NLWJC - Kagan

DPC - Box 029 - Folder 020

Health - Medicare Managed Care

9/26 Medicare HMO meeting
Last yr - 2 plans w/drew
Asking for permission to refile proposals
Expect - 5% of benefs in HMO plans affected
1% left w/out any plan - has to go f-for-s
HMOs have come to provide low-cost plans w/ pharm bens
No penalty if get out this yr - pen kicks in next yr, so may be getting in under gun.

•

Admin burdens -
1. patient protections
2. fraud provisions - to make sure they're telling truth

option - after Oct 1, look at counties where all plans has pulled out - entertain new applicants/plans on expedited basis.

health-medicare managed care

<u>Options for responding to last week's decision by many HMOs to pull out of Medicare</u>:

1. **Explicitly announce a "no action is merited" position.** In short, draw a line in the sand quite publicly and reject any proposal to allow HMOs to shift costs back onto beneficiaries. Blame any subsequent mess on HMOs who signed a contract in May and who now want to renege on their commitment. Highlight all the "selfish" reasons why some HMOs are dropping out and underscore our commitment to never be "black-mailed" into changing the contracts we signed on behalf of the beneficiaries.

   Pros: Strong and decisive action; Puts industry on the defensive and initiates a much more public war with one of the nation's most unpopular industries -- HMOs.

   Cons: Republicans, some Democrats, and AARP may feel we are acting too politically and too abruptly; Charges of callousness to harmed beneficiaries may ensue; If we don't stay tough throughout inevitable "horror" stories, we will look much weaker.

2. **Tacit "do nothing" position, but leave door (quietly) open option.** Under this scenario, we would continue to say we are looking into impact to determine severity, but would say we continue to be skeptical that there is a valid argument to do anything. We would background the press on the weaknesses of the HMOs' arguments, but would hint that we might not reject out of hand any future intervention <u>if</u> our review turns up major problems for beneficiaries.

   Pros: Appears that we are standing up to the industry, but also gives us time and flexibility in case we want to alter our current course; would likely be supported by the Republicans and AARP for now, might be safest -- but certainly not boldest --option for the moment.

   Cons: Could appear weak and indecisive; In the alternative, could appear we are insensitive to beneficiaries' woes; Opens door to HMOs to come in to cut a deal that may viewed by the validators as setting very bad precedent for the Medicare program.

3. **Expedite approval of new plans coming into counties now not served.** This option would highlight our commitment to work with and give expedited approval to HMOs that were not in a service area when another HMO dropped its coverage. These so-called "good-guy" plans could give a less comprehensive benefit or cost-sharing protection package than the one that it would replace.

   Pros: Rewards good players and punishes "bad apple" HMOs; Supports our contention that we are taking reasonable actions to help beneficiaries keep access to an HMO option; In combination with base administrative and legislative package (outlined above), would illustrate that our "first and foremost" commitment is to beneficiaries -- not HMOs.

Cons: Very few new plans can be expected to come into these marginal markets; Will not significantly reduce the number of "victim" stories that will be reported; Makes us potentially more vulnerable to criticism that we did not do everything we could to help beneficiaries; If we pursue this option but eventually cave to HMOs' desires for other plans to get a similar offering, we would be perceived as very weak.

4. **Expedite approval of new plans, but allow selected old plans to apply to come back in if no other option is available.** This approach would allow a plan that withdrew from a service area, which now has no HMO option, to downgrade its benefits package to a level the HMO believes is financially viable.

   Pros: Would help more beneficiaries at least retain some of their current HMO coverage; Would be more responsive to the inevitable pressure from the Congress to do more to give hope that plans will come back; and if -- as is likely -- the old HMOs do not come back, it is easier to lay the blame on them. (In other words, we did everything the HMOs asked for and they still did not come back.)

   Cons: Rewards bad actors; Makes us look somewhat weak -- as though we backed down from pressure of the HMOs, Sets bad precedence for Medicare for future similar disputes with the industry (unless our administrative/legislative package makes it appear certain that we cannot or would not be able to do this again.)

5. **"Third way" option: try to split the difference between option 3 and 4 to attempt to get the best and avoid the worst of both options.** It might be possible (although we are still trying to develop a way to rationally apply this option) to allow only new plans in, but to give the HHS Secretary emergency authority to approve -- in selected cases -- applications from HMOs from the old service area to come back into the county. Under this approach, no such plan could even be considered unless it was clear that no new plan was a contender. There would have to be additional criteria as well to ensure that there is a substantive difference between option 4 and 5.

   Pros: Could argue that we showed how we could respond to beneficiaries' concerns without backing down to the "bad apple" HMOs; See #4 above for similar pros.

   Cons: Could be vulnerable to charges that it is "too cute by half;" Might not be able to develop criteria that provided enough direction/cover to the Secretary to differentiate.

health-medicare managed care

October 5, 1998

MEMORANDUM FOR ERSKINE BOWLES

FROM: Chris Jennings (CJ)

SUBJECT: HMO disenrollment from Medicare and Response by Administration

cc: John Podesta, Rahm Emanuel, Jack Lew, Bruce Reed, Gene Sperling, Ron Klain, Larry Stein, Sylvia Mathews, Elena Kagan, David Beier, Janet Murguia, Dan Mendelson

We are attempting to schedule a meeting later this morning with you, Secretary Shalala and her staff to go over a range of options that could respond to Health Maintenance Organizations (HMOs) that chose to selectively terminate some of their plans from participation in the Medicare program. Because of the growing news coverage of this issue, Rahm and Bruce believe it is advisable for us to move quickly to determine our strategy and public positioning on this issue. They asked me to draft this memo in preparation for such a meeting.

Background

As of late last night, HHS had not completed its analysis of the impact of the roughly 25 (mostly large) HMOs that chose to selectively terminate some of their plans from participation in the Medicare program. Preliminary data and projections appear to indicate that the decisions by these HMOs will affect between 325,000 to 400,000 beneficiaries in about 375 counties. Because the Medicare program has about 6.5 million of its over 38 million beneficiaries in HMOs, about 5 percent of Medicare HMO enrollees and about 1 percent of the entire Medicare population seem likely to be impacted in any way at all. Having said this, because most of the beneficiaries affected will have another Medicare HMO option in their county, there appears to be a much smaller number of beneficiaries enrolled in HMOs (between 30,000 and 80,000 -- about 1 percent of the Medicare HMO population) who will no longer have any such option. (They will, however, always have access to their traditional fee-for-service plan, as well as to at least some supplementary "Medigap" coverage.)

Congressional reaction. The Congress, so far on a bipartisan basis, has been critical of the decision by some within the HMO industry to selectively withdraw from Medicare. On Friday, the Republican Leadership left the Commerce Committee in the hands of the Democrats and some of their party's most vociferous critics of HMOs (such as Dr. Ganske) to excoriate the industry's representative. Mr. Thomas, the Chair of the Ways and Means Subcommittee on Health, has also indicated at least his initial support of our decision not to allow plans to charge more and/or reduce benefits. Having said this, members of states that will be disproportionately affected can be counted on to pressure us to take more actions. Senator Dodd has already weighed in, and we can be sure others will follow.

Reaction from the AARP. The American Association of Retired Persons (AARP) support last week's decision by the Administration to reject the industry's request for changes in their coverage and cost sharing. They have indicated that they want to work with us to make sure that beneficiaries know all of their options and rights (discussed below) relating to the plan terminations from the program. Although they acknowledged that their sentiments may change as more beneficiaries complain, AARP indicated that they now see no reason to move quickly to respond to initial "scare" articles by taking any position that appears to reward "bad apple" HMOs. Having said this, they also do not believe we need to take a strong and public position that appears we have drawn lines in the sand on against doing something on this issue. They are of the mind that we should wait to see how big the problem is and how the public responds to it before taking any formal, final position. They think a quick tough position may unconstructively unify the HMO industry against us.

Options to Respond to HMO Industry's Actions.

Before briefly outlining some options, it is important that you are aware of actions we can and should take regardless of our broader strategy on the Medicare HMO issue. Clearly, we must be quick to ensure that HCFA collaborates with the aging advocates (like AARP), the aging network (like the Area Agencies on Aging), state-based insurance counselors, and others in and outside the Administration to ensure that beneficiaries in impacted areas know that they can always return to the program's fee-for-service plan. Beneficiaries also need to know that the law requires Medicare supplemental insurers to offer beneficiaries access to certain "Medigap" coverage without being underwritten in any fashion. As a result, insurance that fills in the voids that Medicare does not cover is truly accessible for this population. Finally, to illustrate our commitment to find ways to assure this never happens again, we may also want to indicate our intention to introduce legislation that would help ensure that this never happens again. (For example, we might want to contemplate provisions that penalize plans for "cherry-picking" the high reimbursement areas or disallow HMOs to enter any new market if they have withdrawn in others.) Being proactive could help immunize us against any suggestions that we are insensitive to the needs of the beneficiaries.

Options for responding to last week's decision by many HMOs to pull out of Medicare:

1. **Explicitly announce a "no action is merited" position.** In short, draw a line in the sand quite publicly and reject any proposal to allow HMOs to shift costs back onto beneficiaries. Blame any subsequent mess on HMOs who signed a contract in May and who now want to renege on their commitment. Highlight all the "selfish" reasons why some HMOs are dropping out and underscore our commitment to never be "black-mailed" into changing the contracts we signed on behalf of the beneficiaries.

   Pros: Strong and decisive action; Puts industry on the defensive and initiates a much more public war with one of the nation's most unpopular industries -- HMOs.

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combine this w/ 1.

Cons: Very few new plans can be expected to come into these marginal markets; Will not significantly reduce the number of "victim" stories that will be reported; Makes us potentially more vulnerable to criticism that we did not do everything we could to help beneficiaries; If we pursue this option but eventually cave to HMOs' desires for other plans to get a similar offering, we would be perceived as very weak.

i.e. if no new plan?

4. **Expedite approval of new plans, but allow selected old plans to apply to come back in if no other option is available.** This approach would allow a plan that withdrew from a service area, which now has no HMO option, to downgrade its benefits package to a level the HMO believes is financially viable.

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see weakness above

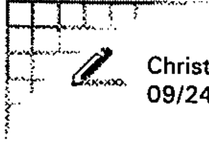
Pros: Could argue that we showed how we could respond to beneficiaries' concerns without backing down to the "bad apple" HMOs; See #4 above for similar pros.

Cons: Could be vulnerable to charges that it is "too cute by half;" Might not be able to develop criteria that provided enough direction/cover to the Secretary to differentiate.

Conclusion. There may be other options, but the above outlines what is most likely to be discussed later today. The White House staff (DPC, NEC, OMB, OVP, Rahm, etc.) has not made any final recommendations. In general, however, the White House tends to want to be a bit more aggressive than HHS. Consistent with this, HHS had indicated an interest in option 4 on Friday. However, some of Donna's staff seemed to be cooling to the idea over the weekend. Regardless, it is clear that all views on this issue will be influenced by the degree to which we receive troubling reports about beneficiaries.

HHS' staff will be meeting early this morning to go over their preliminary analysis and options. We will advise you if anything unusual comes back to us prior to your meeting.

Health - medicare managed care



Christopher C. Jennings
09/24/98 08:35:20 PM

Record Type: Record

To: Erskine B. Bowles/WHO/EOP, Bruce N. Reed/OPD/EOP, Gene B. Sperling/OPD/EOP, Elena Kagan/OPD/EOP

cc: Kevin S. Moran/WHO/EOP, Jeanne Lambrew/OPD/EOP, Melissa G. Green/OPD/EOP
Subject: HHS's managed care briefing

Erskine: Kevin asked me to forward you a quick note on tomorrow's managed care briefing by Donna Shalala and her staff.

Tomorrow, HHS will brief you on threats by a number of major Medicare Health Maintenance Organizations (HMOs) to pull out of the program and stop coverage to perhaps hundreds of thousands of Medicare beneficiaries. The HMOs are citing concerns about "undercompensation and over-regulation" as the underlying rationale for their decisions.

The American Association of Health Plans (AAHP) -- the trade organization that represents numerous HMOs -- just held a press conference today to advise the media that a number of health plans will announce that they are pulling out of the program before next week's October 1st Medicare plan participation deadline.
We are aware that, at the very least, the Wall Street Journal will have an article on this issue tomorrow.

As of this writing, it is unclear how many HMOs will choose to drop out of the Medicare program. We know that Aetna, Prudential, Humana, and Cigna has already indicated that they are pulling out of some Medicare markets. We understand that PacificCare, United Health and some state Blue Cross/Blue Shield plans are seriously contemplating leaving the program.

Although these plans represent many HMOs participating in Medicare, it is important for you to know that they are selectively choosing which Medicare markets they want to stay in depending on the level of their regional payment rates and how large their markets are. As a consequence, the number of beneficiaries affected represents a relative small percentage (5-7 percent) of the 5-6 million beneficiaries participating in Medicare HMOs. In addition, this number does not even net out the over 40 new contracts HCFA has received for new Medicare HMO business. Having said this, 5-7 percent of the current contracts who are threatening to leave still would mean that between 100,000 and 500,000 beneficiaries would be forced to opt for either a new HMO or return to traditional Medicare fee-for-service coverage.

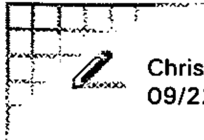
There are two reasons why these large plans can withdraw from the program with very little impact on the number of beneficiaries served. First, only 16 percent of Medicare beneficiaries are enrolled in managed care in the first place. And second, the HMOs appear to be keeping their contracts with Medicare in those markets in which they have a large market share and, conversely, tending to drop those markets in which they serve very small populations. (Large market share protects plans from unexpected, unwanted and expensive risk selection problems; they also cover up the fact that most HMOs do not manage care very efficiently.)

Tomorrow's meeting will give HHS the opportunity to provide you with their analysis of the

Medicare HMO situation. It will also give us the chance to develop an Administration strategy around how best to respond to the news. (One quick final thought: I believe that most key Republicans on the Hill, independent analysts, and the aging advocates will be fairly skeptical about the HMOs' rationale behind their decisions to drop out of Medicare; as a result, we need to make sure that we conclude on a strategy that uses them all as allies so as to avoid making this an Administration-only vs. HMO conflict.

cj

Health - medicare managed care



Christopher C. Jennings
09/22/98 07:54:24 PM

Record Type: Record

To: Bruce N. Reed/OPD/EOP, Elena Kagan/OPD/EOP, Gene B. Sperling/OPD/EOP

cc: Jeanne Lambrew/OPD/EOP
Subject: Medicare managed care

Donna Shalala has scheduled a meeting with Erskine Bowles sometime on Friday to advise us how the Department plans to respond to the likely defection of managed care plans from the Medicare program. Nancy Ann advised us today that they have just received reports that numerous plans are contemplating announcing early next week (prior to the October 1 deadline of intent of participation) that they will cease to participate in the Medicare program in a number of markets around the country.

HCFA believes that the number of beneficiaries currently served by these plans who could be dropped could be as high as 300,000 to 500,000 of the 6-7 million Medicare beneficiaries now enrolled in HMOs. The plans will blame inadequate reimbursement rates and excessive regulation, and will call on the Congress and the Administration to delay implementation of BBA and the regs that implement it.

By all accounts (of independent, credible sources), the claims by the HMOs are highly exaggerated and appear to be taking place primarily because of continuing private sector pressures to limit increases. (In other words, the plans have become used to overpayments by Medicare to offset potentially excessively low private reimbursement rates.) Regardless, this issue has the potential to get a great deal of coverage and we need to prepare an adequate response.

cj