



Abt Associates Inc.

**CMS Demonstration  
Initiative, Phase Two:  
Findings from Interviews  
with Health Plan  
Executives**

**HSRE Working Paper 14**

Cambridge, MA  
Lexington, MA  
Hadley, MA  
Bethesda, MD  
Washington, DC  
Chicago, IL  
Cairo, Egypt  
Johannesburg, South Africa

February 12, 2002

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Phase Two:**

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WITH HEALTH PLAN EXECUTIVES**

**Abt Associates Inc.**

**and the**

**Division of Health Systems Research and Policy,  
University of Minnesota**

**Submitted pursuant to  
CMS Contract No. 500-92-0014, DO 5**

**February 12, 2002**

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## **Acknowledgements**

We would like to acknowledge the contributions of Ronald Deacon, Ph.D., our project officer, and his colleagues in the Demonstration and Data Analysis Group of the Centers for Medicare and Medicaid Services (CMS); Candace Schaller of the American Association of Health Plans (AAHP); Marianne Miller of the Health Insurance Association of America; Samuel H. Havens, independent consultant; and Nancy H. Kichak, ASA, MAAA, director of the Office of Actuaries in the U.S. Office of Personnel Management. We would also like to thank the health plans we interviewed, who generously contributed their time and expertise to this project.

# **CMS Demonstration Initiative, Phase Two: Findings from Interviews with Health Plan Executives**

## **EXECUTIVE SUMMARY**

CMS has undertaken a two-phase process to encourage Medicare + Choice (M+C) plans to remain in the market and to develop new products for Medicare beneficiaries. In Phase One (summer of 2001), CMS accepted unsolicited proposals from M+C plans that otherwise intended to leave the market the following January. In Phase Two (spring of 2002), CMS will solicit proposals from health plans to demonstrate new Medicare products. To support Phase Two, CMS directed two of its research contractors – Abt Associates and the University of Minnesota (UMN) – to interview a sample of health plans by telephone, to identify the most promising options for Medicare to consider and the most important barriers to those options.

### **Product types**

Five types of *new* models or “products” seemed to be receiving the most serious consideration by the 19 health plans we interviewed:

1. Preferred provider organizations (PPOs) or point-of-service (POS) plans – PPO and POS products were distinguished by the fact that the beneficiary’s point-of-purchase cost sharing varies, depending on which provider provides the service and, in some models, on the circumstances under which the services are provided. The POS/PPO model was mentioned much more frequently than any other innovative model, although plans were by no means unanimous in their endorsement of the PPO/POS model.
2. Fee-for-service (FFS) based administrative services only (ASO) models – Interest in ASOs generally came from plans that believed they could manage care, and could not obtain discounts from providers who in recent years have been “pushing back” in negotiations. These plans were satisfied to pay health care providers at FFS Medicare rates, and to receive an administrative fee for managing care.
3. High-deductible models – A few plans are exploring the idea of a high-deductible option for the Medicare market. Some plans feel that this model is bad social policy and likely to exacerbate selection problems in the M+C program. Interest in this model for Medicare may depend on its acceptance in the commercial market.
4. Care-system models – The care system model represents is a hybrid of M+C capitation and FFS Medicare, based on the Buyers Health Care Action Group (BHCAG) model in the Twin Cities. There was some tentative interest in this model among plans.
5. Plans for populations with special health needs – Several plans were interested in setting up and marketing delivery systems within their existing M+C plans to care for

enrollees with particular medical conditions. The most important prerequisite for such systems: adequate payment for the risks of care of the special populations.

## **Barriers to product innovation**

The interviews identified barriers to the introduction of the innovative products outlined above, focusing on barriers deriving from Medicare itself and from CMS practices. This is an incomplete perspective on innovation, but one useful for considering possible Phase Two demonstrations.

Payment barriers. All plans emphasized in interviews that eroding M+C payments under the 1997 Balanced Budget Act (BBA) and successor legislation were a major barrier to innovation. Almost all plans suggested various forms of tying M+C payments to the trend in medical costs, as measured by local FFS payments.

Knowledge barriers. The absence of information makes it more difficult for plans to design and price new M+C options. One area of particular concern is *risk sharing*. The 100 percent risk that plans assume for medical care is difficult to sustain in M+C today, given the much tighter payment levels under BBA and the uncertainties of doing business with CMS. Demonstration options import special unknowns, such as the absence of actuarial data – thus increasing the need for explicit risk sharing by CMS. Second, plans want better *risk adjustment* in Medicare. They unanimously opposed collection of outpatient encounter data in the manner CMS originally required, suggesting instead that CMS take a more statistical approach to data collection. Otherwise, respondents did not have many suggestions to accomplish the goals of risk adjustment.

Regulatory barriers. A third general group of barriers are the obstacles that M+C regulations present to new product innovation.

1. *Suspend the lock-in requirement* – All plans that mentioned the imminent lock-in requirement argued that it should be cancelled. Lock-in would eliminate a safety valve that is important in an unstable market – and in any demonstration of new, untested products.

2. *Revise quality monitoring requirements to fit new models* – Some plans suggested that out-of-network and similar care be exempt from the M+C quality monitoring requirements in a demonstration. Others made a more fundamental argument: CMS should get out of the business of setting separate quality monitoring standards, and instead rely on the same standards that private payers use.

3. *Change requirements to give plans more benefit flexibility* – The development of innovative products for Medicare requires the configuration of benefits in flexible ways that sometimes run afoul of Medicare regulations – often, with regulations concerning “actuarial equivalence.” Some plans urged modification of certain regulations related to the Adjusted Community Rate (ACR) process; others urged elimination of the ACR requirement entirely, to rely more on the market.

4. *Reduce the burden of doing business with CMS more generally* – Many criticisms went beyond specific regulations to a more fundamental critique of how CMS does business. Many plans suggested that CMS should (a) rely to a greater extent on standards used in the private, commercial insurance industry, rather than establishing new, separate, government standards; and (b) make information about choices available to beneficiaries and let them choose, rather than constraining options to meet certain requirements.

5. *Change CMS’ requirements on marketing materials* – These requirements were widely disliked. Some plans urged that the approval period be shortened, while others suggested that the review requirements be eliminated entirely – i.e., that beneficiaries’ best remedy was to “vote with their feet” if they did not get what marketing materials led them to expect. One suggested compromise: a “file and use” process for plans in good standing.

6. *Inappropriate application of FFS regulations to M+C plans* – As noted in one interview, “everything gets compared to the FFS program, and that leads to bad choices for the program.” When FFS is the baseline for judging managed care practices, M+C plans have to spend frustrating and unproductive time explaining or justifying the differences (e.g., in relation to FFS’ three-day hospitalization requirement for SNF coverage).

7. *Make service areas more flexible* – Plans generally wanted to see market-driven definitions of service areas, rather than arbitrary, county-based definitions.

8. *Mid-year changes in coverage requirements* – When CMS changes coverage guidelines for M+C plans mid-year, it should phase-in the implementation of the new guidelines, or compensate plans more fully to cover the costs of the change (e.g., to compensate for unexpected systems and other administrative costs).

9. *Need for a more level playing field with FFS* – Another area of concern for the plans was the need for a more level playing field with FFS.

10. *“Whiplash” among CMS’ Central and Regional Offices* – One plan used the term “whiplash” to describe the lack of regulatory coordination between CMS’ central and regional offices, which undermined Central Office initiatives.

Regulatory Uncertainty. A final set of barriers discussed in the interviews concerned problems that were not associated with existing regulations, but uncertainties about the regulatory environment that CMS or Congress might consider. New models will bring regulatory uncertainties that will have to be resolved for plans to offer the models.

## **Steps leading to Phase Two Demonstrations**

How can a demonstration ease the barriers outlined above, to encourage more innovation and to create a more cooperative relationship between Medicare and M+C plans? CMS’

objective in further discussions with health plans and the policy community will be to answer that question, in order to formulate a solicitation in 2002 to begin the Phase Two Demonstrations.



## **CMS Demonstration Initiative, Phase Two:**

### **Findings from Interviews with Health Plan Executives**

CMS has undertaken a two-phase process to encourage Medicare + Choice (M+C) plans to remain in the market and to develop new products for Medicare beneficiaries. In Phase One (summer 2001), CMS accepted unsolicited proposals from M+C plans that otherwise intended to leave the market the following January. In Phase Two (spring of 2002), CMS will solicit proposals from health plans to demonstrate new types of Medicare products.

This report describes the background of these initiatives and the results of a survey of health plans conducted in November and December of 2001. The survey identified not only new products of interest to health plans and their enrollees, but also the barriers that plans face in offering these new products. As we will describe below, the barriers to these innovative product offerings are not so different from the difficulties that plans describe for product options already offered under Medicare + Choice. Steps needed to enlarge the choices available to Medicare beneficiaries overlap almost entirely the steps plans have advocated for more general reform of the Medicare + Choice program.

To the extent possible, the authors have attempted to present this material in the words and terms that plan executives used in the survey. This report does not represent the authors' or CMS' understanding of barriers to new product innovation. Instead, it attempts to describe in a structured way how the plans themselves view this issue.

The report is organized into three main sections. The first section below provides a brief background of CMS' demonstration initiatives. The second section reports on the Abt/University of Minnesota interviews with health plan executives, summarizing the most promising products that plan executives described in our discussions. The third section describes the barriers to introducing those products in the Medicare program. The ultimate purpose of reviewing this material is to gain some understanding of the barriers that could usefully be removed to ensure the success of the Phase Two demonstrations.

#### **1.0 BACKGROUND ON THE CMS DEMONSTRATION EFFORTS**

CMS faces a significant challenge as it attempts to increase participation in alternatives to traditional Medicare fee-for-service (FFS). Participation by plans in M+C is declining. In addition, Medicare beneficiaries currently have access to fewer health plan models than consumers with commercial insurance. Often, when individuals become eligible for Medicare, they are unable to continue medical coverage in widely available commercial models that they might prefer, such as preferred provider organizations (PPOs) and point-of-service (POS) plans. While the intent of the Balanced Budget Act of 1997 was to provide a wider range of health choices, the health plan

industry generally has chosen to offer traditional HMO products and little else. Plans have expressed concern about their inability to provide more diverse options that are financially viable and appealing to beneficiaries.

CMS is considering how to enhance opportunities for experienced organizations to offer innovative products as Medicare options. CMS has taken a two-phase approach to increasing choices available to beneficiaries.

## **1.1 Phase One**

In the first phase, CMS agreed to respond to unsolicited proposals from existing M+C plans that were considering exiting from the market. Six demonstrations of alternative payment were awarded, with implementation beginning January 1, 2002. This phase occurred at the critical time when plans had to decide whether or not to remain in the program for 2002. With little time to consider a broad range of innovative ideas, CMS limited selection of demonstrations to those involving revised payment. (See the description of Phase One demonstrations in Appendix A.) Plans were told at that time to wait for Phase Two to test other innovative ideas.

## **1.2 Phase Two**

In the second phase, CMS will be looking for new models to test and will be interested in receiving proposals from a wider group of organizations – incumbent organizations and entities that are not current M+COs. Current plans call for CMS to issue a solicitation in 2002 to encourage these more innovative models.

In order to structure the solicitation, CMS is undertaking special efforts to gather information from health plans and others, so that the solicitation can take realistic account of the actual possibilities and constraints that M+COs face. One part of that process of consultation is the interviews described in Section 1.3 below. A second part of that consultation is more direct discussions between CMS and key stakeholders. Throughout Phase Two, CMS will continue to meet with various plans and associations that wish to explore specific policy or product innovations with CMS staff. This consultation process already includes helpful meetings with individual health plans and the Blue Cross Blue Shield Association (BCBSA).

## **1.3 Data collection from health plans: the interviews**

To inform the development of the solicitation, CMS wanted a special set of interviews conducted with insurance industry experts about what health care delivery models might be attractive to beneficiaries, and what barriers currently exist within the M+C program to introducing those models.

Arrangements and methods. To ensure some independence and candor in these interviews, CMS directed two of its research contractors – Abt Associates and University of Minnesota (UMN) – to interview health plan executives about the most promising options for Medicare to consider and the most important barriers to those options. With advice from the American Association of Health Plans (AAHP), the Health Insurance Association of America (HIAA), the Office of Personnel Management (OPM),<sup>1</sup> Abt/UMN, and others, CMS developed a sample of plans for Abt/UMN to interview and a set of questions to be asked of each plan. The nine basic questions are reproduced at Appendix B. Respondents were given a copy of the questions before their interview.

The sample of plans that were interviewed was a judgment sample, including for-profit and non-profit plans, large and small plans, incumbent Medicare plans and plans that had exited the program, plans with large M+C enrollments and small enrollments, and plans from every major region of the country. As a rule, the plan officials to whom Abt/UMN spoke were people responsible for government lines of business in the plans – these being the people most likely to know first hand their organization’s successes and difficulties with Medicare, and to have spent the most time thinking about future possibilities for their organizations in working with Medicare. Nineteen plans were interviewed. Interviews could not be arranged with two plans. As a condition of the interviews, neither the plans nor the managers who responded to the questions were to be identified. Anonymity was not complete, however: CMS demonstration staff from the agency’s Center for Beneficiary Choices (CBC) had the option to listen to each interview and, when they did participate, were introduced at the outset of the discussion. Each interview was led by Dr. Robert F. Coulam of Abt Associates or Professor Bryan E. Dowd of the University of Minnesota, with CMS staff asking occasional questions. The interviews were conducted by conference call, usually with more than one respondent from the plans.

Conduct and limits of the interviews. The interviews were conducted between November 13, 2001, and December 21, 2001. The general format of each interview was to use the nine general questions as starting points for open-ended discussions that would at least touch upon the nine areas of inquiry, but not in any tightly structured way. The interviews could follow almost any direction that the respondents chose. The advantage of this form of discussion is largely exploratory: to see what plans are thinking about and to get some idea of the first issues in the minds of plan executives, in response to the general promptings of the interview questions. That advantage is a fair statement of CMS’ objectives in these interviews. There are necessarily disadvantages, however. Combined with the non-random sample of interviews, the absence of structure in the discussions limits opportunities to aggregate responses, in order to estimate proportions of plans holding particular opinions – e.g., to estimate the proportion of all plans who believe the most promising product innovation is a PPO, or the proportion of all plans who want risk sharing, and so on.

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<sup>1</sup> In its role as administrator of the Federal Employee Health Benefits Program (FEHBP).

## **2.0 WHAT ARE THE MOST PROMISING PRODUCTS FOR CONSUMERS AND HEALTH PLANS? RESULTS OF THE HEALTH PLAN INTERVIEWS**

Obviously, interviews ranged over a diverse array of possible products to be offered in Medicare. But five types of *new* models or “products” seemed to be receiving the most serious consideration by the health plans we interviewed: preferred provider organizations or point-of-service plans, FFS-based administrative services only (ASO) models, high-deductible plans, care-system models, and plans for populations with special health needs. It is worth noting that, to some respondents, the most important issue was how to continue to offer current, HMO-based products in a more stable financial environment and with various refinements. But most plans highlighted new products, usually one of the five noted above. Among these models, the PPO/POS model was mentioned much more frequently than the other models, although plans were by no means unanimous in their endorsement of the PPO/POS model. The plans’ interest in the PPO/POS product seemed to be driven primarily by the plans’ experience with these products in commercial markets, and their perception that the products would be well-received by Medicare beneficiaries under the right circumstances. We discuss each of these five models in turn.

One challenge in discussing the different products is that their names have different meanings for different people. For example, one health plan representative suggested that the difference between a PPO and POS model was that out-of-network providers were paid capitation rates in a POS model, but were paid fee-for-service under a PPO model. Others suggested that POS plans simply were PPO plans run by HMOs, rather than FFS insurers. In order to minimize confusion, we begin our discussion of each product with a definition that represents the modal interpretation of the product among the plans we interviewed.

### **2.1 PPO/POS models**

A PPO or POS product is distinguished by the fact that the beneficiary’s point-of-purchase cost sharing varies depending on which provider provides the service, and in some models, on the circumstances under which the services are provided. Due to that common feature, the terms PPO and POS often are used interchangeably. Among people who make a distinction, PPO generally refers to plans that are offered through a traditional FFS insurer, while POS plans are offered through a traditional HMO. The remainder of this discussion will focus on models that are offered through M+C plans, and so we will refer to the PPO/POS model as a POS model.

The trigger for higher point-of-purchase cost sharing varies among POS models. In some plans, higher point-of-purchase cost sharing is triggered by seeing an in-network specialist without a referral. Other models allow self-referral to in-network specialists with no increase in cost sharing. In some plans, higher point-of-purchase cost sharing is

triggered by out-of-network use without a referral. In other models, out-of-network utilization triggers higher cost sharing with or without a referral.

Generally, the three dimensions of the plan that can trigger changes in cost sharing are:

1. In-network versus out-of-network
2. Specialist versus general or family practitioner (or pediatrician in commercial markets)
3. Referral or no referral (self-referral)

If we imagine these three binary dimensions as a 2x2x2 cube with eight cells, we could categorize the cost sharing of all the plans that we interviewed by the way that point-of-purchase cost sharing varies across the eight cells. There is no “usual” pattern of cost sharing. If the POS products offered to Medicare beneficiaries are to reflect the same variety as the products offered in the insurance market, there will need to be considerable flexibility in the rules regarding different model types.

Demand for the POS product is driven by consumers who want to enjoy the low out-of-pocket premium and additional benefits that frequently are offered by a tightly managed health plan, perhaps a staff or group model HMO, but who also want the assurance that they will receive some minimum level of coverage if they want to bypass the plan’s usual protocol for delivering care. One plan referred to this model as the “yuppie product,” but there seemed to be general consensus that the model would be popular among current Medicare beneficiaries, as well.

CMS has attempted to incorporate POS plans into the M+C market at various times and in various ways over the years, but without a great deal of success. Interestingly, the plans’ concerns have changed over the years. When Christianson, Dowd and Feldman (1995) interviewed Medicare HMOs in 1994, plans were concerned about how they could manage out-of-network care. In our current set of interviews, plans did not seem interested in managing out-of-network care, but they were concerned about the prices they would have to pay for out-of-network care, and whether they would be held responsible for the quality of out-of-network care. We discuss these and other potential barriers to the POS model in Section 3 below.

Despite the general enthusiasm about the PPO model, some plans were quite discouraged about PPOs for Medicare. A number of plans noted that PPOs typically were based on price discounts, and they did not believe that they could obtain prices that were better than FFS Medicare prices in their market area. Other plans believed that the traditional group or staff model was the better model for their company or beneficiaries in their market area. One plan reported that its most popular product in the commercial market was a high-deductible PPO, but that plan did not believe that product was appropriate for the elderly.

Other plans were moving away from PPO models towards open access plans or OAPs. The distinguishing feature of an OAP is removal of the gatekeeper feature found in many managed care plans. However, the “openness” of OAPs can vary. A truly open access plan would not represent an innovative plan, but a return to the health insurance market prior to the introduction of managed care. The open access plans that were described in our interviews were open only within the health plan’s network of providers.

Whereas PPOs have different levels of point-of-purchase cost sharing for different providers, or providers seen under different circumstances, the health plans that are considering an OAP product suggested that there would be only level cost-sharing in OAPs, which might be higher than the cost sharing for either in-network or out-of-network providers in a similar PPO. OAPs that compete against staff model HMOs or PPOs may take additional steps to make their premiums competitive, such as tightening their provider networks.

## **2.2 FFS-based administrative service organizations (ASOs)<sup>2</sup>**

The FFS-based administrative service organization (ASO) model is based on the experience of self-insured firms in the commercial insurance market, and would apply only to FFS Medicare, not to the M+C market. ASOs perform a wide range of services for self-insured firms, including claims processing and care management. ASOs generally are paid an administrative fee, and the fee often contains financial incentives related to performance objectives. The performance objectives can be related to claims experience or quality of care.

Among the plans we interviewed, interest in the ASOs generally came from plans that believed their relative advantage and interest in the M+C market was managing care, rather than obtaining price discounts. Some of these plans operated in market areas where providers were reluctant to give discounts below FFS Medicare rates, and the plans felt that refusal to give discounts made the POS model unworkable. These plans were satisfied to pay health care providers at FFS Medicare rates, and to receive an administrative fee for managing care. The managed care techniques ranged from traditional utilization review to more aggressive disease management strategies. Plans generally reacted positively to financial incentives based on their success at managing care, although one plan thought that that would just introduce incentives for plans to “game” the system. One plan stated that just reducing unnecessary hospitalizations would be enough to produce savings of interest to CMS and a financial reward to their plan.

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<sup>2</sup> ASO often stands for “administrative services only” organizations. In this discussion, these organizations are identical to “administrative services organizations.”

### **2.3 High-deductible plans**

Although they were not mentioned frequently, a few plans are exploring the idea of a high-deductible option for the Medicare market. Some plans that have examined high-deductible plans for Medicare feel that they are both bad social policy and are likely to exacerbate selection problems in the M+C program.

The high deductibles in a typical MSA product apply to the first dollars of expenditures. Some plans noted that the newer products offered by firms like Definity and Destiny often feature first dollar coverage up to a limit, then a “hole” where beneficiaries pay out-of-pocket, followed by complete catastrophic coverage at some upper limit. Destiny also varies coverage and point-of-purchase cost sharing by the type of care. Frequent, low-cost, discretionary services (e.g., preventive care) may not be covered at all, while infrequent, high-cost, non-discretionary services receive 100 percent coverage with no cost sharing.

Most plans clearly were in the very earliest stages of analyzing high deductible options. Interest in these products for Medicare may depend on their acceptance in the commercial market.

### **2.4 A care systems model**

One plan mentioned interest in a care systems model for Medicare. The care system model represents the most significant departure from models currently offered in Medicare, because it is a hybrid of the M+C model and FFS Medicare. It is based on the Buyers Health Care Action Group (BHCAG) model in the Twin Cities.

Under the care-systems model, providers group themselves into care systems. In the BHCAG model, a primary care physician can be affiliated with only one care system.

Care systems submit bids that are a per-member-per-month cost for a standardized enrollee. Those bids place the care system into one of three cost tiers. Employees choose care systems during open enrollment and care systems in higher cost tiers carry higher out-of-pocket premiums. Care systems thus have an incentive to keep both the fee schedule bids and their volume of services under control, although some care systems seem to have established a market niche as higher quality and higher priced systems

Care system providers are paid on a FFS basis. FFS payments to providers ensure that providers will be paid for the services they provide, and the fee schedule and volume performance standards provide market discipline. Payments are adjusted for the risk of the care system’s enrollees. At the end of each three-month period, the providers’ total expenditures per enrollee for a rolling annual period are compared to the PMPM risk-adjusted bid, and fees are adjusted to bring total expenditures in line with the bid. The

care system model thus combines the expenditure accountability of capitation payment systems with the cash flow advantages of FFS.

The care system model is an enrollment model. Services obtained outside of the care system are not covered, unless approved by the care system. The care systems are responsible for most covered services, but are not responsible for out of area emergencies and outlier cases. Thresholds for outliers are based in part on the enrollment level of the care system.

In employment-based insurance, the incentive for care systems to bid low and to provide only appropriate services is the threat of being placed in a higher cost tier that carries a higher out-of-pocket premium. This feature makes the care system model different from most preferred provider organizations (PPOs). In most PPOs, the effect of choosing non-preferred providers on consumers is higher point-of-purchase cost-sharing (i.e., a higher coinsurance or copayment rate).

## **2.5 Models for special populations**

“Models for special populations” can take several forms. What the models have in common is an organization that is dedicated to the care of beneficiaries with a particular medical condition. This organization might contract with:

- CMS as a capitated M+C plan,
- FFS Medicare for management of a subset of FFS beneficiaries under an ASO contract, or
- an existing M+C plan for the care of specific enrollees.

The plans we interviewed vary in how they currently serve populations with special health needs.<sup>3</sup> Many plans reported that they maintain a large provider network, which ensures the availability of specialists that can handle any type of health problem. These plans viewed the problems of special populations from the perspective of access to remedial or chronic care. Other plans take a more aggressive approach to prevention, seeking out enrollees with a high probability of using particular types of services and attempting to intervene early in the disease process to minimize the need for expensive care later in the disease process.

Among the more aggressive plans, some mounted their early detection and prevention efforts internally, while others contracted with organizations external to the plan. There was little interest among the M+C plans we interviewed in developing free-standing health plans to deal with special needs populations. However, several plans were interested in setting up and marketing delivery systems within their existing M+C

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<sup>3</sup> “Special populations” in this discussion refers to populations with specific health conditions, rather than general problems of access to care, language or cultural barriers, etc..

plan to care for enrollees with particular conditions. Diabetes and congestive heart failure were mentioned as two conditions that might be amenable to this model.

Health plans believe that the most important ingredient for success of the model is adequate payment for the risks of care of the special populations (in effect, adequate risk adjustment). They also mentioned assistance with marketing. For example, CMS might examine FFS claims data and identify FFS beneficiaries with these conditions, then alert the beneficiary to the availability of plans that specialize in care for their conditions.

### **3.0 BARRIERS TO PRODUCT INNOVATION IN MEDICARE + CHOICE**

The discussion to this point has reviewed what health plans said to us about the kind of innovative products they would like to introduce in Medicare. In this section, we consider the barriers to innovation in the M+C program, with an eye to crystallizing some of the dimensions of the M+C program that might usefully be varied in a demonstration context. The barriers can be divided into four separate categories: eroding government payments, regulatory barriers, knowledge barriers, and regulatory uncertainties. We discuss each in turn.

One important point to bear in mind throughout the following discussion is that our interviews focused on barriers resulting from Medicare law and regulations and CMS practices. But there are many barriers to these new products that come from other sources. We will have little to say about those other sources, but the fact that we ignored them does not make them lesser barriers to long-term innovation. For example, our interviews considered *state* barriers to product innovation only in passing – plans mentioned problems with state regulations in our interviews, as part of a more general discussion, but we ordinarily kept the focus of the discussions on federal issues. Especially for organizations offering plans in multi-state market areas or organizations operating in states with more demanding regulatory requirements, the difficulties of adapting new products to existing state regulations can be significant. Meanwhile, health plan organizations noted other difficulties to launching new products that included internal obstacles in some of these organizations (e.g., the structure or legal status of the organization), pressures in the financial markets (e.g., reservations in the stock market to these organizations' taking on additional Medicare risk business), marketing challenges (e.g., difficulties in finding a niche for a new M+C product that will not cannibalize either existing M+C products or Medicare supplement business that is also important to the organization), problems of beneficiary education (e.g., the difficulties of educating beneficiaries concerning the important differences among novel plan options), and others.

The listing of barriers below is thus a partial listing, *focusing on barriers that derive from Medicare and CMS*. This is an appropriate emphasis, given CMS' interests in devising a second demonstration initiative based on actions CMS, working with others, can take. But it should not be seen as a comprehensive listing of all the difficulties facing the health plan industry in bringing new products to the Medicare program.

### 3.1 Payment barriers

“Payment is the key to new plan options.” Every plan made this point in some form. All plans emphasized in interviews that eroding M+C payments under the 1997 Balanced Budget Act (BBA) legislation and successor legislative refinements were a major barrier to innovation. Given the backdrop of intense political discussion of this issue, the pervasiveness of these suggestions in the interviews came as no surprise.

A few respondents argued that *no product innovation could occur* without resolution of the payment issues. Most plans were not so strict in their responses, but it was clear that a key issue of the Phase Two demonstrations will be how much additional funding is available for them.

The problem of eroding payments generally was described in four dimensions:

- an inadequate base
- inadequate annual updates
- a generally flawed approach to risk-adjusting health plan payments
- uncertainty regarding payment levels from one year to the next.

The concerns about an adequate base came primarily from plans operating in areas with historically low government payments. These concerns persisted despite the installation of “floor” payments (the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000)) and bonus payments for serving underserved counties (the Balanced Budget Refinement Act of 1999 (BBRA 1999)).

The concerns about annual updates focused on the two percent increases in payments that many plans have received since the 1997 BBA legislation. Plans emphasized that their increases in costs (5 to 10 percent per year) were three to four times the increase in payments. One plan noted that BIPA 2000 had increased payment levels in some of its suburban counties to 110 percent to 115 percent of FFS, while urban counties remained at 90 percent of FFS.

Against these data, almost all plans suggested various forms of tying M+C payments to “the trend” or “the real world.” Generally, this was defined in terms revolving around the 100 percent FFS level as a baseline,<sup>4</sup> with some plans suggesting *quid pro quos* for the increase. The specific recommendations from plans included:

- Stabilize the current program by increasing payments, before worrying about adding options like PPOs and PSOs.

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<sup>4</sup> 100 percent of FFS might represent an increase for most “two percent” counties, but a decrease for floor counties.

- Set payments at 100 percent of average FFS Medicare costs. For that payment, plans would be required to offer a reasonable drug benefit and to meet specific quality requirements. (This suggestion was from a plan in an area with relatively high FFS costs.)
- Set payments at or below 100 percent FFS, depending on the quality rating the plan receives from CMS. This plan would have CMS grade the plans on a simple quality scale (e.g., 5-star, 4-star etc.) and tie reimbursement to this grade (e.g., 5-star plans receive 100 percent FFS, 4-star plans receive 95 percent FFS, etc.). Consumers “need to know quality information,” *including FFS* – this plan feels “very passionate” about this.
- Set payments at 100 percent of FFS plus graduate medical education (GME) payments. One plan suggested that this payment level would make its proposal for a non-gatekeeper PPO financially viable.
- Set payments at 100 percent FFS with the additional five percent (relative to pre-BBA payment levels set at 95 percent of FFS) devoted to risk sharing or rewards for quality performance.
- One plan suggested moving to a competitive pricing system for a benefit package that included prescription drugs, but not limiting payments to the average cost of FFS Medicare.

In sum, while there were consistent claims of the need for higher payments approximating FFS payments, there was a loose division among plans: some plans argued that the higher level of payments would stabilize the program and possibly bring new innovations in due course; others offered a willingness to trade something at the outset for the increase, such as a commitment to quality goals or a minimum drug benefit. Other plans that did not offer such a trade spontaneously (we did not ask for one) might well have agreed to the proposition.

Another clear theme from the interviews is the difficulty plans are experiencing in their negotiations with providers, especially hospitals. BBA 1997 tightened rates of increase in both payments to M+C plans and FFS payments to providers. Providers have begun to push back on plans – they have become much tougher negotiating partners. Comments from plans included the following:

- “Hospitals, especially in outlying areas, have you over a barrel” – the plan “can’t get competitive reimbursement.”
- The BBA’s assumption that the carveout of GME would cascade down to lower prices from hospitals “hasn’t happened.”<sup>5</sup>

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<sup>5</sup> The BBA legislation offered increased GME payments directly to hospitals under FFS Medicare, and excluded GME costs from the M+C plans’ payment base.

- Providers take 100 percent of Medicare amounts, with no room for negotiation.
- Two other plans spoke of having to pay more than Medicare rates to providers.

For these plans, the direct consequence of provider push back was that any kind of PPO arrangement would be difficult financially, because of the provider payment levels. One plan suggested that it would be hard to “fit” a PPO in between its (higher cost) FFS supplements and its (lower cost) HMO options, given this provider push back on rates. A significant number of health plans said that provider consolidation contributed to their inability to negotiate favorable rates.

One interesting effect of this push back by providers was an apparent sense in four plans that price negotiations with providers were an increasingly expensive hassle that could not be won. The solution, from their perspective, was an arrangement that does not require negotiations, i.e., a non-capitated arrangement based on FFS (usually, some form of case management coupled with FFS payments to providers). How better to avoid negotiations than to have a model that pays providers FFS rates? This line of reasoning leads to the administrative services organization (ASO). Working under this kind of arrangement, plans would be at risk for administrative costs, but not medical costs, much as they are in their ASO arrangements with employers. The erosion of government payment to M+C plans and the increased market power of providers has made FFS Medicare look more attractive to some plans as a platform for care management.

A potential barrier to ASO demonstrations that involve disease management interventions is enrollment volume. Enrollment in the disease management program presumably would be voluntary, particularly for disease management programs offered to FFS beneficiaries through ASOs. Maintaining a disease management program is cost effective only if it can serve a significant number of beneficiaries. FFS Medicare beneficiaries have little familiarity with coordinated care or disease management programs. One health plan suggested that CMS might examine FFS claims data to identify beneficiaries with targeted health conditions, then inform the beneficiary that the disease management program was available through a particular M+C plan, either a capitated plan or an ASO.

## **3.2 Knowledge barriers**

A second set of barriers to demonstrating new options in M+C is knowledge barriers. By knowledge we mean the absence of information that would allow plans to design and price new M+C options. Knowledge barriers affect the ways plans think about risks and, as a corollary, the ways CMS could share, adjust, or otherwise buffer plans from risks.

### 3.2.1 Risk sharing

In response to a question about the need for risk sharing in a demonstration, one plan said, “If you step out on the limb a little bit, there needs to be a safety net underneath.” The logic was straightforward. For the kind of new options these plans were considering – and CMS wants to encourage – there were no good data on senior behavior, only suggestive data from other populations. What is the level of out-of-network use by the elderly in a PPO? How do in-network/out-of-network cost sharing differentials affect elderly behavior? Will FFS beneficiaries enroll voluntarily in case management programs and adhere to the case management guidelines?

The uncertainty associated with new health plan options is precisely what makes a demonstration attractive to health plans. An important purpose of the demonstration would be to generate some of the needed data, within a more general test of the desirability and feasibility of the options. But for the pioneers, the fact that the data might be useful to others is not exactly reassuring. In any industry, firms either must be able to profit from the information they gain by risky attempts at innovation, or the risk must be eliminated. The health plans we interviewed emphasized that there has to be gain to innovation, if they are to bear the risk of significant gaps in knowledge. Knowing, perhaps, that it is difficult to keep the information gained from a demonstration proprietary, more than one-half of the plans interviewed offered support for some kind of risk sharing with the government, to buffer the plan against these unknown risks – at least temporarily, until data are available to make more reliable predictions. One plan suggested that risk sharing need not cover all medical risks – risk sharing was needed, in particular, for out-of-network medical costs, given the data uncertainties and uncertainties about reimbursements for out-of-network care (on the latter issue, see Sections 3.1 above and 3.4.1 below). A solution to this latter problem was to limit reimbursement of such providers to FFS rates.

Plans were asked whether there was any way for private reinsurance to protect them against the difficulties of forecasting the results of some of the new options being contemplated. The plans that commented on reinsurance almost uniformly said no. Very few of the plans we interviewed used commercial reinsurance. The rates for private reinsurance of Medicare risks were seen as prohibitively expensive. One plan suggested that short-term reinsurance for risky new products was an appropriate role for the government (CMS), because the transaction costs of reinsurance were so high and because the reinsurers, like the plans, would not themselves have very good data on some of the key risks. Risk-sharing for out-of-network utilization under a PPO model was mentioned specifically.

It is important to note that the usual risk associated with health expenditures was not the only risk that concerned health plans. They also were concerned about the risk of dealing with the government as a business partner. Unpredictable changes in government payment, mandated benefits, changes in benefits after rates have been announced, regional variation in the interpretation of policy, and a constantly shifting regulatory environment were cited as major contributors to the risk of serving Medicare

beneficiaries.<sup>6</sup> Plans felt that risk sharing would be helpful as a way to bring some stability to the business and to keep them in it. In the words of one plan, there needs to be risk sharing “so it’s not feast or famine.” Three to five years ago, the plan would have been “fine with 100 percent risk,” but now there’s a greater downside and plans need to be insulated from significant losses. Another plan cautioned, however, that risk sharing was no substitute for being paid “enough to begin with.”

If the government is to share in the plans’ unbudgeted expenditures, the question arose as to whether there should be sharing of plan profits, as well. Most plans that favored risk sharing seemed flexible on the idea of saving upside and downside risks – something common in their private business – although the interviews did not explore how much sharing occurred or under what circumstances. The most important condition that was mentioned was that any system of risk sharing be *easy to administer*, accountable, and not require an “army of professional help” and take forever – i.e., that it not require expensive actuaries and other professionals, as CMS regulatory arrangements often required, and be dragged out over details, as CMS financial transactions often were. This issue posed a reasonably clear example of a more general issue that deserves separate discussion: could CMS work with the plans in a less burdensome way? See that discussion in Section 3.3 below.

The forms of sharing suggested by the plans were varied and included the following:

- Risk corridors could be established, with sharing of savings and costs. This was the most frequent proposal. One plan suggested requiring plans to meet basic thresholds of quality to receive the full risk sharing. Quality standards would be based on standard measures from HEDIS and NCQA, (not unique CMS measures). This proposal also included a provision for beneficiary education and retail competition over quality: provider report cards would be used to report plan performance to beneficiaries.
- Carve-out or stop-loss for particular disease categories or for the frailest enrollees were also suggested.
- A hold-back of some amount (say, 5 percent of 100 percent FFS payment) might be used to cover losses or to share as savings (or, for another plan, to use as a bonus for quality achievement).

Whatever the method, the principal message communicated was that part of the difficulty of M+C business was 100 percent risk, that that level of risk was less sustainable given the much tighter payment levels and the uncertainties of doing business with CMS, and that a demonstration option – importing special unknowns – called for explicit risk sharing by CMS.

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<sup>6</sup> There have been important improvements in this latter area, however, as noted throughout this paper.

### 3.2.2 Risk adjustment

Whereas risk *sharing* concerns the retrospective treatment of unexpectedly high expenditures, risk *adjustment* is a prospective payment adjustment based on observable characteristics of the beneficiary.<sup>7</sup> In these interviews, risk adjustment was like the weather: everyone complained about it, but no one seemed to know what to do about it.

They did know what *not* to do: almost without exception,<sup>8</sup> they opposed collecting outpatient encounter data in the manner CMS originally planned. The CMS requirements were deemed onerous and unnecessary – plans generally emphasized the desirability of more statistical ways of measuring risk, with less burden on the plans. CMS was given considerable credit by plans for suspending the implementation of the current PIP-DCG risk adjustment system. This was one of the most frequent examples given of a “new attitude” in CMS in its relations with the plans. Plans also were universally opposed to risk adjustment that was triggered by a particular type of utilization, rather than by the diagnosis itself. Identifying the diagnosis through claims or utilization data from a particular setting (e.g., doctors’ offices or hospitals) restricts the plans’ ability to care for patients more efficiently. A particular example was the use of skilled nursing facilities rather than hospitals.

Beyond their consensus on suspending the old requirements, plans did not have many suggestions about how to accomplish the goals of risk adjustment. One plan described risk adjustment as “more an art than a science” and a reason to look to other means to deal with risks. One plan suggested that CMS should pay more for plans offering drug benefit, due to adverse selection into such plans (i.e., use pharmacy data to augment existing risk adjusters, to take account of disease-based pharmacy costs resulting from selection). One group of interviewees – those entertaining FFS-based ASO models – simply conceded the point and favored switching to a model within which Medicare bore the medical risk. Most plans agreed that, if a risk adjustment method could be found that did not unduly burden plans with data collection, it would be worth having. But the interviews gave no indication of a clear strategy to follow.

Perhaps the plans’ difficulties with risk adjustment help to explain their support for risk *sharing* in some form. Rather than prospective risk adjustment, the government could look at the results in some fashion and prevent significant losses or gains through an easily administered sharing algorithm. This sentiment suggests something that was made clear in the first wave of M+C demonstrations last August: while many of the larger parameters of M+C cannot be waived in a demonstration, a demonstration may still be attractive because of the opportunity it offers for devising and testing alternative methods of risk sharing that have become more important in a turbulent market and a tightened funding environment.

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<sup>7</sup> The fact that risk adjustment is made on the basis of known characteristics of beneficiaries makes the term “risk” adjustment somewhat inappropriate (Dowd and Feldman, 2001).

<sup>8</sup> The only exception was one part of one organization. Even in that organization, sentiment was overwhelmingly against CMS’ original data collection plans for outpatient data.

### 3.3 Regulatory barriers

A third general group of barriers are the obstacles that M+C regulations present to new product innovation. Medicare is a public program. The level of regulation and accountability in Medicare is sure to be greater than what plans experience in their private business, and in various ways that will affect and doubtless limit the options that plans can offer to Medicare beneficiaries. It is also true that different groups, with different responsibilities, are likely to draw the line between necessary accountability and unnecessary burden at a different point in the envelope of possible requirements. But while allowing for those differences, the interviews attempted to get at two particular kinds of barriers that were not just variants of self-interest or role:

- Technical barriers to product innovation – There are some regulatory/administrative requirements and some product innovations that do not mix well or easily. Some conflicts are inevitable, since the regulations have mainly been worked out in the context of the current slate of traditional HMO-based offerings. For plans to innovate, the regulations need to be rethought in certain respects. The interviews attempted to highlight regulations that did not fit the changed arrangements that the innovative models envision.
- The burden of doing business with CMS<sup>9</sup> – A different and more contentious area concerns regulatory burdens that arise from how CMS does business. For example, some plans suggested that whatever progress was made on payments, risk sharing, and other important areas, it would be difficult to have options more like the private sector, so long as CMS (in the words of one) used “400 pages of regulations” to tell them how to do the options. The typical metaphor used to describe these burdens was “heavy handed,” the implication being that a different approach, a lighter hand, would be helpful. Notably, plans thought that CMS’ ways of working with plans in recent months were more productive and less burdensome. As a result, comments in this area described important areas of progress, as well as new areas where a different approach would help.

These two categories are not mutually exclusive. But interviews usually reflected somewhat different emphases between the two categories. Thus, some interviews emphasized that technical barriers could be resolved by slight changes to fit a new model within the existing framework – suspending a particular provision of the regulations, for example – while other interviews emphasized the need for more fundamental change in the regulatory framework or administrative regime itself. It is perhaps fair to say that the former are more amenable to a demonstration setting than the latter, although both offer some guidance for CMS’ demonstration plans.

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<sup>9</sup> Note the difference between characterizing doing business with the government as a risk, as opposed to a burden. The “risk” is uncertainty over government policy, the “burden” is the known difficulty of current regulations.

The plans offered a number of specific barriers to innovation that might usefully be remedied in any demonstration.

### **3.3.1 Suspend the lock-in requirement**

Beginning in 2002, M+C enrollees will be “locked in” to their health plan elections after a six-month grace period, ending June 30. Starting in 2003, the grace period is three months, ending March 31. The purpose of a lock-in is to prevent the market for health insurance from deteriorating into a “spot market” for health care, with beneficiaries switching plans to take advantage of particular providers or particular coverage. If high risk beneficiaries move frequently from plan to plan, any data-based form of risk adjustment becomes virtually impossible. The argument against the lock-in is that it might make beneficiaries reluctant to try out M+C plans in general, or the new demonstration products in particular. The general stability of membership in plans also argues against a lock-in requirement, although the stability of beneficiaries with high expenditures is the most important issue.

We did not ask plans specifically about the imminent lock-in requirement. But six plans mentioned it, and all of them argued that it should be cancelled. Their argument, in various forms: given market instabilities and given the buffeting of Medicare beneficiaries with service area reductions and benefit reductions, this was no time to introduce a new and, in their opinion, unnecessary requirement that would only make M+C less attractive to beneficiaries.

These opinions were more emphatic concerning demonstrations. Plans felt that beneficiaries could not be asked to enroll in an untested demonstration option, without the “safety valve” of being able to disenroll at any time.

### **3.3.2 Revise quality monitoring requirements to fit new models**

Some of the new models that plans are considering would provide beneficiaries with flexibility, but leave the plans with limited control over some part of the beneficiaries’ medical care. In these cases, plans argued, they could not be held accountable for the total quality of care that beneficiaries received – e.g., when beneficiaries self-refer to out-of-network providers in a PPO. QISMC and other M+C regulations – based on the rate at which events occur per enrollee – did not readily fit the divided accountability of a PPO. In the ASO model, plans felt that they should be held accountable only for the specific aspects of their administrative services contract, (e.g., improvement in process and outcomes from disease management programs), but not for the care that fell outside the scope of the contract.

Seven plans mentioned quality monitoring in their discussions. They generally suggested two different strategies for resolving the quality monitoring issues and those strategies reflected the emphases noted earlier (technical conflicts versus the burdens of doing business with CMS). In some interviews, plans suggested that PPOs simply be exempt from the M+C quality monitoring requirements in a demonstration. In other interviews, a more fundamental argument was made: CMS should get out of the business

of setting separate quality monitoring standards, and instead rely on the same standards that private payers use (e.g., HEDIS, NCQA, and retail competition based on information in report cards on quality).

### **3.3.3 Change requirements to give plans more benefit flexibility**

The development of innovative products for Medicare requires the configuration of benefits in flexible ways that sometimes run afoul of Medicare regulations – often, with regulations concerning “actuarial equivalence.” Eight plans mentioned this problem. Conflicts were noted in a number of areas:

- One plan is designing a PPO for a high-cost urban area, and the premium that the plan needs to charge to make it financially viable exceeds the national cap permitted under Adjusted Community Rate (ACR) regulations. The problem here is that the plan’s premium is included in and limited by the actuarial equivalence calculation in the ACR. Plans generally do not mind giving CMS their estimates of what benefits cost (although see the next item below, concerning the issue of equivalence item by item, versus overall equivalence). But having done that, they want to be able to charge whatever premium their options require for financial viability (or, thought the plans did not explicitly say this, whatever premium the market will bear).
- Another plan urged that the ACR requirements better reflect data that plans have. As it is, every copayment has to be priced, with some copayments so miniscule that there is no data for them. It would help to allow plans to combine lines to a more summarized level. In addition, it would help if the separate ACR filing for B only beneficiaries were eliminated. For example, in one region, this plan had fewer than 15 Part B-only members, but had to complete an entire worksheet for them. They should piggyback on the filing for Part A and B members – that is sufficient protection.
- Another plan wanted to get rid of actuarial equivalence, and to disconnect the judgment of appropriate premiums from the ACR process.
- Another plan wanted to offer different cost-sharing than would be permitted under the actuarial equivalence requirements of the ACR.
- Another plan emphasized the need to allow health plans to “remix mandates” – e.g., in return for providing a minimum drug benefit, a plan could do such things as reduce DME coverage or impose a cost share for the first 100 days SNF utilization. Only in this way, the plan argued, could beneficiaries get more optimal benefits packages.
- Yet other plans saw one of the biggest problems in designing PPOs to be finding a financially viable benefit configuration that was marketable in

the niche between higher-cost FFS supplements and lower-cost traditional HMOs. In putting together that configuration, these plans needed more flexibility – and the limits of the ACR were viewed as arbitrary, preventing beneficiaries from having the opportunity to consider benefit configurations that, while not actuarially equivalent under CMS regulations, would better meet their preferences.

- One plan was considering a product to offer tiered copayments from beneficiaries for different hospitals, with the level of copayment varying according to what the plan had to pay each hospital. This kind of flexibility is difficult within current ACR regulations.

A second area of benefit flexibility that was mentioned concerned the requirement to charge all beneficiaries the same premium. One plan suggested that PPOs were financially viable in private business only through underwriting, i.e., charging different premiums to people in different risk categories. Medicare does not allow that, leading this plan to conclude that Medicare could not expect to have product options as in the private market – this plan’s young Medicare enrollees would not accept paying higher rates to subsidize older enrollees.

#### **3.3.4 Reduce the burden of doing business with CMS more generally**

The ACR appeared to crystallize a particular view of how to oversee the Medicare program, and six plans mentioned it. One plan suggested that, “if CMS wants to make the market free [to have product options similar to commercial business], they have to rely on it” – i.e., to allow whatever benefit configuration the market would bear. Plans suggested that the ACR process is too complicated and time-consuming and should be “abbreviated.” The implication in most of these comments was not that the respondent knew a better way to do the ACR, but that the ACR was not the way to accomplish what CMS sought.

Criticisms of this sort went well beyond the ACR. For example, one plan suggested that it was a wasteful burden to require site visits for out-of-network providers, since out-of-network providers in a non-gated environment are more or less unregulated. A second plan would eliminate the site visits more generally. Other areas in which CMS’ approach was criticized included benefit flexibility, quality monitoring, review of marketing materials, service area requirements, and benefit constraints, each of which is discussed more specifically elsewhere in Section 3.3.

Most of these criticisms come under the heading of the “cost of doing business with CMS,” noted at the outset of Section 3.3 above. These are not technical barriers in the way of product innovation. These are more general complaints, pointing to the burdens and costs that suffuse the Medicare business for healthcare organizations. The more flexible way to achieve CMS’ goals – the way that would permit more product innovation, according to some of the plans – was to rely on the market. Plans suggested that CMS should:

- rely to a greater extent on standards used in the private, commercial insurance industry, rather than establishing new, separate, government standards; and
- make information about choices available to beneficiaries and let them choose, rather than constraining options to meet certain requirements.

### **3.3.5 Change CMS' requirements on marketing materials**

A salutary role of a demonstration would be to eliminate some of the “ticky tacky stuff,” in the words of one plan. When asked about the burdens of doing business with CMS, the first item mentioned by six plans was CMS’ review of marketing materials. CMS’ review had the effect of making plan communication with beneficiaries a cumbersome process, with needless delays, according to respondents. At one level, these problems were of the generalized irritant variety, suggesting that the delay was needless, the burden costly to a point, etc.. More pertinent to a demonstration, plans argued that the introduction of more diverse options placed a premium on plan outreach, education, and marketing, and these processes needed to be done more fluidly, like private processes.

Plans had a variety of different comments in this area. Some plans urged that the approval period be shortened, so that plans could react more nimbly to the needs of the market. Other plans suggested that the best antidote to beneficiaries who did not get what they expected in their plan marketing materials was for them to “vote with their feet” (assuming no lock-in), rather than for CMS to go to such lengths, with such administrative burden, to prevent beneficiaries from being deceived. Here again, the point of controversy revolved around how much to rely on the market solution (vote with your feet) and how much to rely on a prophylactic regulatory regime (on the premise that the market for information is imperfect, mistakes can be costly, and the government therefore needs to monitor it more actively than the plans would suggest). Two plans offered something of a compromise: a “file and use” process for plans in good standing, whereby all materials would be filed with CMS and, upon filing, could be distributed and used by the plans. In that manner, CMS would have an auditable record, but the plan would not have to wait for CMS or to haggle over what (to these plans) were tedious challenges to the details. One plan also suggested that CMS could pre-approve “templates,” and plans could fill in the details for any specific application.

Two plans expressed concern about the accuracy and utility of standardized benefit language required by CMS. They believe that the required standard language for benefits does not describe their plan very accurately for beneficiaries – and in that sense does not really educate them – and is not a good tool either for advertising plans, since it does not allow them to distinguish themselves from their competitors. They would like to have an opportunity to include more plan-specific language in these CMS templates.

### **3.3.6 Inappropriate application of FFS regulations to M+C plans**

As noted in one interview, “everything gets compared to the FFS program, and that leads to bad choices for the program.” For example, five plans pointed to the Medicare skilled nursing facility (SNF) requirement (that SNF stays in be preceded by hospital stays) as an example of the inappropriate application of FFS regulations to M+C plans. One respondent elaborated on this problem: “For managed care plans, we often direct admit to SNFs without any prior hospitalization. For us to do so under the prior M+C rules, we had to list this and price it as an additional benefit, file it with our annual filings, note it as an exception in member materials, etc., etc.. It has taken several years for this to be addressed – many hours of conference calls, examples provided, etc. to the agency. Small issue – big headache.” This requirement was viewed as symptomatic of doing business with CMS, not only with reference to new M+C options but with reference to old managed care options as well.

### **3.3.7 Make service areas more flexible**

As one plan noted, most beneficiaries don’t think of themselves as living in a county. Real service areas cross county lines, and even state lines. The linkage of a plan’s service area to counties is artificial. One plan said it would be helpful to see greater alignment between CMS service requirements and what works in the commercial world – i.e., market-driven definitions of service areas, rather than arbitrary, county-based definitions. Another plan would like to build service areas around medical groups (smaller than a county, but not respecting county lines). The service area of the medical group is the relevant geographic unit for a PPO product that that plan is considering. Given present county-level requirements, the plan would be forced into marketing and enrollment gymnastics by present rules that defeat the purpose of the product, since two different medical groups within a county would serve only part of the county (thus “denying” one or the other product to some beneficiaries in the county) and the two benefit packages would differ in minor ways. One plan already had encountered a regulatory barrier when it attempted to offer different benefit packages within a county. The different benefit packages were based on enrollment with one of two physician groups in the county. CMS reportedly required the plan to choose one group and disenroll beneficiaries from the other – a result that the plan judged “silly.”

### **3.3.8 Mid-year changes in coverage requirements**

Three plans noted that CMS sometimes changes coverage guidelines in the middle of the year – even when those guidelines have financial implications – without making any adjustment in payment rates. Current regulations (42 CFR §422.109) require CMS to pay for “significant” increases in the costs of service provision due to new national coverage determinations (NCDs) implemented in between the rate-determination cycles for M+C plans. But plans argued that existing compensatory provisions were inadequate or unclear – e.g., did not fully cover the added costs (such as, unexpected systems and other administrative costs) that often accompany coverage changes.

### **3.3.9 Need for a more level playing field with FFS**

Another area of concern for the plans was the need for a more level playing field with FFS. Innovative options must pay their way. They must be financially viable relative to existing HMO-based options and FFS plus a Medicare supplementary policy. But M+C plans face burdens FFS does not. Part of this relates to reimbursement, discussed earlier. But it also relates to regulatory requirements that FFS does not have to satisfy. This was most often mentioned in terms of the M+C marketing requirements.<sup>10</sup>

### **3.3.10 “Whiplash” among CMS’ Central and Regional Offices**

One plan used the term “whiplash” to describe the lack of regulatory coordination between CMS’ central and regional offices. The problem is that “CMS has made significant progress on openness,” but plans sometimes get “whiplashed” between central and regional offices, when regional offices implement modified policies. The regional offices sometimes continue the same distant and more restrictive relationship, thereby reducing the value of what seemed like an important improvement in CMS policy.

Another problem with regional offices mentioned by plans was inter-regional consistency. Different interpretation of coverage requirements was noted as a particular concern. This consistency was mentioned primarily by national plans. Some plans operating only in local markets dismissed this concern saying that national plans have to deal with regulatory variation in their commercial insurance markets.

### **3.3.11 Regulatory barriers: conclusion**

Plans suggested a number of different regulatory barriers that might be considered as the subject of forthcoming M+C demonstration efforts. Some of these are more important than others, and some are viewed symptoms of a larger problem with CMS, rather than as a critical barrier to new M+C options. These problems have been summarized by the AAHP (e.g., AAHP, 2001) and others. The problems represent a challenging menu of policy decisions for Phase Two demonstrations.

## **3.4 Regulatory uncertainty**

A final set of barriers discussed in the interviews concerned problems that were not associated with existing regulations, but uncertainties about the regulatory environment that CMS or Congress might consider. These problems fell into two categories, the reimbursement of out-of-network care, and new case management options.

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<sup>10</sup> The “level playing field” argument cuts both ways. It is unlikely, for example, that M+C plans would welcome a requirement that they be offered in every county in the U.S., or contract with every willing provider.

### **3.4.1 Reimbursement of out-of-network care**

When enrollees in a PPO self-refer to out-of-network providers, the PPO has to reimburse the provider. The question arises: at what rate should such providers be reimbursed? The health plans we interviewed varied in their ability to get discounts off FFS payment rates for their in-network providers. Some plans seemed able to get discounts, while others said their in-network providers required rates above FFS Medicare.<sup>11</sup> However, plans were adamant that they must have a long-term, iron-clad, guarantee that they can pay out-of-network providers at FFS rates under the PPO model. Without this guarantee, models based on in-network/out-of-network coverage differentials are no longer financially viable. Five plans mentioned this as a key problem to PPOs.

Plans also said it was difficult to determine the amount of FFS fees. They need a published fee schedule and payment rules for FFS Medicare that both they and their out-of-network providers understand to be binding. That schedule needs to be consistent, nationwide.

### **3.4.2 Regulatory treatment of new case management options**

A second regulatory uncertainty concerned the specifics of case management options they were considering. One plan was developing an ASO option for FFS case management that would bring savings in hospital utilization to Medicare, while sparing the plan any risk. The case management option was to be voluntary for beneficiaries. The plan was uncertain about the propensity of FFS beneficiaries to enroll in, and abide by, such case management. That kind of uncertainty is encountered by plans in all their new products. But the plan was concerned about how Medicare regulations would treat it: would CMS require hospitals to cooperate with the plan's pre-certification/case management program, as a condition of Medicare reimbursement to the hospital? Hospitals are accustomed to this kind of oversight in private business, but there was no guarantee that CMS would require it of hospitals, for a subgroup of FFS beneficiaries.

This is just one instance of regulatory uncertainty. The Phase Two Demonstrations are designed to encourage new activities and may encounter other instances where regulatory clarification would be helpful.

## **4.0 STEPS LEADING TO PHASE TWO DEMONSTRATIONS**

Given the summary of barriers outlined above, what can be done to ease these barriers in the context of a demonstration? What can be done to encourage more innovation and to create a more cooperative relationship between Medicare and M+C plans? CMS' objective in further discussions with health plans and the policy

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<sup>11</sup> The staff model HMOs that hire physicians, and often own their own hospitals as well, had a more detached view of this problem.

community will be to answer those questions, in order to formulate a solicitation in 2002 to begin the Phase Two Demonstrations.



## REFERENCES

American Association of Health Plans (AAHP), "Status of the Medicare + Choice Program," prepared testimony of the AAHP before the U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Health (December 4, 2001), available on the AAHP website ([www.aahp.org](http://www.aahp.org)).

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**APPENDIX A. CMS FACT SHEET ON  
PHASE ONE M+C DEMONSTRATIONS**

## **APPENDIX A.**

### **Demonstration of Alternative Payment Methods for Medicare+Choice**

#### **Summary by the Center for Beneficiary Choices, CMS**

The Centers for Medicare and Medicaid Services (CMS) has approved five proposals by Medicare+Choice (M+C) managed care plans for alternative payments arrangements. These projects will test a variety of payment and risk sharing arrangements between CMS and the plans. The goal of these demonstrations is to identify options for encouraging continued and expanded participation in the Medicare + Choice program.

#### **Background**

With enactment of the Balanced Budget Act of 1997 (BBA) came the expectation that the Medicare+Choice (M+C) program would continue to grow and offer additional choices to beneficiaries. Unfortunately, the number of plans and percentage of beneficiaries enrolled have declined steadily from a high of 18 percent in 1999. CMS was interested in implementing demonstrations of alternative payment arrangements that could be implemented quickly in order to reduce further declines in M+C participation in 2002.

The approved projects will be in effect for two years beginning January 1, 2002. They will test whether alternatives to the current M+C payment systems, in particular various risk sharing and reinsurance arrangements, can be used to encourage M+COs to remain in the M+C program. CMS goal of continuing to make health care choices available to Medicare beneficiaries.

#### **Legislative Authority**

Section 402 of the Social Security Amendment of 1967 authorizes demonstrations and allows CMS to waive requirements in Title XVIII that relate to reimbursement or payment.

#### **Plans and Alternative Payment Methods**

The selected plans represent a variety of delivery models including closed panel health maintenance organizations (HMOs), a preferred provider organization (PPO), and a private fee for service model plan (PFFS). In addition to a variety of risk sharing arrangements, one proposal involves the implementation of a reinsurance pool.

The table below lists the M+COs selected, the demonstration service area, and the approximate number of beneficiaries involved, and the innovative payment arrangements.

## Medicare + Choice Alternative Payment Demonstration

M+CO / Plan Name	Type of Plan	Location	Approximate # Members	Payment Arrangement
Anthem / Anthem Senior Advantage	Health Maintenance Organization	Trumbull and Preble Counties, OH Boone County, KY	9,000	<ul style="list-style-type: none"> <li>• Payment at M+C Rate</li> <li>• Reinsurance pool funded by difference between M+C and FFS rates. M+CO reimbursed 80% of medical costs in excess of \$75,000 per member per year up to limit of total reinsurance pool</li> </ul>
Employers Health Insurance Co. (a subsidiary of Humana) / Humana Gold Choice	Private Fee For Service	DuPage County, IL	7,900	<ul style="list-style-type: none"> <li>• Payment at M+C rate</li> <li>• 50%/50% risk sharing of all savings/losses in excess of 2% of the targeted medical expense.</li> </ul>
Independence Blue Cross / Personal Choice 65	Preferred Provider Organization	Bucks, Chester, Delaware, Montgomery, & Philadelphia Counties in PA	17,000	<ul style="list-style-type: none"> <li>• Payment at M+C rate if not sole plan in county; Payment at greater of M+C rate or 98.5% FFS if sole remaining plan in county</li> <li>• 50%/50% risk sharing of first 2% of savings/losses compared to targeted medical expense</li> <li>• 80% (CMS)/20% (IBC) risk sharing of savings/losses in excess of 2% of targeted medical expense (excludes non Medicare drugs)</li> </ul>
M-Care	Health Maintenance Organization	Livingston and Washtenaw Counties, Michigan	3,300	<ul style="list-style-type: none"> <li>• Payment at greater of M+C rate or 95% FFS if sole remaining plan in county</li> <li>• 50%/50% risk sharing of all savings/losses compared to the targeted medical expense (no 2% corridor)</li> <li>•</li> </ul>
PacifiCare / Secure Horizons	Health Maintenance Organization	Pueblo County, Colorado	6,000	<ul style="list-style-type: none"> <li>• Payment at 95% FFS if sole remaining plan in county; otherwise M+C rate</li> <li>• Targeted medical expense amount set to 90% all premium revenue (CMS capitation &amp; beneficiary premium)</li> <li>• 50%/50% risk sharing of all savings/losses in excess of 2% of the targeted medical expense</li> </ul>

**APPENDIX B. PROTOCOL FOR THE PHASE TWO  
HEALTH PLAN INTERVIEWS**

**DISCUSSION GUIDE FOR HEALTH PLAN INTERVIEWS**  
**Abt Associates and the University of Minnesota,**  
**on behalf of the**  
**Centers for Medicare and Medicaid Services (CMS)**

**INTRODUCTION**

Our primary objective in these discussions is to develop ways for Medicare+Choice plans to offer more innovative choices to Medicare beneficiaries.

As you will see below, our questions are fairly open-ended: we want to discuss any of the areas of the program that you think might encourage development of more choices for Medicare beneficiaries.

All of these interviews are confidential. We will not identify you or your organization in any public reports of our discussions.

**I. TYPES OF ARRANGEMENTS**

**QUESTION 1. Think about the most popular options you now offer for individuals aged 55 – 65 who are nearing retirement.**

- a. *What are the most popular options?*
- b. *Have you considered offering these to Medicare beneficiaries?*
- c. *Would these options would be good choices for Medicare beneficiaries?*
  - i) *Why?*
  - ii) *Why not? [What is it about serving Medicare or Medicare beneficiaries that makes these options bad options for the Medicare program?]*

**II. PAYMENT METHODS AND RISK SHARING**

**QUESTION 2: What payment arrangements with your commercial clients would generally be desirable for Medicare?**

**QUESTION 3: What changes in Medicare methods for setting payment levels do you believe would encourage greater plan participation in Medicare?**

**QUESTION 4: What changes in Medicare methods for sharing risks do you believe would encourage greater plan participation in Medicare?**

### **III. BENEFITS**

**QUESTION 5: What benefit changes, if any, would encourage greater plan participation in Medicare?**

### **IV. NETWORK**

**QUESTION 6: Are there significant differences between the networks you offer your commercial clients and what would be required under Medicare?**

### **V. PRODUCT DEVELOPMENT**

**QUESTION 7: Thinking about all of the plan features we have discussed, do you see “natural combinations” of benefit, payment, network, or other changes that should be offered by the Medicare program?**

**QUESTION 8: Do you have any suggestions for how current Medicare administrative requirements under M+C could be changed to encourage the implementation of options you have recommended?**

**QUESTION 9: Can you give us some sense of priority among the changes we have discussed? What would you do first? Longer run?**