12,554,440	53%	136%
\$25 and up	170,224	1%	103,694	7%	273,918	1%	445,911	2%	87,919	7%	533,830	2%	95%
	23,321,325	100%	1,483,226	100%		100%	22,580,495	100%	1,308,801	100%		100%	
4A) Rx Coinsurance (%)													
(Average Co-Pay, By County, %)													
Generic													
Under Five %	1,647,682	100%	116,452	100%	1,764,134	100%	1,404,965	100%	124,813	100%	1,529,778	100%	-13%
	1,647,682	100%	116,452	100%		100%	1,404,965	100%	124,813	100%		100%	(0)
Brand													
Under Five %	1,874,268	100%	116,452	100%	1,990,720	100%	2,456,224	41%	124,813	100%	2,581,037	42%	30%
Twenty-five and Up	0	0%	0	0%	0	0%	3,565,353	59%	0	0%	3,565,353	58%	0%
	1,874,268	100%	116,452	100%		100%	6,021,577	100%	124,813	100%		100%	
4B) Rx Coinsurance (%)													
(Minimum Co-Pay, By County, %)													
Generic													
Under Five %	1,647,682	100%	116,452	100%	1,764,134	100%	1,404,965	100%	124,813	100%	1,529,778	100%	-13%
	1,647,682	100%	116,452	100%		100%	1,404,965	100%	124,813	100%		100%	(0)
Brand													
Under Five %	1,874,268	100%	116,452	100%	1,990,720	100%	2,506,526	42%	124,813	100%	2,631,339	43%	32%
Twenty-five and up	0	0%	0	0%	0	0%	3,515,051	58%	0	0%	3,515,051	57%	0%

Medicare Choice
Premium and Benefit Analyses, By # of Medicare Eligibles

	1,874,268	100%	116,452	100%		100%	8,021,577	100%	174,813	100%		100%	
5) Dental Benefit													
Yes	21,721,135	85%	1,073,724	51%	22,794,859	82%	20,786,990	83%	780,070	40%	21,567,060	80%	-5%
No	3,875,160	15%	1,044,979	49%	4,920,139	16%	4,143,573	17%	1,161,370	60%	5,304,943	20%	0%
	25,596,295	100%	2,118,703	100%		100%	24,930,563	100%	1,941,440	100%		100%	
6) Vision Benefit													
Medicare Coverage Only	133,654	1%	88,301	4%	221,955	1%	207,586	1%	98,765	5%	306,351	1%	38%
Additional Benefit	25,462,641	99%	2,030,402	96%	27,493,043	99%	24,722,977	99%	1,842,675	95%	26,565,652	99%	-3%
	25,596,295	100%	2,118,703	100%		100%	24,930,563	100%	1,941,440	100%		100%	

Medicare + Choice Premium and Rx Benefit Analyses

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1. General Summary (1995 - 2000)
2. Nonrenewal Information (Premiums and Benefits - 1999 data)
3. Changes in the Medicare+Choice Industry
 - A. Information by number of Plans
 - B. Information by number of Counties
 - C. Information by number of Medicare

Note: The following pages contain preliminary information based on an analyses of the ACR/BIF data for Medicare + Choice organizations. Analyses is based on an overview of Medicare + Choice organizations only and does not reflect other managed care prepaid contracts (including 1876 contracts, Health Care Prepayment Organizations, and other demonstration contracts). Information is based on data received as of 8/1/99 and is subject to change.

**MEDICARE MANAGED CARE
(AS OF JUNE 1, 199X)**

CONTRACT SUMMARY

MACRISK
OOST
OTHSH DEMOS
HOPP

# of Contracts	Enrollees	# of Contracts	Enrollees	# of Contracts	Enrollees	# of Contracts	Enrollees	# of Contracts	Enrollees	# of Contracts	Enrollees
262	7	309	6,192,892	349	6,710,550	269	4,709,388	216	3,925,942	164	2,671
58	7	47	358,058	94	225,798	36	199,958	34	181,212	30	180,889
35	185,958	37	185,958	29	122,945	19	68,132	6	21,536	3	17,892
15	125,843	15	125,843	43	338,182	48	408,011	51	483,080	58	648,078
389	311,498	402	6,853,949	482	8,388,436	388	5,388,488	369	4,311,763	253	3,472,944

# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)
242	30.5	304	48.9	232	89.6	180	67.4	123	84.7	77	50.7
39	4.9	41	8.8	15	4.5	17	6	7	3.7	12	7.9
156	19.7	130	20.9	43	12.9	43	15.3	26	11.7	28	18.4
130	18.4	89	14.3	23	8.9	20	7.1	24	12.6	18	10.5
80	10.1	40	6.4	16	6.4	10	3.6	8	4.2	13	8.5
146	18.4	18	2.9	1	0.3	2	0.7	2	1.1	6	4
799		622		182		282		189		682	

# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)	# of Plans	(%)
NA	NA	NA	NA	750	96.7 / 99.8 / 38	824	96.8 / 98.3 / 36.2	387	97.4 / 88.3 / 25.3	317	96.7 / 88.8 / 25
598	75	461	77	225	67.4	194	68.8	118	62.5	73	48
721	91	586	94	280	83.2 / 0.6	303	91.5 / 16	178	67.9 / 5.8	144	89.5 / 5.3
NA	NA	NA	NA	243	72.2 / 0.6	249	77.7 / 10.6	147	73.7 / 3.7	158	73.7 / 4
362	48	329	52	124	37.1	113	40.1	73	38.4	63	34.8

MACRISK BENEFITS

PREVENTIVE¹
Rx
VISION²
HEARING³
DENTAL

* - (IN BASIC OPTION PACKAGE)

1 - Includes: Routine Physicals, Immunizations & Health Ed.

2 - Includes: Eye Exams & Lenses

3 - Includes: Ear Exams & Hearing Aids

~ - Includes: 8 Risk Demos

Carlos to write narrative

A. 2000 HCFA Payment Distribution	Benefit Plans *		Affected Enrollees		Counties	
	#	%	#	%	#	%
up to \$449	N/A	N/A	39,002	11.9%	75	22.7%
\$450 - \$499	N/A	N/A	124,343	38.1%	115	34.8%
\$500 - \$549	N/A	N/A	88,572	27.1%	72	21.8%
\$550 - \$599	N/A	N/A	51,382	15.7%	41	12.4%
\$600 +	N/A	N/A	23,286	7.1%	27	8.2%
Total	N/A	N/A	326,585	100.0%	330	100.0%
B. MSA vs. non-MSA						
MSA	94	80.3%	268,010	88.5%	232	70.3%
non-MSA	23	19.7%	37,575	11.5%	98	29.7%
Total	117	100.0%	326,585	100.0%	330	100.0%
C. 1999 Premium Distribution						
\$0	78	67.5%	232,172	71.1%	N/A	N/A
\$0.01 - \$19.99	4	3.4%	8,876	2.7%	N/A	N/A
\$20.00 - \$39.99	11	9.4%	22,540	6.9%	N/A	N/A
\$40.00 - \$59.99	14	12.0%	42,584	13.0%	N/A	N/A
\$60.00 - \$79.99	7	6.0%	18,211	5.6%	N/A	N/A
\$80.00 - \$99.99	2	1.7%	2,202	0.7%	N/A	N/A
\$100.00 - \$149.99	-	0.0%	-	0.0%	N/A	N/A
\$150 +	-	0.0%	-	0.0%	N/A	N/A
Total	117	100.0%	326,585	100.0%	N/A	N/A
D. Rx included in base plan						
Yes	87	74.4%	263,806	80.8%	245	74.2%
No	30	25.8%	62,779	19.2%	85	25.8%
Total	117	100.0%	326,585	100.0%	330	100.0%
E. Other Information (PMPM basis)						
Average Premium			\$22.00			
Weighted Average Premium			pending			
Premium Median			? \$0			
Average Copay			\$25.00			
Average Value of Rx Benefit			\$40.00			
Average Value of Non-Medicare Benefits			\$59.00			

* Based on 2000 nonrenewal data (99 HHS)

Brief analysis
CHPP/HPPA/DPFE

M+C SAR/NR Summary - August 11, 1999 6:30PM

more than
half of plans
have 0
→ these are non-renewals

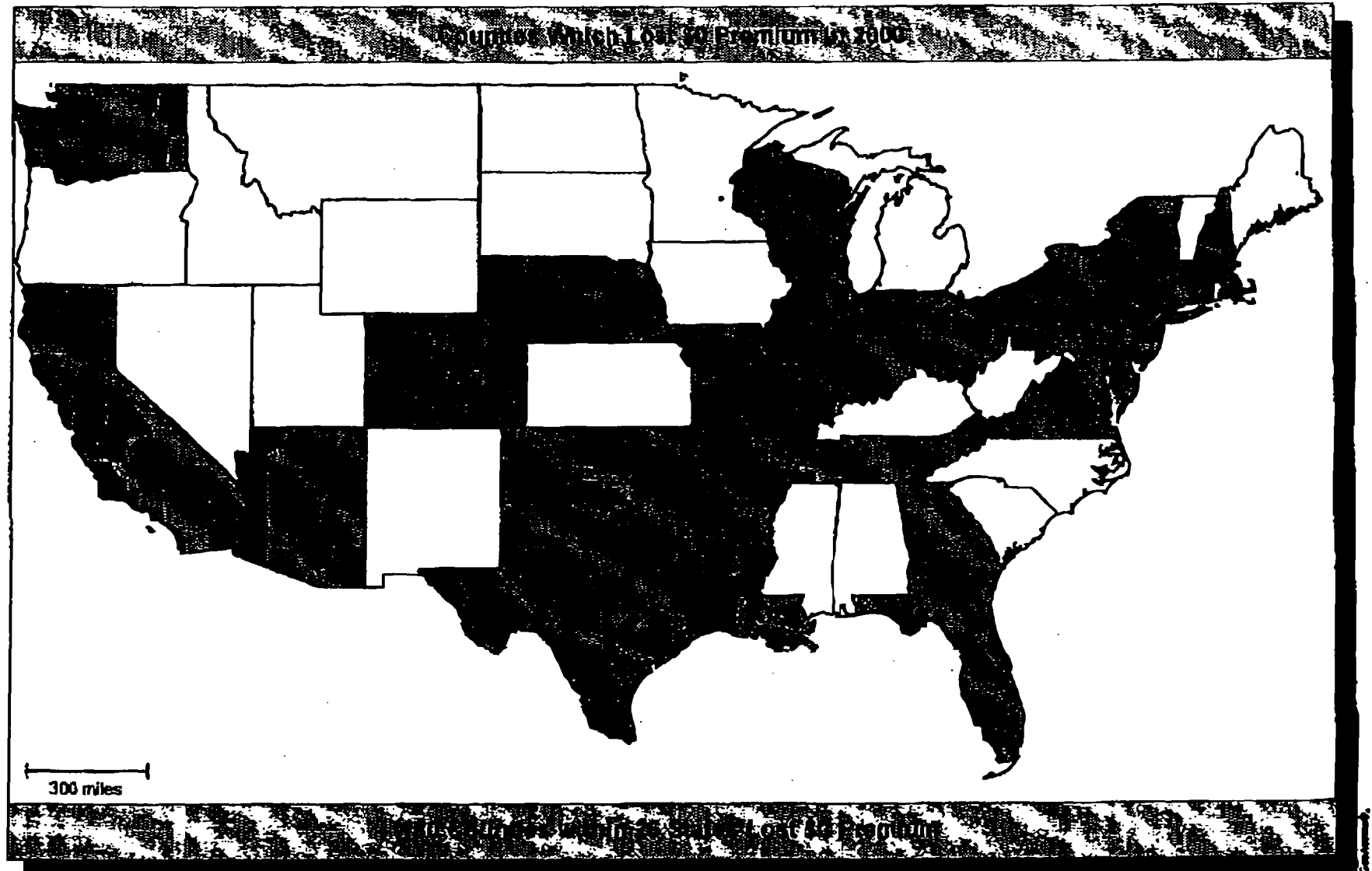
in the package
Nat'l average is \$2

Medicare + Choice Distribution of Plans

No plans available	2123	69.5%	10,602,795	27.3%	2379	74.1%	12,562,124	31.9%
1 or more plans available	932	30.5%	28,207,062	72.7%	831	25.9%	26,876,987	68.1%
1	257	27.6%	3,002,679	10.6%	190	22.9%	2,413,897	9.0%
2	199	21.4%	2,118,191	7.5%	167	20.1%	2,294,945	8.5%
3	105	11.3%	2,062,608	7.3%	127	15.3%	1,958,209	7.3%
4	102	10.9%	2,464,509	8.7%	74	8.9%	1,700,052	6.3%
5	57	6.1%	2,291,720	8.1%	44	5.3%	1,884,938	7.0%
6+	212	22.7%	16,267,355	57.7%	229	27.6%	16,624,946	61.9%

**Medicare + Choice
Weighted Average Premium
By State**

AL	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
AR	\$ 20.56	\$ 19.62	\$ 20.24	\$ 44.50	\$ 34.07	\$ 40.95
AZ	\$ 12.58	\$ 45.48	\$ 17.20	\$ 15.67	\$ 60.08	\$ 20.73
CA	\$ 10.95	\$ 31.35	\$ 11.28	\$ 21.56	\$ 27.38	\$ 21.62
CO	\$ 18.44	\$ 33.07	\$ 19.16	\$ 35.06	\$ 75.15	\$ 37.03
CT	\$ 27.33	\$ 65.67	\$ 28.51	\$ 78.61	\$ -	\$ 78.61
DC	\$ -	\$ -	\$ -	\$ 17.60	\$ -	\$ 17.60
DE	\$ 30.00	\$ -	\$ 30.00	\$ 53.78	\$ 81.00	\$ 61.29
FL	\$ 5.98	\$ 38.34	\$ 6.91	\$ 24.80	\$ 49.34	\$ 25.54
GA	\$ 5.50	\$ -	\$ 5.20	\$ 28.03	\$ -	\$ 28.03
HI	\$ 68.60	\$ 68.60	\$ 68.60	\$ 47.87	\$ 60.53	\$ 51.28
IA	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
ID	\$ 35.00	\$ -	\$ 35.00	\$ 35.00	\$ -	\$ 35.00
IL	\$ 12.46	\$ 3.23	\$ 12.23	\$ 39.07	\$ 12.05	\$ 38.41
IN	\$ 38.25	\$ 50.00	\$ 36.52	\$ 43.48	\$ 50.00	\$ 43.61
KS	\$ 28.74	\$ -	\$ 28.74	\$ 31.43	\$ -	\$ 31.43
KY	\$ 21.35	\$ -	\$ 21.35	\$ 48.83	\$ -	\$ 48.83
LA	\$ 1.75	\$ -	\$ 1.37	\$ 20.30	\$ 15.06	\$ 19.56
MA	\$ 2.58	\$ 15.00	\$ 2.73	\$ 12.45	\$ 12.50	\$ 12.45
MD	\$ 8.03	\$ 75.00	\$ 14.30	\$ 15.91	\$ -	\$ 15.91
ME	\$ 52.71	\$ 62.43	\$ 54.12	\$ 47.00	\$ 47.00	\$ 47.00
MI	\$ 19.46	\$ 60.00	\$ 20.27	\$ 25.98	\$ 82.50	\$ 27.10
MN	\$ 119.93	\$ 128.90	\$ 120.25	\$ 122.28	\$ 99.99	\$ 121.48
MO	\$ 16.53	\$ 27.37	\$ 16.90	\$ 29.48	\$ 50.77	\$ 30.22
MS	\$ -	\$ -	\$ -	N/A	N/A	N/A
MT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
NC	\$ 26.98	\$ 37.23	\$ 28.24	\$ 33.44	\$ 41.39	\$ 34.41
NE	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
NH	\$ 12.05	\$ -	\$ 10.80	\$ 40.00	\$ -	\$ 40.00
NJ	\$ 22.21	\$ -	\$ 22.21	\$ 80.27	\$ -	\$ 80.27
NM	\$ 14.02	\$ 22.27	\$ 15.48	\$ 17.42	\$ 32.14	\$ 20.02
NV	\$ 16.79	\$ 45.03	\$ 17.72	\$ 15.31	\$ 27.28	\$ 15.71
NY	\$ 19.51	\$ 26.02	\$ 19.83	\$ 46.90	\$ 42.87	\$ 46.72
OH	\$ 12.61	\$ 24.55	\$ 13.92	\$ 33.91	\$ 40.74	\$ 34.71
OK	\$ 13.29	\$ 13.82	\$ 13.48	\$ 23.62	\$ 5.52	\$ 17.32
OR	\$ 48.96	\$ 62.65	\$ 51.85	\$ 63.43	\$ 65.14	\$ 63.78
PA	\$ 21.07	\$ 27.02	\$ 21.85	\$ 55.82	\$ 56.21	\$ 55.87
RI	\$ 9.56	\$ -	\$ 9.56	\$ 39.08	\$ -	\$ 39.08
SC	\$ 45.00	\$ -	\$ 45.00	N/A	N/A	N/A
TN	\$ 14.92	\$ 22.42	\$ 16.56	\$ 14.35	\$ 19.17	\$ 15.63
TX	\$ 3.75	\$ 13.70	\$ 5.23	\$ 8.33	\$ 33.02	\$ 11.88
VA	\$ 24.35	\$ 30.53	\$ 24.60	\$ 29.77	\$ 32.69	\$ 29.95
WA	\$ 26.00	\$ 40.99	\$ 28.42	\$ 43.00	\$ 76.48	\$ 47.58
WI	\$ 15.05	\$ 15.00	\$ 15.05	\$ 35.05	\$ 51.97	\$ 37.52
WV	\$ 54.62	\$ 38.31	\$ 48.28	\$ 32.39	\$ 44.00	\$ 39.25
US Total	\$ 16.61	\$ 29.02	\$ 17.47	\$ 34.91	\$ 42.21	\$ 35.44



■ Counties with \$0 Premium in 1999 but not in 2000

DRAFT Talking Points – Year 2000 Benefits and Premiums

INTERNAL ONLY. The following information is based on a preliminary analysis of the Year 2000 ACRP/benefit submissions. This information is not intended for public distribution.

Year 2000 Benefits and Premiums

- Beginning in January 2000, we expect that slightly fewer Medicare eligibles will have access to a managed care health plan.
 - Approximately 70% of the current Medicare eligibles (or 27 of 39 million) now have access to a managed care health plan. Beginning in January 2000, we expect that fewer 67% (or 26 million) of Medicare eligibles will have access to a managed care plan.
- Likewise, slightly fewer Medicare eligibles will have access to a managed care plan with no monthly premiums¹.
 - In 1999, approximately 79% of those Medicare eligibles with access to a managed care plan could join a plan without paying monthly premiums. In the year 2000, we expect that 76% of Medicare eligibles will have access to a \$0 (zero) premium plan than in 1999.
- Although most beneficiaries will continue to have access to a managed care plan with no monthly premiums, we expect a decline in the number of \$0 premium plans offered.
 - In 1999, approximately ½ (or 50%) of Medicare+Choice plans were offered for \$0 premium. In 2000, we expect that only 30% of plans will be offered for no monthly premiums.
- Overall, we expect that managed care enrollees will pay twice as much in monthly premiums, on average, than they paid in 1999².

¹ Medicare eligibility information based on the March 1999 HCFA penetration report now available on the HCFA Internet. Information does not account for partial counties and therefore assumes that plans are available to all Medicare eligibles who reside in a particular county.

² Medicare eligibility information based on the March 1999 HCFA penetration report now available on the HCFA Internet. Information does not account for partial counties and therefore assumes that plans are available to all Medicare eligibles who reside in a particular county.

DRAFT Talking Points -- Year 2000 Benefits and Premiums

- Today, Medicare beneficiaries pay an average of \$21 a month to join a managed care plan. We expect the average monthly premium to increase to approximately \$42 a month beginning January 2000.
- In 1999, approximately 24% of the total managed care plans had premiums in excess of \$40 a month. In 2000, we expect that over 45% of the managed care plans in 2000 will have premiums of more than \$40.
- Based on preliminary estimates ³, it appears that the total amount of 'out-of-pocket' costs that M+C enrollees pay for services will increase significantly in 2000, compared to 1999. On average, enrollees will pay approximately \$75.00 per month in premiums and copayments in 2000, more than twice the approximately \$35.00 per month they are currently paying.
- Medicare eligibles with access to a managed care plan will continue to receive at least some prescription drug coverage as part of their basic services.
 - In 1999 and in 2000, approximately 25 million Medicare eligibles (or over 90% of the total with access to a managed care plan) will have access to a basic managed care plan which includes prescription drug coverage. In addition, another 1%-2% will have the option to pay additional premiums for prescription drug coverage.

Benefits and Premiums for Nonrenewing Plans

- Approximately 79% (73 of 92) of M+C organizations who reduced their service areas or withdrew their managed care contract offered a \$0 (zero) premium plan.
- Approximately 60% (or 58 of 92) of M+C organizations who reduced their service areas or withdrew their managed care contract offered a prescription drug benefit.

³ Year 2000 estimates based on a sample of approximately 700 out of 800 M+C products (or benefit packages) submitted on July 1. Information on cost sharing is based on actuarial projections submitted in the annual Adjusted Community Rate Proposals.

Medicare Choice 1999 vs 2000 Benefit Comparison

(Note: Information based on all M+C plans and related demos which submit annual ACRs)

General Information

- 1) Total Number of M+C Plans (i.e. M+C and related demonstration plans only)
(state information available)
- 2) Total Number of M+C Organizations (e.g. Pacificare of CA, Humana of TX)
(state information available)

Premiums

- 3) % of M+C Plans offered for \$0 premium (excludes optional benefits)

- 4) Distribution of M+C Plan Premiums (all plans)

\$0
\$ 0.01 - \$19.99
\$20.00 - \$39.99
\$40.00 - \$59.99
\$60.00 - \$79.99
\$80.00 - \$99.99
\$100 - \$149.99
above \$150
Not Available

- 5) Beneficiary Access to a \$0 premium plan

(state information available)

As a % of total with access to managed care
% of total beneficiaries

Number (and listing) of counties with \$0 premium
Number (and listing) of counties without \$0 premium

National Data	
1999	2000
656	807
(322) 49%	(236) 49%
<u>% of Total Plans</u>	<u>% of Total Plans</u>
49.1%	29.2%
6.3%	4.7%
20.6%	19.2%
14.0%	16.5%
6.3%	10.2%
2.1%	7.6%
0.3%	7.9%
0.6%	3.0%
0.8%	1.7%
100%	100.0%
79%	76%
55%	51%
7/19/19 (map by COB)	7/18/19 (map by COB)
7/19/19 (map by COB)	7/19/19 (map by COB)

(Note: Information based on all M+C plans and related demos which submit annual ACRs)

6) Premiums for M+C Plans with Rx in 'Standard' Benefit Package

\$0
\$ 0.01 - \$19.99
\$20.00 - \$39.99
\$40.00 - \$59.99
\$60.00 - \$79.99
\$80.00 - \$99.99
\$100 - \$149.99
above \$150
Not Available

Average Premium (all Rx plans)

Average Premium (all non-zero Rx plans)

Unlimited Brand/Generic Coverage

Unlimited Generic / Annual Cap on Brand

Limited Generic and Brand Coverage

7) Reported 'out-of-pocket' costs

Average premium and projected copayments (all plans)

Average premium

Average copayments

Average premium and projected copayments (non zero plans only)

Average premium

Average copayments

Prescription Drugs

8) M+C Plans which include Prescription Drugs (Rx)

% of M+C Plans which include Prescription Drugs (Rx) in 'standard' package

% of M+C Plans which include Rx as 'Optional' benefit only

National Data	
1999	2000
% of Total Rx Plans	% of Total Rx Plans
51.4%	28.7%
6.3%	5.0%
19.9%	20.0%
12.6%	15.0%
6.3%	8.9%
1.8%	8.1%
0.4%	10.2%
0.8%	3.8%
0.6%	2.3%
100%	100%
\$20.93	\$46.70
7/19/99	7/19/99
time permitting	time permitting
time permitting	time permitting
time permitting	time permitting
\$31.00	\$78.00
\$21.84	\$42.62
7/19/99	7/19/99
7/19/99	7/19/99
7/19/99	7/19/99
7/19/99	7/19/99
7/19/99	7/19/99
7/19/99	7/19/99
77.4%	75.1%
0.8%	2.0%

(Note: Information based on all M+C plans and related demos which submit annual ACRs)

% of M+C Plans which do not include Rx

9) Annual Limit on Rx Benefits

Limitations on Benefits

Unlimited (Brand and Generic)
Unlimited Generic, Limited Brand
Limited Generic and Brand

Distribution of Annual Limits

Up to \$500
\$501 - \$799
\$800 - \$999
\$1000 - \$1999
\$2000 - \$2499
Over \$2500
Data not available

10) Distribution of Rx Copayments (per script)

Generic
\$0
Under \$5
\$6 - 10
\$11 - 15
\$16 - 25
over \$25

National Data	
1999	2000
21.8%	22.9%
100.0%	100.0%
<u>% of Total RX Plans</u>	<u>% of Total RX Plans</u>
7/19/99	13.8%
7/19/99	47.3%
7/19/99	38.9%
	100.0%
<u>% of RX Plans w/ Limits</u>	<u>% of RX Plans w/ Limits</u>
-	31.7%
7/19/99	10.4%
7/19/99	26.3%
7/19/99	26.1%
7/19/99	3.0%
7/19/99	2.2%
	0.2%
	100.0%
<u>% of Total Rx Plans</u>	<u>% of Total Rx Plans</u>
7/19/99	2.6%
7/19/99	0.9%
7/19/99	50.0%
7/19/99	43.3%
7/19/99	3.2%
7/19/99	0.0%

(Note: Information based on all M+C plans and related demos which submit annual ACRs)

Brand

\$0
Under \$5
\$6 - 10
\$11 - 15
\$16 - 25
over \$25

11) Access to Rx Benefits

(state information available)

% of Medicare beneficiaries with access to Rx

As a % of total with access to managed care
% of total beneficiaries

% of Medicare beneficiaries without access to Rx

As a % of total with access to managed care
% of total beneficiaries

List of states where all beneficiaries lost Rx benefit:

	# of eligibles
Arkansas	138867
Iowa	14094
Nebraska	60110 7114
West Virginia	70772 54040

Number (and listing) of counties without Rx

Number (and listing) of counties with Rx

Other Benefits

National Data	
1999	2000
	100%
7/19/99	1.6%
7/19/99	0.2%
7/19/99	2.2%
7/19/99	8.8%
7/19/99	65.3%
7/19/99	22.0%
	100%
91%	7/19/99
63%	62%
8.8%	6.6%
6.3%	4.5%
7/19/19 (map by COB)	7/19/19 (map by COB)
7/19/19 (map by COB)	7/19/19 (map by COB)

(Note: Information based on all M+C plans and related demos which submit annual ACRs)

12) Reported value of non-Medicare benefits (excludes optional benefits)

Average reported value of non-Medicare benefits

As % of average HCFA premium (reported APR)

note: footnote with or without copayments

Distribution of non-Medicare benefit types included in plans

As % of total plans (e.g. % plans with Vision, Hearing, etc.)

Relative reported values

National Data	
1998	2000
7/19/19 (cob)	7/19/19 (cob)
7/19/19 (cob)	7/19/19 (cob)
time permitting	time permitting
time permitting	time permitting
time permitting	time permitting

 **DRAFT**Only

Medicare+Choice in 2000: Plan Participation Summary

All information is as of July 8, 1999. Except where noted, "enrollees" refers to Medicare+Choice enrollees. Except where noted, the term "non-renewal" includes both actual non-renewal of entire contracts as well as service area reductions.

Year 2000 Benefits and Premiums Based on preliminary review and analysis of ACR data.

- Beginning in January 2000, we expect that fewer Medicare eligibles will have access to a managed care health plan. Approximately 70% of the current Medicare eligibles (or 27 of 39 million) now have access to a managed care health plan. Beginning in January 2000, we expect that fewer than 67% (or 26 million) of Medicare eligibles will have access to a managed care plan.
- Fewer Medicare eligibles will have access to a managed care plan with no monthly premiums. In 2000, fewer Medicare eligibles will have access to a \$0 (zero) premium plan than in 1999. In 1999, approximately 65% of those Medicare eligibles with access to a managed care plan could join a plan without paying monthly premiums. Based on preliminary estimates, we expect that only 36% of persons living where managed care plans are available may join a \$0 premium plan.
- Overall, we expect that managed care enrollees will pay more to join a managed care plan in 2000, compared to what they paid in 1999. In 1999, approximately 15% of the total managed care plans (or benefit packages) had premiums in excess of \$30 a month. In 2000, we expect that over 50% of the managed care plans in 2000 will have premiums of more than \$30.

Based on preliminary estimates, it appears that the total amount of out-of-pocket costs that M+C enrollees pay for services will increase significantly in 2000, compared to 1999. On average, enrollees will pay approximately \$75.00 per month in premiums and copayments in 2000, more than twice the approximately \$35.00 per month they are currently paying.

- The majority of Medicare eligibles with access to a managed care plan continue to receive prescription drug coverage as part of their basic services. In 1999 and in 2000, approximately 25 million Medicare eligibles (or over 90% of the total with access to a managed care plan) will have access to a basic managed care plan which includes prescription drug coverage. In addition, another 1%-2% will have the option to pay additional premiums for prescription drug coverage.

DRAFT**Non-renewal Summary*****General***

- About 95% of current Medicare+Choice enrollees will be able to continue with their current plan.
- There were 56 service area reductions affecting 152,482 enrollees. These plans will continue serving other parts of their current service areas. There were 41 non-renewals affecting 168,628 enrollees.

In total, 97 contracts non-renewed or reduced their service areas, affecting 321,110 enrollees (5.1% of the 6.2 million Medicare+Choice enrollees) who live in 327 counties in 33 states.

- In 1998, there were 54 service area reductions affecting 191,851 enrollees. There were 45 non-renewing contracts affecting 214,687 enrollees. In total, 405,538 enrollees (about 6.5 percent of enrollment at the time in 1998) were affected, in 407 counties in 29 states and the District of Columbia.

Abandoned Counties

- 79,186 (1.3 percent of all enrollees) of the 321,110 affected enrollees will have no other M+C plan available. These enrollees live in 110 counties in 21 states.
- In 1998, 51,276 enrollees (less than 1 percent of enrollment at the time in 1998) were left with no other plan. They lived in 79 counties. Four of these counties (Kent and Sussex in Delaware, Monroe in Florida and Muskingum in Ohio) now have an M+C plan available.

Benefits and Premiums for Nonrenewing Plans

- Approximately 79% (73 of 92) of M+C organizations who reduced their service areas or withdrew their managed care contract offered a \$0 (zero) premium plan.
- Approximately 60% (or 58 of 92) of M+C organizations who reduced their service areas or withdrew their managed care contract offered a prescription drug benefit.

Payments in Affected Areas

- Two-thirds of affected enrollees -- more than 200,000 enrollees -- live in areas where the payment rate was between \$450 to less than \$550.
- Some areas were disproportionately affected. The most disproportionately affected areas were where the payment rate was between \$450 to less than \$500 and with growth rates between 5 percent to less than 7.5 percent --- about 13.8 percent of all enrollees were affected in such areas compared to 5.1 percent of enrollees nationwide.

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In this category (\$450 to less than \$500), growth rates did not matter. For example, in area with growth rates of 10 percent or higher, 11.1 percent of enrollees were affected compared to 5.1 percent of enrollees nationwide. Overall, in this category, 12 percent of enrollees were affected.

- Beneficiaries in counties with payments from the floor to \$500 make up 24.2 percent of beneficiaries enrolled in M+C but represent 50.1 percent of withdrawals.
- Beneficiaries in counties with payments from the floor to \$550 make up 50.8 percent of M+C enrollees but represent 77.7 percent of withdrawals.
- The national median payment rate, weighted by beneficiaries is \$499.04 for 2000. The national median payment rate, weighted by enrollees is \$548.59 for 2000. The national mean payment rate, weighted by beneficiaries is \$513.62 for 2000. The national mean payment rate, weighted by enrollees is \$560.20.
- On the other hand, some areas were not as hard hit.
 - 1.3 percent of enrollees in areas with payment rates of \$600 or more were affected.
 - 2.3 percent of enrollees in areas with 2 percent growth rates were affected.

Choices

- About 75.3 percent of affected enrollees will have one or more M+C plan available.
- 58.2 percent of affected enrollees will have two or more M+C plans available.

Geographic Distribution

- Enrollees in 33 states were affected by non-renewals.
- Some of the hardest hit states include:
 - The following states have the most enrollees affected (number of enrollees in parentheses): New York (39,000); Louisiana (34,000); Texas (32,000); Florida (29,000); and Arizona (27,000).
 - In terms of enrollees affected as a percentage of all Medicare+Choice enrollees in the state, the following states were most affected: New Hampshire (83% -- 13,000 enrollees affected); South Carolina (69% -- 1,100 enrollees affected); Nebraska (45% -- 5,400 enrollees affected); Iowa (44% -- 1,400 enrollees affected); and Louisiana (43% -- 16,700 enrollees affected).

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- In terms of affected enrollees as percentage of all beneficiaries in the state, the following states were most affected: New Hampshire (8% -- 13,000 enrollees affected); Louisiana (6% -- 34,000 enrollees affected); Nevada (4% -- 9,600 enrollees affected); Arizona (4% -- 27,000 enrollees affected); and Colorado (3% -- 15,000 enrollees affected).

Other Plan Types

- 18,702 enrollees in cost plans and 7,058 enrollees in demonstration plans were affected by non-renewals.
- In 1998, about 53,000 enrollees were affected by non-renewals by other plan types.

Other Payors

- FEHB expects to lose 36 plans (about 13 percent) out of the current 280. This will affect about 36,000 contract holders (i.e., employees and retirees but not including dependent) out of about 3.8 million contract holders. Thus about 1 percent of contract holders will be affected.

- ~~\$~~ # less than 5%?
- will return to the traditional MC program b/c there was only one mgd care option
- however - new #
- more bennies going in but than being affected
- date of GAO study
GAO overpaid too
- full geographical adjustment
→ more \$ to plans
before dedication of the surplus
- At least as important
(not moreover)
- Unlike today, they can
change to cost they choose
to bennies.
- not linked to one payment
AAPC

Draft -- July 13, 1999 (4:55 PM)**Statement of HCFA Deputy Administrator Michael Hash
Medicare+Choice Plan Renewals**

As you know, the July 1 deadline for managed care plans to tell Medicare whether or not they will provide care for beneficiaries in the year 2000 has passed. We have now heard from all of the Medicare+Choice plans that participated last year and have reviewed their submissions.

These are the plans who treat the 6.2 million Medicare beneficiaries who have chosen managed care. That's out of the total number of more than 39 million seniors and disabled Americans who are covered by Medicare. And this is the largest number of beneficiaries in managed care in the program's history.

As you know, HMOs decide each year whether they will participate in Medicare. They can choose not to renew contracts or to reduce their service areas.

Let's look at what has happened over the past year. A year ago, a number of HMOs said they were leaving Medicare because payments weren't high enough. Some complained about requirements that were included in the law or regulations aimed at ensuring that beneficiaries receive the quality care they deserve.

We invited suggestions for changes we could make, and we issued a new regulation addressing those concerns.

We worked with Congress to delay -- from May 1 until July 1 -- the date set in law for notifying Medicare whether plans will serve beneficiaries next year.

Payments have continued to increase. Remember, every managed care plan that wants to serve Medicare beneficiaries will be paid more in 2000 than in 1999, about 5 percent on average. Every area will receive at least 2 percent more. In fact, 25 percent of all counties in the US will see increases as large as 7.5 percent. Many of the areas where plans are leaving, such as Washington state, had increases of 10, 11, and 12 percent.

Yet, the General Accounting Office said Medicare continues to pay HMOs adequately, that many HMOs are still overpaid, and that last year's withdrawals could not be traced to a single cause; a portion may have been the result of plans deciding they could not compete effectively in a market, were unable to establish provider networks or were dissatisfied with payment levels.

Many HMOs have entered Medicare in the last year. We have approved applications for 20 new HMOs or service area expansions since January, and approved three more new contracts today.

And more beneficiaries have been enrolling in HMOs. About 45,000 have been signing up each month for the past five months.

That brings me to the information received from HMOs about whether they'll serve Medicare beneficiaries next year. And I want to underscore that these are not statistics, they are beneficiaries.

Before discussing the final tally, it is important to understand the 250,000 estimate released by the American Association of Health Plans (AAHP) on June 30 based on an informal survey of its largest members. Many plans are not members of AAHP, so that estimate was not a full count of the number of beneficiaries who were affected.

Forty-one plans have told us they will not renew their contracts for 2000 and 56 are reducing their services areas, affecting just over 321,000 beneficiaries, or about five percent of all Medicare+Choice enrollees. Of those, slightly more than 79,000 will have no other managed care options and will return to fee-for-service Medicare, the system Medicare beneficiaries have relied on for more than 30 years. Like last year, they represent about one percent of all Medicare beneficiaries.

For many of those beneficiaries whose Medicare+Choice plans are not leaving Medicare, it is worth noting that they may see higher premiums and reduced benefits.

We're disappointed that HMOs are making decisions that will force some Medicare beneficiaries to change their health coverage and at the same time scaring them about their Medicare benefits.

We want to make sure that each affected beneficiary won't be confused by these announcements. Medicare is still there for every Medicare beneficiary wherever they live. We are working with our partners and the plans to make sure that each and every beneficiary will be given reliable and accurate information to help them make the decisions they will need to before the year is out.

The lesson from this year's non-renewals is that the nation needs the President's comprehensive initiative that will strengthen and modernize Medicare and prepare it for the 21st century through fee for service reforms, true competition among managed care plans, savings contributions from providers and beneficiaries alike, a new drug benefit, the elimination of all copayments and deductibles for all preventive services, and an explicit dedication of 15 percent of the surplus to extend the life of the trust fund.

The plans have argued that the lesson is that they are not paid enough. However, there are several studies that show this is simply not true. Every managed care plan that wants to serve Medicare beneficiaries will be paid more in 2000 than in 1999 -- about 5 percent on average. The General Accounting Office and others have shown that plans, in the aggregate, are overpaid. In fact, 25 percent of all counties in the United States will see increases as large as 7.5 percent. Many of the areas where HMOs are leaving, such as Washington state, had increases of 10, 11 and 12 percent.

Many of the plans that have left the program offered very generous benefits, such as zero premium plans with drug coverage to entice beneficiaries to enroll in managed care. The HMOs are now finding they can't afford to provide those benefits so they are leaving the program, trimming back on some of those benefits, or they are complaining that they are not being paid enough to offer all of these benefits that they had been able to offer in the past.

As a long term strategy though, this makes no sense. This is a risk averse population, and now, after two years of non-renewals, they are beginning to question if their plans will be there for them in the future.

Yet, plans are making business decisions based on the overall market. As Kaiser Permanente has publicly said, their decision to leave was based on the industry, not the Medicare+Choice program. Kaiser Permanente, like many other plans, left not only Medicare but the private market as well. Kaiser dropped XXX Medicare beneficiaries, in addition to XXX person in the private market.

And although these are plan decisions, we have been trying to make participation in M+C as easy as possible. We've been working, and will continue to work, with the plans to make the Medicare+Choice rules less restrictive.

And, most of all, we are going to work on passing the President's Medicare Reform Plan since this offering a prescription drug benefit in Medicare is the best way to resolve this problem.

We are concerned that Medicare beneficiaries, whether they are choosing managed care or fee-for-service, will be able to continue to get the health care benefits they deserve. That's why we need to enact President Clinton's Medicare proposal, to make sure that Medicare beneficiaries have access to some of the important new prescription drug therapies without being afraid of losing them when their HMO decides they are too expensive. Medicare has been there for millions of seniors and disabled Americans since 1965 and we need to be sure it will continue to be there in the future.

Seniors and disabled Americans deserve a strong Medicare program. We're committed to making sure they have health care -- whether they choose managed care or traditional fee-for-service.

###



HEALTH CARE FINANCING ADMINISTRATION

**ADDRESSEE:***Deborah***PHONE:** _____**FROM:** *Peter*

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Talking Points

M+C Minireg and Citizens Advisory Panel on Medicare Education

General Overview

- HCFA announced refinements to the Medicare+Choice program designed to improve beneficiary protections and access to information while making it easier for health plans to offer more options to beneficiaries.
- HCFA is also working with Congress to give plans an additional two months to file their Adjusted Community Rates (ACRs), the information used to approve the benefits and premiums offered to Medicare beneficiaries. The anticipated move from May 1 to July 1 is expected to help managed care plans base the costs and premiums for health care to Medicare beneficiaries on current trends and costs in the health care marketplace.
- HCFA is also establishing a federal advisory committee, the Citizens Advisory Panel on Medicare Education.

Beneficiary Protections

The minireg assures that Medicare beneficiaries can enroll in other Medicare managed care plans in their community if they are enrolled in a managed care plan that withdraws or is terminated from the Medicare program. This should help those Medicare beneficiaries who choose to remain in managed care.

To help provide input to help inform, shape and improve policies and strategies for educating beneficiaries, HCFA created the Citizens Advisory Panel on Medicare Education. A public call for membership nominations will appear shortly in the Federal Register. This notice is now on display at the Federal Register.

The 10-member advisory panel will include representatives for older Americans; specific diseases and disabilities organizations; minority communities; health communicators; health services researchers; health insurers and plans; health providers and clinicians; labor and retirement interests; and the general public.

The advisory panel will work with the National Medicare Education Program, a comprehensive communications effort which includes expanded and updated print materials such as the *Medicare&You* handbook; a toll-free telephone line -- 1-800-MEDICARE (1-800-633-4227) -- and a beneficiary-oriented Internet web site -- www.medicare.gov, as well as a coordinated partnership program with more than 200 national and local organizations who work with Medicare beneficiaries.

Making Plan Requirements Easier

In June 1998, HCFA published an interim final rule to implement Medicare+Choice. The new mini-reg makes several changes in response to public comments on the interim final rule. They

include stronger beneficiary protections while making the administrative requirements on plans serving Medicare beneficiaries less burdensome.

HCFA expects to issue a more extensive final rule later this year.

The rule also reduces a number of administrative responsibilities identified in the June 26 interim final rule. These include:

- + Requirements for health assessments of beneficiaries enrolled in a managed care plan;
- + Allowing the requirement for an initial assessment within 90 days of enrollment to be considered met for commercial health plan enrollees who remain in the same managed care organization's Medicare+Choice plan when they become eligible for Medicare at age 65 or for enrollees who switch plans but remain under the care of the same primary care provider; and
- + Providing managed care plans the ability to choose the form of the initial assessment.

###

Summary of Items Included in the M+C Mini-Reg

1. Beneficiary Enrollment Options

Although existing regulations provide for unlimited enrollment and disenrollment opportunities for enrollees until 2002, there is no explicit requirement (until 2002) that an M+C plan be open to new enrollees in situations where a plan drops out of the program or is terminated. This rule clarifies that individuals enrolled in an M+C plan that withdraws or is terminated from the M+C program have an opportunity for a special election period among other M+C plans in the affected area, effective July 1, 1998. It also specifies that the Medigap "guaranteed issue" provisions of the BBA were effective July 1, 1998 for enrollees in an M+C organization whose contract terminates.

2. Notification Requirement for Rule Changes

To avoid situations where an M+C plan's rules could change after HCFA provides beneficiaries with comparative information about available M+C plans, this rule specifies that for M+C organizational rule changes that will become effective on January 1 of each year, an M+C organization must notify enrollees of those changes by October 15 of the previous year. (The existing 30-day notification rule still applies for midyear changes.)

3. Coordination of Care

The M+C regulations include provisions designed to ensure that M+C organizations have adequate procedures to (1) identify, monitor, and treat individuals with serious or complex medical conditions and (2) ensure continuity of care for all enrollees. This rule retains these requirements but increases plan flexibility in determining how and when care is coordinated. For enrollees with serious or complex medical conditions, it specifies that a treatment plan can be updated by the appropriate health care professional (such as a specialist or a physical therapist), rather than limiting this function to the enrollee's primary care provider.

4. Initial Care Assessments

This final rule retains the existing requirement that an M+C organization conduct an initial assessment of each enrollee's health care needs within 90 days of enrollment. However, we have clarified that the assessment requirement may be considered met for patients who "age in" to a plan or who switch plans, but remain under the care of the same primary care provider. We also clarify that an M+C organization may

choose the form of the initial assessment (e.g., a screening methodology), provided that the assessment is adequate to meet the regulatory goals of identifying the health care needs of enrollees and ensuring effective patient care. In addition, we indicate that an organization must make a "best-effort" attempt to conduct these assessments, to recognize the possibility that some patients may refuse to cooperate with the initial assessment process.

5. Involuntary Terminations of Specialists

The M+C regulations initially required that when a specialist is involuntarily terminated from an M+C plan for a reason other than for cause, the organization offering the plan must provide the names of other M+C plans in the area that contract with that specialist. In view of the implementation difficulties associated with this requirement, we have changed the regulations to require that when a specialist is terminated for any reason, the same notification rules would apply as for all other provider terminations. That is, the M+C organization must make a good faith effort to provide written notice of the termination to all enrollees who are patients seen on a regular basis by the terminating provider. We believe this provision provides sufficient protection for M+C enrollees without imposing an undue burden on M+C organizations.

6. Provider participation rules

As directed by the BBA, the M+C regulations contain several provisions governing the relationships between M+C organizations and their participating providers. Although the statutory provisions for the most part apply only to physicians, the provider participation requirements contained in the initial M+C regulations generally applied to all health care professionals. In this rule, consistent with Congressional intent, we are limiting the applicability of the provider participation requirements to physicians. We have also adopted a less expansive interpretation of what constitute participation rules, basically limiting the notification requirements associated with participation rules to policies directly related to participation decisions. Finally, we have limited the availability of the provider appeals process to cases involving suspension or termination of participation privileges, rather than including initial denials of an application to participate.

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Q & A for the Medicare + Choice (M+ C) "mini" reg

Q. Why is HCFA calling this a "mini" reg?

A It's an informal name we use within the agency to differentiate it from the more comprehensive final M+C regulation that we expect to publish in the late fall.

Q. What is the mini-reg's relationship to the M+C "interim final" rule the agency published on June 26, 1998?

A. The interim final rule was published on June 26, 1998 and became effective on July 27, 1998. It is the regulatory structure the M+C program currently operates under. As the term "interim final" implies, however, it is not the final program regulation, and we intend to publish a comprehensive final rule in the late fall of 1999. There were several urgent issues that we decided could not wait that long, however, and we've addressed them in the mini. These issues include:

- + clarifying that a beneficiary enrolled in an M+C plan that withdraws or is terminated from the Medicare program is entitled to enroll in the other remaining M+C plans in his or her area;
- + limiting the applicability of provider participation requirements to physicians rather than all health care professionals;
- + specifying that any changes in plan rules must be made by October 15 to ensure beneficiaries have all information they need to make an informed choice during the November annual open enrollment period;
- + eliminating redundancy in the 90-day health care assessment requirement;
- + aligning the requirements for termination of specialists with the process established for other providers;
- + stipulating that the coordination of care function can be performed by a range of qualified health care professionals, and is not limited to primary care providers.
- + Indicating that the availability of the provider appeals process applies only to cases involving suspension or termination of participation privileges, rather than including initial denials of an application to participate.

Q. The existence of the Administrator's October 9 letter to Chairman Thomas (of the House Ways & Means Subcommittee on Health) is well known. Isn't the mini-final simply pandering to the Chairman's demands?

A. No. Chairman Thomas identified a number of pressing issues affecting the successful administration of the M+C program. These issues, by and large, were areas where HCFA had to develop policy as soon as possible because they affect the structure of the program that began on January 1. Mr. Thomas identified several of these issues, but so did a number of other individuals and organizations who submitted written comments to the agency as part of the official comment process. We took all of these comments into account in developing the mini regulation.

Q. How did the rules for special enrollment elections change?

A. The mini rule clarifies that plans' obligation to accept enrollments during special election periods applies in years prior to 2002. Moreover, consistent with Medicare enrollment practices, the rule protects a beneficiary's longstanding right to enroll in other plans when the organization in which they are enrolled ceases to contract with Medicare.

Q. Why is HCFA moving up the date for plans to notify beneficiaries of rule changes?

A. The effective date was changed to ensure that beneficiaries receive accurate information about all plan rules in time for the annual election period each November. This will provide beneficiaries with all the information they need to make an informed choice.

Q. Why are Primary Care Providers (PCP) no longer required to provide coordination of care services?

A. The changes were made to allow for greater flexibility in coordination of care, because not all types of managed care plans require enrollees to be assigned to PCP. These services must still be provided by qualified health care professionals.

Q. Why is HCFA changing the 90-day initial health assessment requirement?

A. M+C organizations are still required to complete the initial assessment within 90 days of enrollment. However, to avoid duplication, we clarified that the requirement for an initial assessment may be considered met for patients who "age in" to a plan (i.e., from an M+C organization's commercial product to its Medicare product) or who switch plans, but remain under the care of the same primary care provider.

Q. Why is HCFA limiting the applicability of the provider participation requirements only to physicians?

A. After carefully considering comments we received on this issue, we decided to make these provisions more closely conform with limits indicated by the underlying statute in this area. A number of commentors argued that the expansion of these requirements to all health care professional, which HCFA implemented in the interim final rule, exceeded the intent of the BBA.

Q. How will the change in the participation rules affect access to services in rural areas?

A. The change in the provider participation rules does not affect the M+C organizations' obligation to meet the access and service requirements outlined in the M+C regulation.

Q. How have the provider participation rules changed?

The rules clarify that the availability of the provider appeals process applies only to cases involving suspension or termination of participation privileges. Further, the rules were revised to indicate that written notice of the rules of participation will include terms of payment, credentialing policies, and other rules directly related to participation decisions.

Q. Can non-participating physicians appeal an application denial to the M+C organization?

A. No. In view of our more narrow definition of participation rules, congressional intent, and the comments HCFA has received, we have determined that it would be inappropriate to grant appeal rights to physicians who have never been accepted into the M+C organization's network. Further, it is important to recognize the significant administrative burden organizations would have in implementing these provisions.

Q. How does the change in the provider participation rules comport with the anti-discrimination provisions?

A. We did not address this issue in the mini-regulation. We received a number of requests for clarification and will address the issue in the comprehensive final rule later this year.

Q. Aren't the provisions in the mini-regulation an example of HCFA being more sympathetic to health plans than beneficiaries?

A. We have addressed a balanced list of issues based on comments from a range of interested parties, not just health plans. Our intention is to relieve administrative burdens where appropriate while, at the same time, ensuring continuing beneficiary protection. The administrative burdens that this rule focuses on largely deal with plan-provider interactions. The rule strengthens the extensive beneficiary protections already implemented by the interim final rule. For example, the mini-regulation provides for such beneficiary-friendly policies as improved information requirements for the November open enrollment and special enrollment periods for beneficiaries when an organization in their area no longer contracts with Medicare.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington D.C. 20201 - 0001

PRESS RELEASE

FOR IMMEDIATE RELEASE

February 11, 1999

CONTACT: HCFA Press Office**(202) 690-6145****REFINEMENTS MADE TO MEDICARE+CHOICE PROGRAM****Patient Protections, Access to Information and
Reductions in Administrative Burdens Included in New Rules**

The Health Care Financing Administration today announced refinements to the Medicare+Choice program that improve beneficiary protections and access to information while making it easier for health plans to offer more options to beneficiaries.

HCFA is working with Congress to give plans an additional two months to file the information that is used to approve the benefits and premiums offered to Medicare beneficiaries. The move from May 1 to July 1 should help managed care plans base the costs and premiums for health care to Medicare beneficiaries on current trends and costs in the health care marketplace.

Today's announcements also include the creation of a federal advisory committee to help HCFA reach out to Medicare beneficiaries and better inform them about changes in the Medicare program, while learning from beneficiaries what information they want and need and the best ways to get it to them.

"These steps will help us start fulfilling President Clinton's commitment to improve protections for beneficiaries when plans leave Medicare," HHS Secretary Donna E. Shalala said. "They should also make it easier for plans to continue to serve Medicare beneficiaries."

"We're establishing the advisory committee to help us make sure that our education efforts will help beneficiaries navigate the world of managed care," HCFA Administrator Nancy-Ann DeParle said. "At the same time, it's clear that we can ease the administrative burden on plans without compromising beneficiary protections. And that will help plans provide beneficiaries with even more choices."

The Balanced Budget Act of 1997 established the Medicare+Choice program which expands the range of health care options available to Medicare beneficiaries and provides them with information they can use to make informed decisions about how they want to receive their health care. In June 1998, HCFA published an interim final rule to implement the new Medicare+Choice program. The new rules make several changes in response to public comments on the interim final rule. The adjustments include stronger beneficiary protections while making the administrative requirements on plans taking part in Medicare+Choice less burdensome. HCFA expects to issue a more extensive final rule later this year.

- More -

As part of the Medicare+Choice program, HCFA created the National Medicare Education Program, a comprehensive communications effort which includes expanded and updated print materials such as the *Medicare&You* handbook; a toll-free telephone line -- 1-800-MEDICARE (1-800-633-4227) -- and a beneficiary-oriented Internet web site -- www.medicare.gov, as well as a coordinated partnership program with more than 200 national and local organizations who work with Medicare beneficiaries.

As an addition to these initiatives, HHS and HCFA are establishing the Citizens Advisory Panel on Medicare Education to provide a broad range of public input into the operation of HCFA's National Medicare Education Program. A public call for membership nominations will appear shortly in the Federal Register.

To help make sure the Medicare education program is as effective as possible, the members of the Citizens Advisory Panel on Medicare Education is expected to include representatives of organizations representing older Americans; specific diseases and disabilities; minority communities; health communicators; health services researchers; health insurers and plans; health providers and clinicians; labor and retirement interests; and the general public.

The new rule assures that Medicare beneficiaries have the opportunity to enroll in other Medicare managed care plans in their community if they are enrolled in a managed care plan that withdraws or is terminated from the Medicare program. This provision should help those Medicare beneficiaries who choose to remain in managed care.

The rule also reduces a number of administrative responsibilities identified in the June 26 interim final rule. These include requirements for health assessments of beneficiaries enrolled in a managed care plan. The new rule allows the requirement for an initial assessment within 90 days of enrollment to be considered met for commercial health plan enrollees who remain in the same managed care organization's Medicare+Choice plan when they become eligible for Medicare at age 65 or for enrollees who switch plans but remain under the care of the same primary care provider. The rule also gives managed care plans the ability to choose the form of the initial assessment.

"Together, all of these provisions and improvements to the Medicare+Choice program should help both Medicare beneficiaries and the managed care plans that many have come to rely on for their health care needs," DeParle said.

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MEDICARE FACT SHEET

February 11, 1999

PARTIAL MEDICARE+CHOICE FINAL REGULATION PUBLISHED

Background: *The Health Care Financing Administration today announced refinements to the Medicare+Choice program that improve beneficiary protections and access to information while making it easier for health plans to offer more options to beneficiaries. The refinements also include the creation of a federal advisory committee to help HCFA reach out to Medicare beneficiaries and better inform them about changes in the Medicare program, while learning from beneficiaries what information they want and need and the best ways to get it to them.*

In August 1997, President Clinton and Congress enacted the Balanced Budget Act, and, on June 26, 1998, the interim final regulations for Medicare+Choice, the program that created new health care options and patient protections for Medicare beneficiaries, were implemented. Currently there are more than 340 Medicare+Choice plans -- primarily health maintenance organizations or HMOs -- providing health care services to more than 6 million Medicare beneficiaries who chose to enroll in managed care plans. They represent about 15 percent of the nearly 40 million Medicare beneficiaries across the United States.

After reviewing nearly 90 comments from interested individuals and organizations on the interim final rule, the Health Care Financing Administration identified the need for changes or clarifications in the interim final regulation. These include provider participation procedures, beneficiary enrollment options, coordination of care requirements and procedures to help health plans who serve Medicare beneficiaries.

Medicare+Choice Regulations

The Balanced Budget Act of 1997 created the Medicare+Choice program which provides Medicare beneficiaries with a wider range of health plan choices and information about these options. These include both the traditional managed care plans, such as HMOs, that have participated in Medicare on a capitated payment basis, as well as Medicare+Choice coordinated care plans (HMOs with or without point of service options, provider-sponsored organizations and preferred provider organizations); medical savings accounts and private fee-for-service plans.

On June 26, 1998, HCFA published an interim final rule that explained and implemented the provisions outlined in the BBA. This rule became effective on July 27, 1998. Since it is an "interim final rule," it does govern operation of Medicare+Choice, but is still subject to further revision in response to public comments. After a careful review of public comments, HCFA determined that several policy changes were needed to help in the implementation of the Medicare+Choice program. The adjustments include stronger beneficiary protections while making the administrative requirements on plans taking part in Medicare+Choice less burdensome. HCFA expects to issue a more extensive final rule later this year.

- More -

Beneficiary Provisions

All Medicare beneficiaries are in fee-for-service Medicare unless they choose to enroll in a managed care plan. The new rule expands some of the protections available to those beneficiaries whose managed care plans decide to withdraw from the Medicare program. The rule clarifies that these beneficiaries will have the opportunity for a special election period among other plans available in the community. This provision should facilitate continued choice and continuity of care.

In addition, the rule clarifies that plans will have to insure that beneficiaries are advised, in advance, of any last-minute changes so that they will have all the information they need to make informed choices during the November 1999 open enrollment period called for in the BBA.

In addition to the new rule, HCFA is establishing the Citizens Advisory Panel on Medicare Education to assist the agency in developing and disseminating unbiased information for Medicare beneficiaries to help them make informed decisions about how they receive health care. The Advisory Panel will also work with the National Medicare Education Program.

Reducing Administrative Burdens

The rule reduces a number of administrative responsibilities identified in the June 26 interim final rule. These include requirements for health assessments of beneficiaries enrolled in a managed care plan. The new rule allows the requirement for an initial assessment within 90 days of enrollment to be considered met for commercial health plan enrollees who remain in the same managed care organization's Medicare+Choice plan when they become eligible for Medicare at age 65 or for enrollees who switch plans but remain under the care of the same primary care provider. The rule also gives managed care plans the ability to choose the form of the initial assessment.

###

Talking Points

M+C Mini-reg and Citizens Advisory Panel on Medicare Education

General Overview

- HCFA announced refinements to the Medicare+Choice program designed to improve beneficiary protections and access to information while making it easier for health plans to offer more options to beneficiaries.
- HCFA is also working with Congress to give plans an additional two months to file their Adjusted Community Rates (ACRs), the information used to approve the benefits and premiums offered to Medicare beneficiaries. The anticipated move from May 1 to July 1 is expected to help managed care plans base the costs and premiums for health care to Medicare beneficiaries on current trends and costs in the health care marketplace.
- HCFA is also establishing a federal advisory committee, the Citizens Advisory Panel on Medicare Education.

Beneficiary Protections

The mini-reg assures that Medicare beneficiaries can enroll in other Medicare managed care plans in their community if they are enrolled in a managed care plan that withdraws or is terminated from the Medicare program. This should help those Medicare beneficiaries who choose to remain in managed care.

To help provide input to help inform, shape and improve policies and strategies for educating beneficiaries, HCFA created the Citizens Advisory Panel on Medicare Education. A public call for membership nominations will appear shortly in the Federal Register. This notice is now on display at the Federal Register.

The 10-member advisory panel will include representatives for older Americans; specific diseases and disabilities organizations; minority communities; health communicators; health services researchers; health insurers and plans; health providers and clinicians; labor and retirement interests; and the general public.

The advisory panel will work with the National Medicare Education Program, a comprehensive communications effort which includes expanded and updated print materials such as the *Medicare&You* handbook; a toll-free telephone line -- 1-800-MEDICARE (1-800-633-4227) -- and a beneficiary-oriented Internet web site -- www.medicare.gov, as well as a coordinated partnership program with more than 200 national and local organizations who work with Medicare beneficiaries.

Making Plan Requirements Easier

In June 1998, HCFA published an interim final rule to implement Medicare+Choice. The new mini-reg makes several changes in response to public comments on the interim final rule. They

include stronger beneficiary protections while making the administrative requirements on plans serving Medicare beneficiaries less burdensome.

HCFA expects to issue a more extensive final rule later this year.

The rule also reduces a number of administrative responsibilities identified in the June 26 interim final rule. These include:

- + Requirements for health assessments of beneficiaries enrolled in a managed care plan;
- + Allowing the requirement for an initial assessment within 90 days of enrollment to be considered met for commercial health plan enrollees who remain in the same managed care organization's Medicare+Choice plan when they become eligible for Medicare at age 65 or for enrollees who switch plans but remain under the care of the same primary care provider; and
- + Providing managed care plans the ability to choose the form of the initial assessment.

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Summary of Items Included in the M+C Mini-Reg

1. Beneficiary Enrollment Options

Although existing regulations provide for unlimited enrollment and disenrollment opportunities for enrollees until 2002, there is no explicit requirement (until 2002) that an M+C plan be open to new enrollees in situations where a plan drops out of the program or is terminated. This rule clarifies that individuals enrolled in an M+C plan that withdraws or is terminated from the M+C program have an opportunity for a special election period among other M+C plans in the affected area, effective July 1, 1998. It also specifies that the Medigap "guaranteed issue" provisions of the BBA were effective July 1, 1998 for enrollees in an M+C organization whose contract terminates.

2. Notification Requirement for Rule Changes

To avoid situations where an M+C plan's rules could change after HCFA provides beneficiaries with comparative information about available M+C plans, this rule specifies that for M+C organizational rule changes that will become effective on January 1 of each year, an M+C organization must notify enrollees of those changes by October 15 of the previous year. (The existing 30-day notification rule still applies for midyear changes.)

3. Coordination of Care

The M+C regulations include provisions designed to ensure that M+C organizations have adequate procedures to (1) identify, monitor, and treat individuals with serious or complex medical conditions and (2) ensure continuity of care for all enrollees. This rule retains these requirements but increases plan flexibility in determining how and when care is coordinated. For enrollees with serious or complex medical conditions, it specifies that a treatment plan can be updated by the appropriate health care professional (such as a specialist or a physical therapist), rather than limiting this function to the enrollee's primary care provider.

4. Initial Care Assessments

This final rule retains the existing requirement that an M+C organization conduct an initial assessment of each enrollee's health care needs within 90 days of enrollment. However, we have clarified that the assessment requirement may be considered met for patients who "age in" to a plan or who switch plans, but remain under the care of the same primary care provider. We also clarify that an M+C organization may

choose the form of the initial assessment (e.g., a screening methodology), provided that the assessment is adequate to meet the regulatory goals of identifying the health care needs of enrollees and ensuring effective patient care. In addition, we indicate that an organization must make a "best-effort" attempt to conduct these assessments, to recognize the possibility that some patients may refuse to cooperate with the initial assessment process.

5. Involuntary Terminations of Specialists

The M+C regulations initially required that when a specialist is involuntarily terminated from an M+C plan for a reason other than for cause, the organization offering the plan must provide the names of other M+C plans in the area that contract with that specialist. In view of the implementation difficulties associated with this requirement, we have changed the regulations to require that when a specialist is terminated for any reason, the same notification rules would apply as for all other provider terminations. That is, the M+C organization must make a good faith effort to provide written notice of the termination to all enrollees who are patients seen on a regular basis by the terminating provider. We believe this provision provides sufficient protection for M+C enrollees without imposing an undue burden on M+C organizations.

6. Provider participation rules

As directed by the BBA, the M+C regulations contain several provisions governing the relationships between M+C organizations and their participating providers. Although the statutory provisions for the most part apply only to physicians, the provider participation requirements contained in the initial M+C regulations generally applied to all health care professionals. In this rule, consistent with Congressional intent, we are limiting the applicability of the provider participation requirements to physicians. We have also adopted a less expansive interpretation of what constitute participation rules, basically limiting the notification requirements associated with participation rules to policies directly related to participation decisions. Finally, we have limited the availability of the provider appeals process to cases involving suspension or termination of participation privileges, rather than including initial denials of an application to participate.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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From: Chris Peacock / 202-690-6149

Subject: AP ON HMOs + BENEFICIARIES

Losing HMO Coverage, Bjt,750 HMOs closing doors to 200,000 elderly, disabled

WASHINGTON (AP) The 200,000 elderly and disabled Americans losing their health care coverage when some HMOs cut off Medicare beneficiaries next year need to choose an alternative.

But Medicare officials stress that those affected can stay in their health plans until the end of this year and shouldn't rush to make a change.

"I would caution them not to act too quickly, to really consider their options," said Carol Cronin, Medicare's director of beneficiary services.

HMO pullouts from Medicare are expected to affect at least 200,000 people nationwide next year, according to estimates from the American Association of Health Plans.

HMOs must notify affected beneficiaries individually by mail no later than Oct. 1. But many will hear from their health plans within the next few weeks, AAHP President Karen Ignagni said.

"Plans are going to do their level best to get them a letter very soon," Ignagni said.

HMOs faced a July 1 deadline to let Medicare know their intentions for 2000, and the government is expected soon to complete an official tally of pending closings. Some large health plans have announced pullouts from selected markets already, including Cigna HealthCare, Pacificare Health Systems, United HealthCare and Humana.

For those looking for another HMO, industry experts recommend waiting until fall to shop around.

Closing HMOs will have to provide service through Dec. 31. More importantly, those staying in business have until mid-September to notify beneficiaries of changes in their fees or benefit packages for 2000. The same financial pressures that have prompted some plans to close are expected to lead many others to make such changes this year.

"We would encourage people not to move too quickly because they really need to wait to have a sense of what their alternatives are going to be," said Howard Drescher, spokesman for Cigna HealthCare.

Those wanting to return to traditional Medicare coverage are even more strongly cautioned to stay with their HMOs until Dec. 31. That's because special protections allowing them guaranteed access to certain Medigap policies regardless of pre-existing medical conditions apply only after the HMO terminates coverage, not if a person leaves voluntarily. Medigap policies are for private indemnity insurance and are designed to supplement Medicare.

One exception is for those who joined an HMO for the first time within the last 12 months: If they quit before the end of the first year of HMO enrollment, they are guaranteed re-enrollment in any Medigap policy held immediately prior to joining the HMO.

The anticipated closings in 2000 will mark the second consecutive year of upheaval among some of the more than 6 million elderly and disabled Americans who, instead of submitting each medical bill directly to the government, choose to get their Medicare coverage through private managed care health plans that receive flat federal payments.

This year, about 400,000 Medicare beneficiaries in more than 30 states were affected when about 100 HMOs opted against renewing 1999 Medicare contracts after lawmakers cut the growth in payments to the plans as part of their 1997 agreement to balance the federal budget.

Retirees and disabled Americans who lose their HMOs are still covered by Medicare.

"Whatever decisions HMOs make about doing business with Medicare, Medicare will always be there for every beneficiary," said Medicare Administrator Nancy-Ann DeParle.

This fall, Medicare will conduct an education campaign to help people understand their choices, including mailing them basic information about HMOs still available in each zip code and offering more details on the Internet and through a toll-free telephone number.

Those beneficiaries who take no action to change their coverage will automatically be re-enrolled in traditional Medicare in which the government directly handles each medical bill on Jan. 1.

However, many of those affected by health plan closings have become accustomed to more comprehensive coverage offered by many HMOs. HMO perks often include lower out-of-pocket fees and benefits Medicare does not normally cover, such as prescription drugs, hearing aids and eye examinations.

Options to fill these voids include joining another HMO in most places there will be plans left to choose from or buying a Medigap policy.

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- * Plans used to get about 95% of medicare fee for service
- * Where payment rates are going given annual reductions up until now, withdrawing of graduate medical education and 7% negative risk adjustment
 - \$11 Billion cut over 5 years
 - if same cut applied to all medicare - \$66 Billion
- * 2001 chart
 - 10% of risk adjustment by 2000
 - 30% " " " by 2001
 - 50% " " " by 2002
 - 80% " " " by 2003
 - 100% " " " by 2004
- * 2004 chart
- * Especially hard hit by reduction of grad med ed
 - New York, Miami, Houston, Los Angeles (12-13%)
- * Seniors figured out way to get more coverage than they do with medigap/cost and now the administration is cutting that off
- * Result is that people in select places will lose benefits they now have - many plans currently provide more benefits than traditional medicare
 - * increase copays
 - * cut drug coverage
- * Expansion of medicare HMOs will be slowed and in some places curtailed
 - * various comments from Wall Street
- * Seniors will be informed in the changes in their plans in fall
 - * chart and booklet
- * Democrats are having increasing trouble holding seniors
 - * chart
- * Other interest groups
 - we are basically alone other than seniors
 - hospitals are fighting their own cuts
 - AARP is close to administration and not fighting
 - unions getting nervous but not acting yet
 - will need to negotiate the gap
- * Republicans
 - Roth considering alternatives to HCFA plan
 - too burdensome
 - CBO has said HCFA methodology is flawed
 - Bilirakis plans to introduce legislation
- * Suggested solution - freeze at 10% and take a look at 2nd year

**FINANCIAL ANALYSTS HIGHLIGHT SERIOUS PROBLEMS FACED BY HEALTH PLANS
PARTICIPATING IN MEDICARE+CHOICE**

Payment Falls Short of Cost Increases

"Future [Medicare managed care] annual rate increases are unlikely to exceed 2%, and this is, quite simply, inadequate, as medical cost trends continue to run at least 5%. Strategically it makes little sense to focus on a market where price increase are capped at 2% when the alternative (the commercial market) is garnering rate increase in the high single digits."

"Managed care companies cannot forever hold the Medicare cost trend below 2% through capitation without eventually bankrupting providers."

"While several companies have successfully managed Medicare costs in recent years, we do not believe this is sustainable because every year starts with a negative spread between the government's rates and the underlying medical cost trend."

Joseph D. France

Credit Suisse/First Boston - *Managed Care: The Competitive Environment*

February 19, 1999

"Medicare presents by far the greatest risk to HMO 1999 earnings. ... With rate increases capped at 2% and medical costs projected to rise 7%, we believe that margin contraction is all but certain. HMOs had two options to reduce the risk of margin contraction, both of which had to be implemented well before January 1999: exit markets and reduce benefits. It remains to be seen whether their actions were sufficient to stem losses, and despite market exits, exposure remains high."

Christine Arnold

Goldman Sachs -- *1999: Issues and Outlook*

December 1998

"1998 proved to be another tough year for HMO investors, caused mainly by the bottom falling out of the Medicare business in the summer, as it became clear that the new reimbursement structure wrought by the Balanced Budget Act of 1997 was inadequate."

"The stability of knowing the 2% annual rate increase for Medicare HMOs was initially considered a positive; however, the implementation has shown this rate to be woefully inadequate in many areas."

Edmund G. Kroll

SG Cowen - *1999 Outlook: Half-full or Half-empty*

March 9, 1999

"HMOs have quite a challenge in 1998. Per-beneficiary rate increases will not come close to meeting historical cost trends."

Christine Arnold

Goldman Sachs – *Managed Care Overview*

April 9, 1998

Withdrawals and Benefit Cuts

"Without changes to the current Medicare risk program, we believe that there will be a continued period of service area retrenchment and substantial benefits rationalization [i.e., reduction] in Medicare risk."

Greg Crawford

Fox-Pitt, Kelton - *1999 HMO & Payor Outlook*

December 16, 1998

"Many companies have withdrawn from numerous Medicare markets. We think that the HMOs are finally addressing the mismatch in premiums and costs. However, we continue to believe that exposure to Medicare increases the risk profile of the HMOs. The companies revised benefits in May 1998 for implementation in 1999 and yet they may not have had a complete knowledge of the cost trends to cut back sufficiently."

William McKeever

PaineWebber – *A Monthly report on HMOs*

October 23, 1998

"Our analysis of 65 Medicare HMO benefit packages leads us to believe that many managed care companies have not reduced benefits adequately to compensate for lower rate increases."

Christine Arnold

Goldman Sachs – *Managed Care Overview*

April 9, 1998

Plans Avoiding Medicare+Choice Viewed Favorably

"While not a long term solution to the problem of inadequate government premiums, we believe that the impact of large scale reductions in the Medicare service areas announced by the industry will be a positive development for 1999 earnings."

Greg Crawford

Fox-Pitt, Kelton - *1999 HMO & Payor Outlook*

December 16, 1998

"Therefore, we prefer to invest in companies that have minimal exposure, although the companies have reduced their risk in Medicare by exiting a number of markets and reducing plans for enrollment growth."

"We have only one Medicare HMO that we are recommending due to our concern that the industry may not have cut enough in light of another mismatch between prices and costs in 1999."

William McKeever

PaineWebber – *A Monthly report on HMOs*

October 23, 1998

"Unlike all of its peers in the managed care industry that dove headfirst into the privatization of the Medicare program, WellPoint management was skeptical of the adequacy of reimbursement for Medicare HMOs. Management's caution proved prescient this past summer when HMO after HMO declared that their margins were being squeezed by inadequate Medicare rates. Thus, WellPoint should stand out from its peers since our long-term growth assumption for the company is not affected by the industry pullback from Medicare enrollment."

Edmund Kroll

SG Cowen – *Perspective: WellPoint Health Networks*

March 9, 1999

"We continue to believe that Medicare poses a risk to the managed care industry in 1999. Consequently, we favor companies with minimal Medicare exposure, including Trigon and WellPoint."

Christine Arnold

Goldman Sachs – *Medicare: Where Will the Seniors Go?*

December 1998

Risk Adjuster

"The key fallacy in [HMO risk adjustment] is that the government insists on using an inherently flawed methodology that is dependent on hospital use, which ignores HMO efforts to emphasize outpatient care and disease management. Why is the government in a rush to introduce such a flawed methodology? It is trying to cut payments so that HMOs will be forced to cut highly popular supplemental drug benefits and encourage beneficiaries to join HMOs. It wants to drive HMOs out of the Medicare program because it dislikes competition, even if 15% of the Medicare population directly benefits."

Kenneth Abramowitz

In a letter to the Editor of *The Wall Street Journal*

February 5, 1999

Overall Market Analysis

"Medicare is a big problem."

Todd B. Richter

NationsBanc Montgomery Securities

March 1999

"Current policy is bad economics for [Medicare] beneficiaries and unfair to the health plans."

Kenneth Abramowitz
Sanford C. Bernstein & Company
March 15, 1999

"We remain concerned longer-term about the economics of the Medicare business for HMOs, given the lingering negative impact on reimbursement wrought by the Balanced Budget Act of 1997."

Edmund E. Kroll
SG Cowen - *Perspective. PacifiCare*
March 9, 1999

"The long-term outlook for managed Medicare is not bright and those companies that are entrenched...have committed themselves to a very difficult business."

Joseph D. France
Credit Suisse/First Boston - *Managed Care: The Competitive Environment*
February 19, 1999

"Without question, Medicare remains a troubled sector."

Christine Arnold
Goldman Sachs - *1999: Issues and Outlook*
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