

**Medicare+Choice in the Heartland:
Challenges and Opportunities for Change**

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For

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Thank you Mr. Chairman and Members of the Committee for the opportunity to testify on our experience in the Medicare+Choice program. I am Vic Turvey, Midwest President of UnitedHealthcare, responsible for our Midwestern health plan operations, including Medicare+Choice offerings in Iowa, Nebraska, Missouri, Wisconsin and Illinois. I am pleased to speak on behalf of our experience in your home state as well as in the other adjoining states where we do business.

UnitedHealthcare, and its parent company UnitedHealth Group, have a longstanding commitment to Medicare beneficiaries. Our participation in the Medicare program is fundamental to our core mission – to support individuals, families, and communities to improve their health and well being at all stages of life. We aim to facilitate broad and direct access to affordable, high quality health care through a variety of arrangements and to be there when people need us most.

UnitedHealth Group is the largest provider of health care services to seniors in America. For over 20 years, we have provided seniors and disabled individuals a comprehensive alternative to traditional Medicare benefits, now known as the Medicare+Choice program. Today, over 400,000 beneficiaries are enrolled on our health plans in 25 different markets across the country – including over 10,000 members in Pottawattamie County in Iowa and neighboring Douglass County in Nebraska. Through our EverCare program, we provide coordinated care services to an additional 20,000 frail elderly individuals in various care settings (under the auspices of Medicare+Choice). In addition, through AARP's Health Care Options program, we provide Medicare Supplement ("Medigap") and Hospital Indemnity insurance to roughly 3.5 million AARP members nationwide.

We bring value beyond the traditional Medicare program by coordinating the fragmented, diverse elements of the health care system and organizing the delivery of care around the best interests of the patient. Since 1996, we have offered Iowa and Nebraska beneficiaries a health plan that requires no additional premium beyond the monthly Part B premium. Beneficiaries who enroll in our plans get comprehensive coverage, much

like the commercial coverage that many had through their employers. They benefit from many of our value-based offerings such as individually assigned customer service representatives, access to a 24 hour nurse line and internet-based health information resources, and programs that track their special health conditions and remind them to get regularly scheduled diagnostic tests. They also become a part of our Care Coordination program where dedicated nurses follow their hospitalizations and make sure that services are understood, accessible and coordinated before, during and after they are in the hospital. These services are unavailable outside of the Medicare+Choice program.

The Medicare+Choice product – and program – has undergone considerable change during the past 20 years. One thing that has remained constant is our desire to provide members access to a broad network of providers and comprehensive coverage for benefits. When that cannot, in our opinion, occur we have ceased participating in the particular market.

Issues unique to rural Medicare+Choice offerings

While Pottawattamie County is not exclusively rural (it encompasses the greater Council Bluffs area and some adjacent rural areas), I can share with you some of the unique – and not so unique – experiences we have had in developing, marketing and providing health care coverage in the county's rural areas as well as in other rural counties we serve across the country.

Recruitment of New Beneficiaries: One of the greatest challenges facing rural Medicare+Choice arrangements is the addition of new members. Plans need members to exist and sufficient volume to leverage discounts with hospitals and physicians. These days, beneficiaries are becoming increasingly hesitant about Medicare+Choice. Rural beneficiaries are often not as familiar with managed health care arrangements as their urban and suburban counterparts. Those who are familiar are understandably skeptical, having heard about the many Medicare+Choice exits in rural markets. We have heard from many seniors that they are receiving sales calls from Medigap brokers who tell them that they should not take a chance on Medicare+Choice because it won't be around for

the long term. As a result rural beneficiaries demand much more time and information to close a new sale. Agents must first work to establish the plan's reputation in the market, then explain how the Medicare+Choice program works, and then walk the beneficiary through a line-by-line description of the plan and how the coverage improves upon traditional Medicare benefits.

Provider Partnerships: Two of the biggest hurdles in providing quality coverage to beneficiaries is the development of a broad physician and hospital network and the ability to establish a shared philosophy of practice and care coordination throughout the network. Network development is difficult in rural areas, and is becoming increasingly so. The limited supply of physicians and hospitals effectively means there is little incentive to enter into risk-sharing contracts with Medicare+Choice plans who cannot compensate them at the same level as traditional Medicare and cannot assure additional patient volume beyond their current load. To the extent that hospital systems and physicians continue to act this way, rural beneficiaries will face limited choices and coverage options.

Reimbursement: In rural areas, the reimbursement level has a strong effect on our ability to offer benefits beyond the standard Medicare offerings and to contract with physicians and hospitals. Our rural counties are all considered "floor" counties, and thus benefited from the payment increase under the Medicare, Medicaid and SCHIP Benefits Improvement Protection Act of 2000 (BIPA). However, the payment increase still lags behind overall medical trend. Hospitals also received a considerable Medicare payment increase under BIPA, exacerbating our ability to offer competitive reimbursement, as most physicians in these areas are associated with or employed by a hospital system or physician hospital organization. This, in turn, means that programs with rich benefit coverage – such as coverage for prescription drugs – cannot be offered economically to beneficiaries in these areas.

Issues across all Medicare+Choice offerings

In many parts of the country, our Medicare+Choice members are experiencing the fall-out of many of the same issues that the program is facing in rural areas. They are seeing the richness of benefit coverage decrease and at times, are forced to switch physicians as provider groups end contracts with health plans mid-year.

Reimbursement: In our experience, beneficiaries have seen a deterioration of benefit offerings since enactment of the Balanced Budget Act (BBA) in 1997, as annual payment increases have not kept pace with inflation. We have been able to continue to provide quality coverage to beneficiaries in many markets by streamlining our administrative procedures. We also have had to adjust benefit coverage, increasing copayment amounts for outpatient visits and hospitalizations and reducing or eliminating our coverage for prescription drugs. In almost half of our Medicare+Choice markets we no longer offer coverage for outpatient prescription drugs. Where we do offer coverage, the annual maximum is in the \$200 to \$500 dollar range (with the exception of Dade County, Florida where it is \$1,500) with coverage limited to generic equivalents or steep copayment differentials for generic and brand. While we would like to see additional funding for the program, we believe that fundamental reform of the reimbursement system is necessary to address the many moving parts of the payment system and ensure long-term stability and viability of the program.

Provider Contracts. Hospital systems and provider hospital organizations are demanding increasing reimbursement from our health plans – particularly as the gap between their payment for services under the traditional Medicare program and Medicare+Choice plans grows and they can pick and choose between participation in the two programs. As mentioned above, BIPA served to widen the gap considerably as hospital payment increases generally outpaced Medicare+Choice increases. Consequently, in most markets we were forced to dedicate all BIPA increases to hospital and physician reimbursement to meet their contracting demands. In some markets, physician groups simply can no longer afford to do business with us and have ended their contracts mid-year, inconveniencing

our members who often have to find new primary physicians in the remaining network or disenroll from their health plan to maintain their physician relationship.

Our success in urban areas -- specifically, St. Louis -- has been primarily with sophisticated physician groups who know and understand how to capitalize on the valuable data we can provide to them and accordingly how to manage shared risk effectively. We believe that UnitedHealthcare is unique in its ability to track utilization patterns and outcomes data, and this powerful information makes it possible for physicians to deliver quality care to their patients while sustaining the financial viability of our relationship with them. Unfortunately, this level of sophistication rarely exists in rural areas. It can and should be developed, and UnitedHealthcare can do that, but it will take time and an economic incentive for physicians to invest the time and effort to improve.

Administrative Issues: We believe that regulation and accountability is important and necessary to ensure fair, quality coverage for Medicare beneficiaries. However, the way that current administrative rules and procedures are established and enforced is burdensome and strains health plan resources. The complexity of Medicare+Choice administrative requirements, coupled with the lack of coordination between states, HCFA regions, and central HCFA, means that plans may face conflicting interpretation of rules and be subject to multiple audits. In addition, the number of new rules has grown exponentially since enactment of the BBA. The new HCFA monitoring guide used to evaluate health plans during their biennial site visits includes 279 items for review (not including the BIPA requirements); before BBA, there were 146 items. Our Nebraska and Iowa health plan has had to add one full-time staff person focused exclusively on Medicare+Choice compliance and reporting.

Based on our experience, the more problematic administrative items are:

- Encounter data collection. The current requirement to submit encounter data is very time consuming and costly, given questionable returns. Foremost in our concerns is

the process for submitting the data to HCFA, which is cumbersome and resource intensive under the current fee-for-service based claims system. Additionally, the scope of data required for submission seems excessive, given the more limited data that is required for risk adjustment.

- ACR process. The new June filing deadline (formerly in the fall) makes it very difficult to make accurate financial projections, and thus appropriate benefit decisions, given the limited data available from the current year.
- Marketing materials/HCFA review. The new marketing requirements, particularly the 45-day review time, makes it very difficult to get materials finalized in a timely manner. The 45-day approval time has had a particular impact on our ability to communicate product changes with our members within the required 30 day timeframe, often leading to confusion for our members who hear about changes in media reports, but then fail to receive notice until much later. Moreover, the prescriptive nature of the review often requires the materials to be sanitized, taking away our ability to make sales statements based on our unique attributes. In our Nebraska and Iowa counties, the delay in HCFA approval has had a specific impact on our sales efforts. Direct mail materials that usually are sent out in February are just now being mailed out due to multiple communications with HCFA prior to final approval.
- Regulatory implementation. The frequency and content of new regulatory and policy changes has increased staff time and resources considerably. In 2000, HCFA issued 15 new Official Policy Letters (OPLs), two revisions of one OPL, and the final Medicare+Choice regulation (the “mega reg”). Additionally, new policies have been issued on national coverage of clinical trials, revisions to the standard summary of benefits, and enrollment policies due to Medicare+Choice plan non-renewals. Inconsistencies between regional offices and central HCFA add to the strain of regulatory interpretation, particularly for national health care organizations, such as UnitedHealthcare.
- 2002 Enrollee “Lock-In.” The new lock-in requirement, which will be phase- in beginning next year, will likely add to beneficiary confusion and anxiety about the

product, placing additional strains on a Medicare+Choice plan's ability to attract and retain members. Currently, one of our greatest selling points is the ability to disenroll at any time throughout the year if members become dissatisfied with the plan and want to switch to a different one.

How do we fix the program and ensure its future viability?

While there clearly are a number of obstacles facing the current Medicare+Choice program, we believe the program continues to have much to offer seniors and disabled individuals and believe there are a number of changes that could significantly enhance the future viability of the program. First and foremost, we believe that the program must undergo fundamental reform to provide beneficiaries broad choices of coverage that best meet their needs and the kind of coverage they will be able to enjoy and count on for years to come. Absent such reform, Medicare+Choice may not be sustainable in rural America.

There are four key areas for reform: reimbursement, administrative simplification, provider relations, and evolutionary program design.

- Fundamental reform of the reimbursement system is necessary to address the many moving parts of the payment system and ensure long-term stability and viability of the program. A fair, competitive payment approach that is more closely aligned with current medical cost trend and factors in cost variability in rural and urban markets is desirable.
- A thorough review of current administrative requirements with an aim to streamline processes, improve coordination and eliminate items that have negligible benefits for members would be advantageous.
- Congress should explore the increasing difficulties with hospital and physician participation in Medicare+Choice, focussing particularly on Medicare+Choice plans' limited provider payment leverage in rural areas.
- Reform of the system must recognize the evolutionary nature of the health care system, developing a program that allows for change as the system warrants. We encourage Congress and HCFA to study successful contracting arrangements in the

employer sector, including non-risk-based alternatives, as the basis for its own contracts with private health plans. HCFA could operate like an employer who leverages its assets by self funding employee health coverage and partnering with health plans, like ours, to bring value to their offerings by administering and managing the health and operational aspects of the benefit.

Medicare+Choice has much to offer. We encourage Congress and HCFA to experiment with different types of product offerings within Medicare that are tailored to specific populations and geographic areas. To this end, we already have begun to explore options with HCFA that bring the many unique, value-based attributes of our product offerings to the more traditional Medicare benefits and may be more sustainable in rural markets. Working together to address many of the items raised today, we can help to develop a renewed Medicare program that meets the needs of today's and tomorrow's beneficiaries in rural America and across the country. The problems with the program are very real, but there is a great opportunity for positive change.

Thank you for the opportunity to share our thoughts. I would be happy to answer any questions you might have.