Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	Cindy Buhl to Devorah Adler re: phone number (partial) (1 page)	11/02/1998	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20463

FOLDER TITLE:
Massachusetts and Drugs [Folder 1]

2012-0463-S
rc782

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DEC - 8 1998

Sharon Smith
Senior Vice President
Blue Cross Blue Shield
100 Summer Street
31st Floor
Boston, Massachusetts 02110

Dear Ms. Smith,

This letter confirms that HCFA has no objection to described arrangements under which Medicare+Choice organizations in Massachusetts would provide assistance to certain individuals who will lose eligibility for "unlimited" drug coverage in 1999. This assistance would be offered to Medicare beneficiaries who were enrolled in an "unlimited" drug benefit option offered by a Medicare-contracting HMO in 1998, but who would no longer have the option available in 1999. HCFA feels that if (1) no premium is imposed for the assistance, (2) no Medicare payments are used to cover the cost of the assistance, and (3) it is available without regard to whether the individual is enrolled in a particular Medicare+Choice plan in 1999, the arrangements would fall outside the scope of both Medigap rules and the Medicare+Choice program, and would not be subject to HCFA approval.

We have received written descriptions of proposals that meet these criteria from Blue Cross and Harvard-Pilgrim. In the case of Blue Cross' proposal, a statement of financial need would be required of Medicare beneficiaries, while Harvard-Pilgrim would impose a more formalized means test on beneficiaries. Based on the limited information provided in these descriptions, the arrangements are not subject to HCFA approval, and are permissible under Federal law. While we have heard informal preliminary descriptions of possible approaches being considered by Tufts and Fallon, these arrangements are not yet sufficiently final to comment upon.

We appreciate the efforts you have made on behalf of beneficiaries in Massachusetts. Prescription drug benefits are very important to many of the Medicare beneficiaries who have chosen managed care plans, and we would encourage all plans to offer these types of additional benefits. We hope that the arrangements being discussed prove effective.

Sincerely,

Michael M. Hash

Comparison of Massachusetts Plans
Source: 1999 ACR Data

November 3, 1998

HMO	Premium	Drugs	Comment	Annual Net Premium Cost for Drugs
Fallon: (33,000)				
1 Segment: Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolks, Suffolk, Worcester				
Basic	None	None		
Opt.Supp #1	$84.72	Unlimited		
Opt. Supp #2	$49.94	$1,000 limit		$134.44
Harvard: (61,000)				
Segment 1: Barnstable				
Basic	None	$800 limit	$200 qtr cap	$800 benefit w/ no cost
Segment 2: Berkshire, Franklin, Hampden, Hampshire				
Basic	$25	$800 limit	$200 qtr cap	$500 net beneft
Segment 3: Bristol, Exxex, Middlesex, Norfolk, Plymouth, Suffolk, Worcester				
Basic	None	$800 limit	$200 qtr cap	$800 benefit w/ no cost

HMO	Premium	Drugs	Comment	Annual Net Premium Cost for Drugs
HMO Blue: (13,000)				
Segment 1: Essex, Middlesex, Norfolk, Plymouth, Suffolk, Worcester				
Basic	None	None		
Hi Option	$59	$1,200 limit	$300 qtr cap	$492 net benefit
Segment 2: Franklin, Hampden, Hampshire				
Basic	$20	None		
Hi Option	$79	$1,200 limit	$300 qtr cap	$252 net benefit
Segment 3: Barnstable, Bristol				
Basic	$30	None		
Hi Option	$89	$1,200	$300 qtr cap	$132 net benefit
Tufts: (86,000)				
1 segment: Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, Worcester:				
Basic	None	None		
Opt. Supp #1	$81.15	Unlimited	Deleted	
Opt Supp #2	$72.13	$1,500 limit	Deleted	
Enhancement	None	$500 limit	$125 qtr cap	$500 benefit w/ no cost
United: (11,000)				
1 segment: Bristol, Norfolk, Plymouth, Worcester				
Basic	None	$300 limit		$300 benefit w/ no cost
Opt Supp (11/99)	$233.74	Unlimited		

HMO	Premium	Drugs	Comment	Annual Net Premium Cost for Drugs
WORCESTER				
Fallon: (27,657)				
Basic	None	None		
Opt.Supp #1	$84.72	Unlimited		
Opt. Supp #2	$49.94	$1,000 limit		$134.44
Harvard: (5,121)				
Basic	None	$800 limit	$200 qtr cap	$800 benefit w/ no cost
HMO Blue: (1,786)				
Basic	None	None		
Hi Option	$59	$1,200 limit	$300 qtr cap	$492 net benefit
Tufts: (6,960)				
Basic	None	None		
Opt. Supp #1	$81.15	Unlimited	Deleted	
Opt Supp #2	$72.13	$1,500 limit	Deleted	
Enhancement	None	$500 limit	$125 qtr cap	$500 benefit w/ no cost
United: (1,021)				
Basic	None	$300 limit		$300 benefit w/no cost
Opt Supp (11/99)	$233.74	Unlimited		

HMO	Premium	Drugs	Comment	Annual Net Premium Cost for Drugs
MIDDLESEX				
Fallon: (3,522)				
Basic	None	None		
Opt.Supp #1	$84.72	Unlimited		
Opt. Supp #2	$49.94	$1,000 limit		$134.44
Harvard: (20,590)				
Basic	None	$800 limit	$200 qtr cap	$800 benefit w/ no cost
HMO Blue: (254)				
Basic	None	None		
Hi Option	$59	$1,200 limit	$300 qtr cap	$492 net benefit
Tufts: (22,395)				
Basic	None	None		
Opt. Supp #1	$81.15	Unlimited	Deleted	
Opt Supp #2	$72.13	$1,500 limit	Deleted	
Enhancement	None	$500 limit	$125 qtr cap	$500 benefit w/ no cost

HMO	Premium	Drugs	Comment	Annual Net Premium Cost for Drugs
HAMPDEN				
Fallon: (75)				
Basic	None	None		
Opt.Supp #1	$84.72	Unlimited		
Opt. Supp #2	$49.94	$1,000 limit		$134.44
Harvard: (1,625)				
Basic	$25	$800 limit	$200 qtr cap	$500 net beneft
HMO Blue: (5849)				
Basic	$20	None		
Hi Option	$79	$1,200 limit	$300 qtr cap	$252 net benefit
Tufts: (6,390)				
Basic	None	None		
Opt. Supp #1	$81.15	Unlimited	Deleted	
Opt Supp #2	$72.13	$1,500 limit	Deleted	
Enhancement	None	$500 limit	$125 qtr cap	$500 benefit w/ no cost

HMO	Premium	Drugs	Comment	Annual Net Premium Cost for Drugs
NORFOLK				
Fallon: (344)				
Basic	None	None		
Opt.Supp #1	$84.72	Unlimited		
Opt. Supp #2	$49.94	$1,000 limit		$134.44
Harvard: (10,395)				
Basic	None	$800 limit	$200 qtr cap	$800 benefit w/ no cost
HMO Blue: (1,586)				
Basic	None	None		
Hi Option	$59	$1,200 limit	$300 qtr cap	$492 net benefit
Tufts: (8,338)				
Basic	None	None		
Opt. Supp #1	$81.15	Unlimited	Deleted	
Opt Supp #2	$72.13	$1,500 limit	Deleted	
Enhancement	None	$500 limit	$125 qtr cap	$500 benefit w/ no cost
United: (287)				
Basic	None	$300 limit		$300 benefit w/no cost
Opt Supp (11/99)	$233.74	Unlimited		

November 2, 1998

To: Karl Moeller
Legislative Aide
Congressman Jim McGovern

From: Richard Burke
Director of Public Affairs
Fallon Community Health Plan

RE: Medicare Prescription Drug Issue

Per your request for an update:

On Friday, October 30, Federal District Court Judge Richard Stearns ruled that the Balanced Budget Act of 1997 preempted a Massachusetts law mandating full prescription drug coverage for Medicare recipients enrolled in managed care health plans. The ruling leaves Fallon as the only plan in Massachusetts offering full drug coverage for seniors. A situation in which only one health plan offers this option is unworkable. Fallon will experience such serious financial harm that its viability as a non-profit health plan will be threatened.

In May, Fallon filed with HCFA to offer a full prescription drug option because it was obligated under state and federal law to do so. Other Massachusetts plans ignored that State law and filed for limited drug coverage, or made special arrangements with HCFA. It was not until Judge Stearns ruling last Friday that the full drug coverage obligation was definitively lifted, leaving Fallon as the only plan offering this benefit. While Fallon would like to be in a position to offer this benefit to seniors, it cannot do so alone.

Fallon officials have been working closely with HCFA officials over the past several weeks. We have offered HCFA a number of proposals, including options that would allow Fallon to preserve full drug benefits for the vast majority of its members. It is our understanding that HCFA is sympathetic to our situation. Specifically, we have been working with Dr. Robert Berenson, Director, Center for Health Plans and Providers, and his staff. We have also been working with individuals at the Department of Health and Human Services Office of General Counsel.

Where do we stand on November 2nd?

We do not have a decision from HCFA and time is of the essence. Why?

1. Open enrollment for Massachusetts (and for the rest of the country) began this morning.

2. Fallon is receiving numerous calls from seniors who want to know what their options are.

3. Fallon has no marketing materials approved from HCFA.

4 Fallon is receiving numerous calls from the press.

5 The Attorney General and Divison of Insurance are weighing their next steps which could involve action against Fallon and/or other plans - and we therefore need Federal cover.

Thank you for help with this very important and urgent matter.

MA & Hosp.

10/28 MA Letter to HCFA

1993 MA passed law requiring HMOs to provide drug benefits to seniors.
1997 BBA pre-empts &
for Medicare + Choice plans
wants exemption.
Carl Moeller called Chris.

cases decided in favor of federal pre-emption

HCFA would allow them to Δ ACR to drop unlimited drug (Fallon & United)

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	Cindy Buhl to Devorah Adler re: phone number (partial) (1 page)	11/02/1998	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20463

FOLDER TITLE:
Massachusetts and Drugs [Folder 1]

2012-0463-S
rc782

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

513 Cannon House Office Bldg
Washington, D.C. 20515
(202) 225-6101
Fax: (202) 225-5759

1 Park Street
Attleboro, MA 02703
(508) 431-8025
Fax: (508) 431-8017

34 Mechanic Street
Worcester, MA 01608
(508) 831-7356
Fax: (508) 754-0982

218 South Main Street, Room 204
Fall River, MA 02721
(508) 677-0140
Fax: (508) 677-0982

James P. McGovern

Congress of the United States
House of Representatives
www.house.gov/mcgovern/
Third District Massachusetts

To: Devorah Adler
c/o Office of Chris Jennings
Date: 11/2/98

Fax #: 456-5557
Pages: 4, including this cover sheet.

From: Cindy Buhl

COMMENTS:

Devorah - here's the letter - per our conversation - on the drug benefits.

- Karl Moeller will be back in our Washington office on Thursday NOV. 5th.

* Richard Burke - confirmed -

Fallon P6/(b)(6) P6/(b)(6) [001]

Congress of t ie United States

Washington, DC 20515

October 28, 1998

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration
Hubert H. Humphrey Building
200 Independence Ave.
Washington, DC 20201

Dear Administrator DeParle:

We are writing to alert you to an evolving situation that may require the Health Care Financing Administration to accept and quickly process re-submissions under section 1854 (a) of the Social Security Act by Massachusetts' Medicare+Choice plans for 1999. This Friday, October 30, a federal district judge in Boston will rule on two cases relating to the status of a Massachusetts law and regulations that require all health plans and issuers to offer Medicare beneficiaries a comprehensive outpatient prescription drug benefit.

As you know, the Balanced Budget Act of 1997 created a section (1856 (b) (3)) that preempts many state laws and regulations for Medicare+Choice plans. Unfortunately, HCFA and some health plans in Massachusetts have interpreted this section as pre-empting the Massachusetts law and regulations that require all Medicare supplemental insurers (explicitly including the former risk- and cost-contract plans that are now incorporated in the Medicare+Choice program) to offer beneficiaries a comprehensive outpatient prescription drug benefit.

We believe that Congress never intended such pre-emption, and that HCFA's interpretation is incorrect. We recently sought new legislation by Congress to clarify the status of the state law. We had the strong support of the Clinton Administration for our proposed legislation, and we had significant bipartisan support for it in both the Senate and House of Representatives. But in the circumstances leading up to the recent final adjournment of Congress, a tiny minority was able to prevent its enactment. The question is now before the court. Accordingly, we urge HCFA to reconsider its view in light of what we feel is the clear Congressional intent not to pre-empt the Massachusetts law and regulations.

The Massachusetts law was enacted in 1993. It went into effect on January 1, 1995, and has been working well. Approximately 75 percent of the eligible beneficiaries have purchased the prescription drug benefit, and the market has thrived. In part due to this drug benefit, enrollment in managed care is high among Medicare beneficiaries in the state. The state's Medigap waiver and uniform prescription drug coverage requirements for both the HMOs and Medigap plans have contributed to a stable market that provides many beneficiaries with a benefit not currently covered under Medicare. During the implementation of the 1993 law, HCFA provided a legal opinion, at the state's request, which confirmed that the state law was not

in conflict or inconsistent with the federal statute.

The Massachusetts law was never the target of section 1856 (b) (3). The section was quietly inserted, at the request of the insurance industry, primarily as a proactive step to guard against future state laws that may affect Medicare+Choice plans. Our understanding is that the only specific state law discussed during the enactment of section 1856 (b) (3) was a Texas law that related to the separate issue of so-called "any willing provider" requirements. The authorizing committees of Congress have indicated that they were not aware of the Massachusetts law during the debate and negotiations on the Balanced Budget Act. If we had been aware of the potential for misinterpretation of this provision and its potential effect on the Massachusetts law before passage of the Balanced Budget Act, we would have done all we could to clarify the Act's effect on the Massachusetts law, and we are confident we would have prevailed. As you know, members of Congress rarely act to take important benefits from Medicare beneficiaries.

The terms of section 1856 (b) (3) raise two critical questions with respect to its application to the Massachusetts law. First, it applies the pre-emption to the specified laws and regulations only "to the extent that such law or regulation is inconsistent" with the federal statute governing Medicare+Choice. Because Medicare covers virtually no outpatient prescription drugs, the state law and regulations are not in conflict or inconsistent with the federal statute. The situation would be very different, for example, if a state law were in conflict or inconsistent with requirements for a Medicare-covered item or service, such as hospital length-of-stay.

Second, section 1856 (b) (3) (B) (i) specifies that state standards on "benefit requirements" are superseded by this section. However, this term is not used elsewhere in Title XVIII. We believe Congress did not intend to create a new term, but instead is referring to the similar term "required benefits," which applies only to Medicare-covered benefits. We find it significant that the House and Senate conferees on the Act did not explicitly specify both "required" and "supplemental" benefits or otherwise define the term. If Congress intended this new term to include all possible benefits, the language would have reflected this broader use of the term.

Opponents of the Massachusetts law have argued that Congress intended to create more choices in Medicare through the Balanced Budget Act, and, therefore, Congress wanted to create more choices at the plan level by allowing plans to avoid requirements under state law. While it is true that Congress intended to expand choice in Medicare, the focus was on expanding the types of plans available (such as preferred provider organizations, provider-sponsored organizations, and point-of-service options). Congress did not intend to take away the prescription drug coverage choices that are currently available for Medicare beneficiaries in the state.

If the state law is upheld on Friday, we would like your assurances that the plans in

HEALTH CARE FINANCING ADMINISTRATION

ADDRESSEE:
Deborah Adler
Bob Donnelly

PHONE: _____

FROM: Peter Harbage

OFFICE OF THE ADMINISTRATOR
200 INDEPENDENCE AVE., S.W.
ROOM 314G
WASHINGTON, DC 20201

PHONE: 202-690-6726
FAX : 202-690-6262

TOTAL PAGES:	ADDRESSEE'S FAX MACHINE NUMBER:	DATE:
15	456-5557 395-7848	11/10/98

REMARKS:

Massachusetts Issue

DEPARTMENT OF HEALTH & HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

Office of the
Regional Administrator

Region I
John F. Kennedy Federal Bldg.
Government Center
Boston, MA 02203

November 10, 1998

Ms. Margaret McKenna and Mr. Jay Egan
Acting Interim Co-Executive Directors
Fallon Community Health Plan, Inc.
Senior Plan
10 Chestnut Street
Worcester, Massachusetts 01608

Dear Ms. McKenna and Mr. Egan:

Many managed care companies offer Medicare beneficiaries a number of supplemental benefits --such as prescription drug coverage -- in addition to those normally provided under fee-for-service Medicare. Like you, I think that these additional benefits are valuable to the many beneficiaries who choose managed care plans, and on behalf of the Health Care Financing Administration (HCFA), I encourage plans to offer them. Several issues have caused uncertainty this year in Massachusetts regarding the prescription benefits that would be available to beneficiaries.

On October 30th, a federal judge ruled that federal law prevents Massachusetts, or any other state, from requiring Medicare plans to provide unlimited drug coverage. Senator Edward Kennedy proposed that this year's federal budget bill grandfather in the Massachusetts requirement. The Clinton Administration, several members of the House and Senate, and Governor Paul Cellucci supported the bipartisan effort, but the proposal was not enacted.

HCFA will allow health maintenance organizations (HMOs) in Massachusetts that have currently approved Adjusted Community Rates (ACRs) for 1999 a brief, time-limited opportunity to resubmit the prescription drug portion of the previously approved 1999 ACR. This proposal applies to coverage and premiums related to prescription drugs only. Plans will not be allowed to change their service areas or any of the other benefits for enrollees. The attachment to this letter provides specific details as to what is allowed under this proposal. As always, plans have the option to improve the benefits in their packages, including the submission of an unlimited prescription drug benefit.

Massachusetts health plans participating in Medicare will have until November 17, 1998 to submit new prescription benefit packages, if they so choose.

This decision reflects factors that created a unique situation in Massachusetts:

- A conflict between federal and state laws created confusion over the drug-coverage requirements. As a result, when plans prepared their Medicare benefit packages this spring, Massachusetts officials warned that the state's requirement for unlimited drug coverage would be enforced.

- Before the Medicare+Choice regulation was published, HCFA let one plan submit a contingent benefit package that otherwise would not have been allowed. While this should not have happened, the intent was to protect the choices available to beneficiaries.

HCFA wants to do everything possible to work with your plan to minimize any confusion that may result from even this limited benefit change. Therefore, we will act quickly on these submissions so that beneficiaries will have enough time to consider their Medicare options before the new packages take effect on January 1. HCFA will contact beneficiary groups to help them better understand our policy. As I am sure you are aware, under law, HMOs will need to notify their beneficiaries of any changes in the benefit package 30 days prior to when those changes take effect. Also, as required by law, HCFA must review all marketing material that will be used with beneficiaries.

Beneficiaries also will be able to obtain assistance in understanding their options through the Massachusetts State Health Insurance Assistance Program at 1-800-882-2003, or their local area agency on aging. They can call the U.S. Administration on Aging at 1-800-677-1116 for a referral to their local agency.

Medicare+Choice is a new program, created last year and implemented this year. In the wake of this situation, we intend to issue new guidelines to clarify our policies in order to avoid similar situations in the future and prevent late changes in the coverage available to beneficiaries.

Thank you for your time and attention to this matter. I look forward to continuing to work with you and organizations in the future. If you have any further questions, please contact Phil Doerr in the Central Office at (410) 786-1059.

Sincerely,

Robert A. Berenson MD

Robert A. Berenson, M.D.
Director
Center for Health Plans and Providers

Attachments

Attachment 1

Adjusted Community Rating Proposal

The Health Care Financing Administration (HCFA) will allow health maintenance organizations (HMOs) in Massachusetts that have currently approved Adjusted Community Rates (ACRs) for 1999 a brief, time-limited opportunity to resubmit the prescription drug portion of the previously approved 1999 ACR. This applies to coverage and costs related to prescription drugs. For example, changes may include increases or decreases in the prescription drug benefits that are included as additional benefits, mandatory supplemental benefits, or optional supplemental benefits. We will also accept changes in beneficiary cost-sharing related to prescription drugs (premiums, deductibles, coinsurance or copayments), consistent with the actuarial analysis assumptions contained in your previous filling. As HCFA has previously stated, nothing in the federal law prohibits a plan from voluntarily complying with state law by offering unlimited prescription drugs to all Medicare beneficiaries.

On the other hand, HCFA will not accept changes in the ACR that are unrelated to the prescription drug benefit (unless the prescription drug change affects the calculation of "additional benefits.") We will also not accept proposals to change the service area for the plan. Please note that premiums for previously approved prescription drug benefit packages can only be increased if the prescription drug benefit package will be improved. To the extent that a plan changes the prescription drug benefit, the premium for that revised benefit must use the actuarial assumptions in your existing filing.

All changes must be submitted in the form of a revised 1999 ACR proposal that is received by HCFA no later than 5:00 p.m. on Tuesday, November 17, 1998.

If you intend to make any changes in your ACR, please forward the appropriate material to:

Center for Health Plans and Providers
Health Plan Purchasing Administration
ATTN: Phil Doerr, Room C-4-18-27
Health Care Financing Administration
7500 Security Boulevard
Baltimore MD 21244-1850
FAX: (410) 786-8933

Possible impact on the ACR that may result from a re-filing:

The objective of the Adjusted Community Rate Proposal (ACRP) is to:

- Determine if the ACR is reasonable,
- Compare the rate to the payment and determine savings,
- Distribute any savings, in the form of benefits, to the beneficiary, and
- Ensure the beneficiary is not overcharged.

HCFA uses an automated ACRP to expedite the preparation and review of the ACRP. The primary parts of the ACRP as follows:

- Exhibit 1: States the contract period and gives the geographic area covered by the contract.
- Exhibit 11: Outlines the basic benefits and copayments provided to enrollees.
- Exhibit 111: Lists the optional supplemental benefits and copayments.
- The ACRP spreadsheet (outlined below).

In addition to the ACRP, the organization must submit a Beneficiary Information Form (BIF) that sets forth the covered benefits as well as the additional benefits.

Primary line items in the ACRP are as follows:

Lines 1-25 is a calculation to compare the average payment rate (APR) to the adjusted community rate (ACR) to determine savings. This comparison requires the pricing of all Medicare required benefits and the anticipated payment rate the HMO expects to receive. Line 25 displays the amount by which the APR exceeds the ACR. Any savings shown on line 25 must be returned to the beneficiary in the form of additional benefits or contributed to a rate stabilization fund. In nearly all cases the savings are eliminated through the offering of additional benefits. *These lines should not change from the HMO's original ACR submission.*

Lines 26-36 prices these additional benefits, adds the annual Medicare deductibles and coinsurance, deducts the savings from line 25 and arrives at the maximum amount that can be charged to the beneficiary prior to the subtraction of any copayments. *These lines could change, but plans may not change their actuarial assumptions from their previous filing.*

Lines 37-38 computes the value of any copayments charged by the HMO. This amount reduces the maximum premium to be charged, and shown on line 36. Line 39 then illustrates the final maximum premium that can be charged following the copayment calculation. *These lines could change.*

Line 40 indicates the amount of premium waiver that the HMO will offer. *This line could change.*

Lines 45-46 calculates any optional supplemental benefits, including copayments, that the HMO is offering. *These lines could change.*

Technical Questions and Answers on the ACR Proposal

Q1. Can the HMO eliminate or reduce drugs that were previously shown as an additional benefits?
A1. Yes, however there has to be sufficient waiver of premium or other additional benefits to offset the amount of drugs being deleted. If there is not sufficient waiver or additional benefits the HMO must include other additional benefits to offset the amount of drugs being deleted. Any reduction or inclusion in benefits must be fully documented. Plans can also voluntarily submit an unlimited or otherwise more generous prescription drug benefit.

Q2. Can the HMO eliminate or reduce drugs that are offered as an optional supplemental benefit?
A2. Yes. If there is a reduction the HMO must document the change in premium. Premium calculations must be consistent with the actuarial assumptions from the previous filing.

Q3. Can the HMO increase the premium and/or copayments charged to the beneficiary?
A3. Yes, as long the premium and/or copayments increase reflects only increased drug coverage.

Q4. Can the HMO enhance the benefit package where there is no additional cost to the beneficiary?
A4. Yes. As always, if there is no additional premium or no additional cost to the beneficiary, then the HMO can enhance benefits at any time.

Q5. Can an HMO add benefits other than drugs and charge a premium and/or copayment?
A5. No. The current opportunity to revise ACRs is applicable only for drug benefits.

Q6. Can an HMO revise its service area or segments within the service area?
A6. No. HCFA is not allowing any service area changes.

Q7. Can an HMO switch drug benefits from an additional benefit to an optional supplemental benefit?
A7. Yes. Please see question 1 above regarding elimination or reduction of additional benefits. All documentation supporting these change must be submitted to HCFA.

Q8. Can an HMO offer drugs as an optional supplemental benefit but delay its offering?
A8. Yes, providing the HMO indicates to HCFA and to the beneficiary when it will be offered. Documentation supporting the benefit must be submitted to HCFA.

Q9. Can an HMO add a non-formulary drug benefit with a copayment?
A9. Yes, providing the copayment is reasonable and does not discourage use.

Internal Questions and Answers for Massachusetts health plan situation
November 9, 8:00 p.m.

Q: Why are you forcing beneficiaries to pay higher drug prices by letting plans drop their unlimited prescription drug coverage now?

A: Obviously, we want beneficiaries to get the broadest range of extra benefits at an affordable cost from their Medicare+Choice plan. But under federal law, the state can't force plans to offer unlimited prescription coverage.

Most plans decided to drop the unlimited drug benefit in May when they submitted their benefit package for the 1999 year. At the time, some plans maintained the unlimited benefit in a good faith belief that state law required it.

The Clinton Administration also supported Senator Ted Kennedy's legislation, which would have allowed the Massachusetts' requirement to prevail. Despite the support of several senators and Gov. Paul Cellucci, it was not enacted.

We don't expect every plan to make changes now. It's also possible that some plans, which had a no-drug option, now will offer some drug coverage. And any plan is free to offer unlimited drug benefits as part of this revision process. In fact, they can use the opportunity to adjust the premiums so they can offer that coverage to beneficiaries.

Q: How will beneficiaries know what their drug coverage is, or will be?

A: Health plans will have until November 16 to submit any changes in their prescription benefit packages, if they so choose. We will finalize the benefits quickly so that beneficiaries will have enough time to consider their Medicare options before the new packages take effect on January 1.

The health plans must notify beneficiaries at least 30 days in advance of any changes to their benefits package, so all current managed-care enrollees will be told about any changes in time to consider all their available Medicare options. **In addition, we are asking the plans to tell beneficiaries about their other options in those notices.**

Beneficiaries also will be able to obtain assistance through the Massachusetts State Health Insurance Assistance Program at **1-800-882-2003**, or their local area agency on aging. They can call the U.S. Administration on Aging at 1-800-677-1116 for a referral.

In addition, updated comparative information about the options available in each Massachusetts county will be posted at WWW.MEDICARE.GOV -- our consumer site on

the World Wide Web. Many libraries and senior centers can help beneficiaries obtain information from this site.

Q: How will beneficiaries pay for their drugs now?

A: Beneficiaries will still have all the benefits covered by Medicare, and those in managed-care plans will have many additional benefits, including some drug coverage in most cases. And Massachusetts health plans could use this opportunity to provide beneficiaries with an unlimited drug benefit through narrow changes to their prescription coverage plans.

Also, beneficiaries who choose to switch out of their managed-care plan and return to original Medicare can get unlimited drug coverage through Medigap supplemental insurance. Two companies offer the unlimited drug benefit in Massachusetts.

Under current state policy, beneficiaries can sign up in February and March next year with coverage effective June 1, 1999. The premiums for unlimited drug benefits under these Medigap plans are more expensive than the premiums charged by the HMOs. For more details, beneficiaries should contact the Massachusetts Division of Insurance at 617-521-7777 or the Massachusetts State Health Insurance Assistance Program at **1-800-882-2003.**

In addition, Massachusetts has a state program that covers the costs of some prescription drug coverage that could help some beneficiaries. The Senior Pharmacy Program will cover up to $750 of therapeutic classes of prescription drugs for seniors who have annual incomes under $12,084. Beneficiaries should call 1-800-953-3305 for more details.

We obviously want our beneficiaries to get as many extra benefits as possible, including drug coverage. However, federal law is clear on this point: Neither Medicare nor the states can force plans to offer unlimited drug coverage.

Q: Why did HCFA allow Tufts to drop the unlimited prescription drug benefit?

A: Uncertain about the state requirement for unlimited drug benefits, Tufts asked for permission earlier this year to submit more than one proposal and then withdraw options later. At the time, HCFA approved the request, although in retrospect we probably shouldn't have.

The decision was made in an attempt to preserve as many options as possible for beneficiaries. However, the result is that Tufts received an unfair advantage vis-a-vis its competitors.

Q: Newspapers claim HCFA made a mistake by approving Tufts' request. Did it?

A: In retrospect, we shouldn't have granted Tufts' request. At the time, though, the decision was made with the best interests of beneficiaries in mind. We wanted to preserve the managed-care options available to residents in Massachusetts.

Now, we are granting all plans a brief and limited opportunity to modify the prescription drug portion of their packages. We will not allow changes to any other benefit in their Medicare packages.

Q. When will beneficiaries learn about the new benefits being offered by plans?

A. Health plans must notify beneficiaries at least 30 days in advance of any changes to their benefits package, which would take effect on January 1. So all current managed-care enrollees will be told about any changes in early December. That will give beneficiaries time to assess their options and decide whether to change their Medicare coverage.

Remember, we are only allowing health plans a brief opportunity to change the prescription drug portion of their proposals, not any other benefits or service areas. In addition, some plans likely will choose not to make any changes at this time.

Beneficiaries who need assistance in understanding any changes can contact their State Health Insurance Assistance Program at **1-800-882-2003,** or their local area agency on aging. They can call the U.S. Administration on Aging at 1-800-677-1116 for a referral to a local agency.

In addition, updated comparative information about the options available in each Massachusetts county will be posted at WWW.MEDICARE.GOV -- our consumer site on the World Wide Web. Many libraries and senior centers can help beneficiaries obtain information from this site.

Q: The Boston Globe reported that Blue Cross Blue Shield asked HCFA to "grandfather" existing seniors into an unlimited drug plan. Will you do this?

A. Allowing a two-tiered benefit is not permitted under the Balanced Budget Act of 1997 or the Medicare+Choice regulation published this year. The law requires that supplemental benefits, including drug coverage, be available to all beneficiaries in a Medicare+Choice plan to ensure fairness and to prevent discrimination against groups of plan members.

Obviously, a plan could offer unlimited drug coverage to all their Massachusetts

beneficiaries. In fact, HCFA would encourage all the HMO's to voluntarily offer the unlimited drug benefit. This would clearly be the best solution for beneficiaries. However, under the law, we cannot require plans to do that.

Q: **Aetna/U.S. Healthcare this fall decided to pull out of Massachusetts altogether. Now, will you allow them to revise their prescription benefits package and return?**

A: No. This opportunity is limited to those plans which already made the commitment to continue to serve Medicare beneficiaries in Massachusetts. We are not allowing any of the plans to expand or shrink their service area as part of this narrow, restricted opportunity.

Q: **Why won't you let plans in other states change their benefits packages so they won't have to abandon beneficiaries in those markets?**

A: First of all, the Massachusetts situation is unlike any other in the country: A conflict between federal and state laws created confusion over the drug-coverage requirements, and state officials warned plans in the spring that they would enforce the state law.

In addition, HCFA provided one plan with an unusual opportunity to submit contingent benefit packages that otherwise would not be allowed. While this probably should not have happened, the intent was to protect the choices available to beneficiaries.

As a result of this, we are allowing plans a brief-and-limited opportunity to revise their drug benefits. Plans will not be allowed to change their service areas or any of the other additional benefits for enrollees.

This fall, the American Association of Health Plans had asked us to allow all plans around the country to change all their benefits and premium packages. We rejected that proposal, which could result in higher premiums and fewer benefits for virtually all of the more than 6 million Medicare beneficiaries now enrolled in managed care plans.

Of those more than 6 million Medicare beneficiaries, about 50,000 are losing their only managed-care option. We have put new applications from managed-care plans to serve their communities on a fast track, as President Clinton ordered. But we don't think it would be in the best interest of beneficiaries to allow all plans to raise rates and cut benefits now.

Q: **In Florida, Humana recently said that it would re-enter certain markets, if they could change their ACR, but you won't let them. Now, beneficiaries in at least one**

county will remain without a HMO. Why are you letting plans change their ACRs to cut benefits in Massachusettes but you aren't letting Humana do it to preserve access in Florida?

A: The circumstances are completely different. In Massachusetts, we have a unique situation, where a conflict between state and federal law created broad confusion about what drug benefits HMOs had to provide. In addition, one plan was given a special opportunity to submit contingent benefit packages that otherwise would not be allowed. While this probably should not have happened, the intent was to protect the choices available to beneficiaries.

In Florida, you didn't have any of the circumstances, which taken together, created a unique situation in Massachusetts. In addition, Humana already decided to abandon the beneficiaries that it had served in that area. Nearly all those beneficiaries have access to other Medicare health plans, which chose to stay there.

Now, Humana promises to return if it can drastically cut benefits **and** raise premiums for Medicare beneficiaries. That just doesn't make sense, and we won't allow that to happen there or anywhere else.

However, we would move quickly to approve Humana's application if it chose to honor its commitments in the benefits package that it previously submitted.

In addition, as President Clinton ordered, we will move quickly to expedite approval of any new health plans applying to enter counties like the one in Florida, in which Medicare beneficiaries lost their only Medicare+Choice option. That situation affects about 50,000 Medicare beneficiaries out of the more than 6 million in managed-care plans nationwide.

Q: **HCFA Administrator Nancy-Ann DeParle recently said that she couldn't reopen the ACR process because "The law is the law." But now, HCFA is allowing Massachusetts plans to reopen their ACRs. Does the law not apply there?**

A: In Massachusetts, we're dealing with a unique set of circumstances created by a conflict between federal and state laws created confusion over the drug-coverage requirements. As a result, when plans prepared their Medicare benefit packages this spring, Massachusetts officials warned that the state's requirement for unlimited drug coverage would be enforced.. The quote in question dealt with a request to enable Medicare plans around the country to drastically raise their premiums and cut benefits on virtually all of the 6 million beneficiaries in managed-care plans. We rejected that proposal, which would have involved much broader and more ominous changes than the limited, narrow ones we are now allowing in Massachusetts

Moreover, it is clear from other answers in the same interview that the Administrator

did not intend to suggest that HCFA was legally precluded from allowing an HMO to revise its ACR proposal. For example, in a later statement, the Administrator defended HCFA's decision on the grounds that it is not "in our beneficiaries' best interests or the Medicare program's best interests to allow them to come in at this late date and increase premiums and lower the benefits, and change this program around for beneficiaries who have relied on it." The reporter noted that the Administrator made the point that "[a]llowing some HMOs to revise their rates...would have opened the door to identical requests from all the health plans covering six and a half million Medicare beneficiaries in managed care."

The complete reference to the law was that "the law is the law, and there's only so much that I can do to be flexible around that." This was a reference to the fact that the law limited HCFA's flexibility in permitting ACRs to be reopened in that the statute requires that information on benefits be provided to beneficiaries in time for an open enrollment period in November. It would not have been possible to permit every HMO to make changes to ACRs and still comply with the law's deadlines. This does not mean that it is not legally permissible for HCFA to permit targeted revisions under the exceptional circumstances presented in Massachusetts, for the reasons set forth above.

Internal Talking Points for Massachusetts health plan situation
November 9, 3:00 p.m.

- The Health Care Financing Administration (HCFA) encourages health plans that serve Medicare beneficiaries to offer additional benefits, including prescription drug coverage.

- Several issues have caused uncertainty this year in Massachusetts regarding the prescription benefits that would be available to beneficiaries.

- On October 30th, a federal judge ruled that Federal law prevents Massachusetts or any other state from requiring Medicare plans to provide unlimited drug coverage.

- Senator Ted Kennedy tried to insert language into this year's federal budget act that would have grandfathered in the Massachusetts requirement. The Clinton Administration, several senators, and Governor Paul Cellucci supported the bipartisan effort, but the proposal was not enacted.

- Because of the confusion that has existed and because HCFA did not respond clearly to the situation, we are now giving health maintenance organizations (HMOs) in Massachusetts that have currently approved Adjusted Community Rates (ACRs) for 1999 a brief, time-limited opportunity to resubmit the prescription drug portion of the previously approved 1999 ACR.

- This change applies to coverage and premiums related to prescription drugs only. Plans will not be allowed to change their service areas or any of the other benefits for enrollees.

- Massachusetts health plans participating in Medicare will have until November 17, 1998 to submit new prescription benefit packages, if they so choose.

- This decision reflects factors that created a unique situation in Massachusetts:
  - A conflict between federal and state laws created confusion over the drug-coverage requirements. As a result, when plans prepared their Medicare benefit packages this spring, Massachusetts officials warned that the state's requirement for unlimited drug coverage would be enforced.

  - Before the Medicare+Choice regulation was published, HCFA let one plan submit a contingent benefit package that otherwise would not have been allowed. While this should not have happened, the intent was to protect the choices available to beneficiaries.

- HCFA wants to do everything possible to work with your plans to minimize any confusion that may result from even this limited benefit change. Therefore, we will act quickly on these submissions so that beneficiaries will have enough time to consider their Medicare options before the new packages take effect on January 1. Beneficiary groups will be contacted by

HCFA to help them better understand our policy.

- Under law, HMOs will need to notify their beneficiaries of any changes in the benefit package 30 days prior to when those changes take effect. As also required by law, HCFA must review all marketing material that will be used with beneficiaries.

- Medicare+Choice is a new program, created last year and implemented this year. In the wake of this situation, we intend to issue new guidelines to clarify our policies in order to avoid similar situations in the future and prevent late changes in the coverage available to beneficiaries.

- Beneficiaries who need assistance in understanding any changes can contact their State Health Insurance Assistance Program at **1-800-882-2003,** or their local area agency on aging. They can call the U.S. Administration on Aging at 1-800-677-1116 for a referral to a local agency.

Massachusetts will be able to resubmit their applications to HCFA in order to come into compliance with the state law as soon as possible. If the state law is not upheld, we would greatly appreciate your consideration of the arguments we have made above in your final rule.

With respect and appreciation,

Sincerely,

Sen. Edward M. Kennedy

Sen. John Kerry

Rep. Martin Meehan

Rep. Barney Frank

Rep. James McGovern

Rep. John Tierney

Rep. John Olver

Rep. Richard Neal

Rep. Edward Markey

Rep. Joseph P. Kennedy II

Rep. Joe Moakley

Rep. William Delahunt

cc: The Honorable Argeo Paul Celluci
The Honorable Scott Harshbarger
The Honorable Linda Ruthardt