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Health Reform, IT, Medicare Advantage, Part D Plans Lead Agenda for 2009

As we enter the end of the decade and the beginning of a new administration, the stage is set for serious health care system reform debate, with representatives of government, providers, insurance, manufacturers, and pharmaceuticals all willing and ready to play a role in reforms.

Members of the Advisory Board for *Health Plan & Provider Report* were asked to list their top health care/managed care issues for 2009 and at the head of everyone's list was health care reform/insurance reform. That topped the list for 2008, too, but this year it has momentum, more interest, a framework, direct attention from prominent Democrats in Congress who will lead committee action, and White House support.

Health Care Reform

Setting the scene on reform, George Strumpf, with EmblemHealth, Washington, told BNA, ''There is a good possibility that we could see a scenario roughly analogous to 1964-65 when strong political support to enact Medicare and Medicaid finally succeeded. The pent up demand among many in Congress for broad based reform, supported by public opinion, may overwhelm the deficit hawks and the conservatives resulting in a series of bills, starting with [reauthorization of the State Children's Health Insurance Program] in the early spring, and culminating with a budget reconciliation bill that reshapes the entire health insurance industry.''

Alissa Fox, senior vice president, office of policy and representation for the Blue Cross and Blue Shield Association, said, ''There is agreement that health care reform is needed and we expect the new Administration and Congress to begin this debate early-on.'' The insurance group supports building on the employer-based system to expand access, rein in costs, and improve quality.

Putting reform efforts into perspective, Howard Wizig, founder of Vivius Inc., Minneapolis, said that ''Unlike the Clinton years, the advocates of reform have started by building a broad coalition of stakeholders who are now supportive of reform. As of now, everyone gets 'something' so there is nobody left to undermine reform efforts....''

Wizig warned, though, that while some incremental components could be implemented quickly, such as waiving pre-existing conditions for people who have two years of continuous coverage, or price transparency, any major reform will have a multiyear phase-in, so ''even though something passes, it may later be repealed, delayed, or modified.''

Peter Kongstvedt, of P.R. Kongstvedt Co. LLC, McLean, Va., predicted ''at least an even chance that Congress will pass substantial reform measures.'' He predicted action on payments to Medicare Advantage plans, especially private fee-for-service plans. ''Congress will be looking for money, and that's a politically easy place to get it,'' he said.

In addition to the reform debate, the Obama administration is expected to release an economic stimulus package in January that could include a number of health care provisions—related to funding for health technology and Medicaid— and Congress will work on reauthorization of the State Children's Health Insurance Program (SCHIP), the experts told BNA.

While sources said it is too early to determine how the health care agenda will truly play out in 2009, the first step in the process was the selection of former Senate Majority Leader Tom Daschle (D-S.D.) by President-elect Obama to serve as secretary of health and human services.

Elizabeth Fowler, chief health counsel for Sen. Max Baucus (D-Mont.), has been mentioned as a possible new administrator for the Centers for Medicare & Medicaid Services.

Top 10 Issues for 2009

Advisory Board members for *BNA's Health Plan & Provider Report* were asked to list their top managed care, health insurance, and Medicare issues for 2009. Those issues are as follows:

1. Debate and possible action on health care system/insurance reform
2. Medicare Advantage: funding cuts and increased oversight
3. Medicare Part D drug program: congressional action on federal price negotiation, increase in audits
4. Health IT: the new Medicare e-prescribing program and private industry incentives, development of federal standards, improving interoperability, increasing data exchanges
5. Medicare payment reforms: debate and support of value based purchasing
6. The cost of premiums in the small group market, with an emphasis on the rising number of uninsured
7. The possible role of a public plan in health reform legislation and the insurance industry's ability to compete on provider reimbursement levels
8. Efforts to advance comparative effectiveness, promote wellness programs, manage chronic conditions
9. Continued decline of the employer-sponsored insurance market and growth of the individual market
10. Mental health parity: implementation of new federal requirements, impact on plans

Other possible new CMS administrators include Kenneth E. Thorpe, a former Clinton administration official and current chairman of the Department of Health Policy and Management at Emory University; and Judith Feder, a professor of public policy at Georgetown University, who also served in the Clinton administration, according to those interviewed by BNA.

Medicare changes could be integral to reform of the U.S. health care system, and are likely to be included in any comprehensive reform package considered by lawmakers this year.

Health IT

The advisory board had a range of predictions for action on improving nationwide health information technology, but a number looked to the new Medicare e-prescribing incentive program, beginning this month, as a positive influence.

Judith A. Cahill, executive director of the Academy of Managed Care Pharmacy (AMCP), listed one of the top five health issues for 2009 as ''reaching agreement on standards for protocols and incentives for adoption of HIT systems that will permit widespread use of electronic medical records and e-prescribing.''

Wizig called health technology a ''hot button'' issue for 2009. ''Both hospitals and physicians may object to the investment that will be required to administer their obligations under any technology requirements,'' he said. ''These are the same doctors and hospitals who object to giving a patient a copy of a medical report, and we are to expect that they will embrace spending millions to make it available electronically?''

The effort to encourage widespread adoption of health IT must involve interoperable data standards used by all stakeholders, strong uniform privacy and security policies, widespread provider adoption, and consumer engagement so they understand the value and benefits of health IT, BCBSA's Fox told BNA.

BCBSA supports the Medicare e-prescribing incentive program, she said. Fox said many Blue plans have programs under way in their states to advance e-prescribing, and the association thinks the new Medicare program will ''foster greater provider adoption of e-prescribing and other health IT tools.''

Neal, Gerber & Eisenberg LLP advised its health plan clients to follow Medicare's lead and implement similar e-prescribing financial incentives for their network physicians.

''Health plans that structure e-prescribing incentives based on the Medicare model may find less resistance as their incentive programs should cause little or no added administrative or technology burdens for physicians adopting e-prescribing to gain the Medicare e-prescribing financial incentives,'' the Chicago-based law firm said.

Mental Health Parity

In 2008, President Bush signed into law the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 as part of the Emergency Economic Stabilization Act (Pub. L. No. 110-343). The law takes effect for plan years beginning after Oct. 3 regardless of whether regulations are issued. For collectively bargained plans, the effective date is Jan. 1, 2010 (14 HPPR 1353, 12/17/08). Small plans with 50 or fewer employees are exempt.

''As a result of the new parity law, health plans will generally need to move away from explicit limits on mental health and substance use benefits to more active management of these benefits. One major challenge is that the regulated community may need to implement the new law—which is effective beginning in October 2009—in the absence of implementing regulations,'' BCBSA's Fox told BNA.

She said that while many aspects of the new law are straightforward, others are complicated and would benefit from regulatory guidance in the near term. Also, since the new federal law is a ''floor'' and has to be implemented against state laws already in place, plans will need to look at both federal and state laws when redesigning their benefits.

Pamela Greenberg, president and chief executive officer with the Association for Behavioral Health and Wellness, told BNA that ''from our perspective, the regulations can't be written soon enough.'' She said there are many questions that organizations have about the parity bill that will need to be addressed by the regulators. ''These include simple issues like what are all of the entities that the bill applies to and more complex issues like how do you determine what is 'no more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical and surgical benefits.' ''

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Employers have other questions too, Greenberg said. ''[F]or example, if an employer currently offer employees three different medical plan options and one behavioral health option will they now have to offer three different behavioral health benefit packages that provide for parity with each health plan option?''

Medicare Part D

General consensus among health care industry experts, policymakers, and beneficiary advocates is that the Medicare Part D drug program has worked well and is providing a valuable benefit to enrollees.

Nevertheless, some anticipate that 2009 could bring a renewed effort to make changes to the program as beneficiaries experience higher program costs—a trend expected to continue—and as the government seeks to do more to oversee Part D plans and enforce program rules.

BCBSA's Director of Regulatory Affairs Jane Galvin was among those who said they expect Congress to consider amending the Medicare drug law to give the government the ability to negotiate Part D drug prices, discounts, and rebates in an effort to ensure the program is getting the best deal—much like the government already does in the Medicaid market.

As program changes are considered, policymakers and plans will have more information available to them about how the program has fared since it launched in 2006. Under rules issued in 2008, CMS will begin in 2009 to release specific Part D claims and trend data that previously had been unavailable.

Galvin said that the wealth of new data about the Part D program to-date would be ''an opportunity to assess how things are working.'' The new data also will give plans more information on which to develop bids for the 2010 plan year and beyond, Galvin said.

''Data is just beginning to emerge on how the program is working, particularly the generic dispensing rates, how many hit the so-called donut hole, what are the top 100 drugs dispensed, how many medications on average beneficiaries receive and what are their out of pocket costs overall,'' Galvin said. ''Plans will be able to refine their bids, using this new data, as they move forward with more experience and data.''

Higher Plan Bids. While 2009 premiums already are set (they were announced in September in advance of the 2009 open enrollment period), Part D plans will begin bidding for the 2010 benefit year in the spring. And industry watchers anticipate a continued increase in bids that will result in higher premiums for beneficiaries.

Kongstvedt said plans could submit higher bids in spring 2009 for the 2010 Part D plan year because of cost shifting by providers. Barbara Kennelly, National Committee to Preserve Social Security and Medicare president and chief executive officer, also said she expects higher plan premiums in 2010.

''Premiums for the top 10 stand-alone drug plans increased by 30 percent from 2008 to 2009, and trends in Medicare drug spending point to hefty increases to come,'' Kennelly said. As in past years, plan premiums for 2010 will be announced in fall 2009.

Kennelly said soaring drug costs are among the factors expected to contribute to predicted higher plan premiums and higher program costs. Among solutions that she said could curb rising program costs would be for Congress to allow CMS to negotiate Part D drug prices, giving the government the same leverage it has in the Medicaid program to tamp down costs.

However, some in the health care industry remain concerned about continued price negotiation proposals they believe would undermine the competitive structure of the drug benefit, said AMCP's Cahill.

In addition to possible legislative activity in the coming year, Kennelly predicts the incoming Obama administration will more tightly manage contracts with Part D plans.

''There will be greater accountability expected for the handling of grievances, exceptions, and appeals by beneficiaries,'' she said. ''For example, CMS is likely to use data collected on the numbers of exceptions and appeals to encourage plans to improve their utilization management processes.''

Health care reform that is expected under the new administration also could mean new market opportunities for Part D plans, according to Wizig.

Wizig said that depending on how a reform package is crafted, Part D plan sponsors could ''see an opportunity to amass greater market share that may have a favorable impact on their post-reform (under 65) products.''

Enforcement, Oversight. Even as most industry analysts agree that the Part D program has worked well, most also see 2009 as the first time CMS, the HHS Office of Inspector General, and other agencies will ramp up oversight of plans and more vigorously enforce program rules.

Attorney Kirk J. Nahra, Wiley Rein LLP, Washington, said he anticipates no significant changes in the Part D program in 2009, other than increased enforcement activities, where he expects major developments.

Notably, Nahra said he anticipates the unsealing of Part D whistleblower lawsuits for the first time as well as new False Claims Act cases initiated by the Department of Justice, absent qui tam relators.

Nahra said those enforcement activities will come as Congress, CMS, and DOJ continue to focus on Part D marketing activities and as policymakers ''struggle'' to make the drug benefit program ''visible and effective to the right people within the very challenging restrictions set by the current rules.''

In addition, Nahra said he expects that CMS will begin penalizing plans for not having done enough with their fraud, waste, and abuse programs.

Attorney Marci Handler, Epstein Becker & Green P.C., Washington, similarly said that going into 2009, plans already should be developing fraud, waste, and abuse programs, using the OIG's 2009 work plan, released in October 2008, as a guide to where they should focus internal compliance efforts.

Handler said she expects that the OIG, as part of its Part D program oversight efforts, will begin reviewing plans' data submissions for reconciliations, bid submissions, true out-of-pocket-costs, pharmacy benefit manager negotiated prices, price concessions, and PBM oversight.

In addition, Handler said plans should document compliance with CMS requirements, particularly concerning training requirements for downstream entities.

Medicare Advantage

The future funding cuts for MA have been supported by recent reports about MA plans' negative impact on beneficiaries and Medicare insolvency from such parties as the Government Accountability Office, beneficiary advocates, the Medicare Payment Advisory Commission, and the chairman of the Senate Finance Committee.

Wizig predicted that, rather than eliminating the MA program, ''which is well liked by millions of members,'' Congress ''will likely reduce funding, making the health plans look 'evil' for withdrawing from the program, even if they do so because it is no longer financially viable.''

A December 2008 GAO report was critical of one type of MA plan—the private fee-for-service (PFFS) plan—saying their members disenroll at higher rates than other MA plans and can be left with larger bills for medical care than from other managed care plans or from traditional Medicare, among other issues.

In its March 2009 report, the Medicare Payment Advisory Commission plans to reiterate its 2005 MA recommendations, one of which is for CMS to set the MA benchmarks—county rates that form the basis of plan payments—on par with traditional Medicare costs.

Commenting on the policy of reducing MA funds to that of traditional Medicare, Brent V. Miller, director of federal government relations for the Marshfield Clinic in Wisconsin, warned that ''an across the board meat axe cut of Medicare Advantage will be enormously unfair in low payment rural localities throughout the country.''

Some observers predict more of a formalistic, phased-in approach to reimbursement reductions that would keep MA plans from leaving the program as they have in the past.

In his white paper on health reform, Senate Finance Committee Chairman Baucus discussed problems with matching MA payments to levels in traditional Medicare.

''Simply setting MA payments equal to traditional Medicare could maintain overpayments in some areas and create severe underpayments in other areas relative to insurers' costs,'' the chairman said.

He instead suggested basing MA payments on a blend of local and national Medicare costs, reducing MA payments in high-use areas, and increasing payments in low-use areas.

As an alternative method, ''insurers' payments could be based on a blend of their own costs per enrollee with Medicare's costs per beneficiary at the local or national level,'' Baucus wrote.

Finding alternative methods of setting MA payments is also a requirement under the Medicare Improvements for Patients and Providers Act (Pub. L. No. 110-275) for MedPAC, which must report to Congress by March 2010 on different approaches.

Market Disruption. Bonnie Washington, a vice president for consulting company Avalere Health LLC, said it is unlikely that Congress will reduce MA funding to 100 percent of traditional Medicare ''everywhere, all at once.'' To do so would be ''highly disruptive to the market,'' she said.

Instead, she foresees funding changes based on how plans are currently paid—certain areas with higher payments would be targets for more aggressive cuts.

She pointed out that there is already some consolidation among plans and that premiums are going up.

John Gorman, president of the Gorman Health Group, a consulting firm, told BNA that bringing down payments in a ''secondary market'' from 140 percent of traditional Medicare to 100 percent would lead to plans ''running to exit'' the MA program.

He said be believes that ''cooler heads'' will prevail in the Senate Finance Committee and there might a five-year phase-down or a blended rate.

Adjusting to the Situation. With a reduction in reimbursement considered a foregone conclusion by many, MA plans are discussing how to adjust their business models.

Once cuts are made, Gorman predicted ''a lot of pruning'' by plans.

However, even before any future cuts to the program take place, MA plans, like Part B providers, will be affected by the implementation of MIPPA provisions.

''MIPPA was a complex piece of legislation that covers a number of areas in Medicare Advantage,'' Galvin of BCBSA said.

One of the provisions with the ''most immediate impact,'' she said, requires PFFS plans to have networks by 2011 if they are in counties with at least two network type plans, like PPOs.

Another provision is the authorization of special needs plans (SNPs), which serve beneficiaries who are dual eligibles, institutionalized, or have chronic conditions, through plan year 2010, requiring them to enroll only from their targeted population, report additional quality data, and—for those that serve dual eligible beneficiaries—to contract with a state Medicaid agency before serving new territory.

Avalere analysts showed that the number of SNPs is already falling—from 720 in 2008 to 674 in 2009.

First to Leave. According to Gorman, among those SNPs to leave the market first would be those that managed care companies put forth to get around open enrollment. SNPs are not subject to the same enrollment periods as other MA plans. For example, CMS created a special enrollment period to allow beneficiaries to enroll in a chronic care SNP at any time.

After a few years of allowing chronic care SNPs to serve any enrollee group with a specific medical need, new CMS rules, based on MIPPA, require chronic condition SNPs to serve beneficiaries with one of 15 recently named conditions that are considered more medically complex, substantially disabling, or life threatening .

Avalere statistics show that the number of chronic condition SNPs is falling, from 232 in 2008 to 206 in 2009.

Concerning SNPs for dual eligible beneficiaries, the Center for Health Care Strategies, a nonprofit policy resource center for vulnerable populations, predicted that new MIPPA requirements for contracting with Medicaid agencies may lead some to convert to regular MA plans. Plans newly operating in 2010 must have such a contract; existing plans without a contract can continue to operate but cannot expand their service areas.

The limited SNP authorization timetable—to Dec. 31, 2010—and the new restrictions ''may have an effect on

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the health plans as even those who have expressed interest may be cautious about expanding or entering the market,'' the center said. ''It may also cause states to rethink how much they want to invest in such relationships/infrastructure until the future of SNPs becomes clearer.''

Gorman predicted that by 2011, the current number (674) of products offered will dwindle to the 400 or 500 SNPs that best excel at case management.

Enrollment Growth. Despite the mercurial funding and regulatory environment to which the Medicare managed care program has been exposed throughout the years, enrollment growth—which MedPAC analysts in December 2008 termed ''rapid''—continues.

CMS reported total MA enrollment as of Dec. 1, 2008, at close to 10.3 million, compared with 9 million a year before.

The number of plans is also growing, although where the growth is occurring among various MA plan types is changing.

Kaiser Family Foundation, using CMS files, found that MA plans will increase from 2,741 in 2008 to 2,861 in 2009. Kaiser counts plans as health maintenance organizations, preferred provider organizations, cost plans, PFFS plans, medical savings account (MSAs) plans, and other demonstration contracts but excludes employer-only and SNP-only contracts.

One of these growth trends is the shift among plan types away from PFFS plans—which have had the most growth, the largest payments, and the most criticism—to PPO products.

Avalere said that in 2009, the number of PFFS plans will decline for the first time, while PPOs are growing. This jibes with predictions made right after MIPPA added new requirements for PFFS plans on networking and quality improvement programs.

Plan Trends. Similarly, in a December 2008 presentation on enrollment trends, MedPAC analysts said that the rate of growth for PFFS plans has been slowing compared with PPOs. Between 2007 and 2008, enrollment growth for PFFS plans was 35 percent, compared with 53 percent for local PPOs and 37 percent for regional PPOs, MedPAC staff said.

Gorman remarked that one of his clients is offering 40 new PPO plans.

He said that PPOs will grow as competition to Medigap for the middle- and upper-income beneficiaries. A beneficiary paying $200 a month for a Medigap plan and another $75 for a prescription drug plan will be better off shifting to a PPO that will charge her less than half of that, he said.

According to the Kaiser Family Foundation, between 2008 and 2009, local PPOs will increase from 422 to 525 and regional PPOs from 43 to 51, while PFFS plans will decrease from 794 to 696.

Blue Cross and Blue Shield of Florida, for example, said it will expand PPO plans in seven counties and an HMO in one county. However, it is not expanding the service area for its BluMedicare PFFS plan.

Concerning employer plans, a report released by the Kaiser Family Foundation in December 2008 discussed the popularity of PFFS plans among employers but questioned the viability of employers continuing to contract with PFFS plans for their retirees. Under new MIPPA restrictions, employer or group PFFS plans must have networks by 2011 in all counties in which they operate.

''Because PFFS plans are not required to have provider networks, health plans can offer employers a single group PFFS plan that operates nationally and can cover retirees wherever they live,'' the report said.

In contrast, network-based HMOs and PPOs are localized in nature and cannot meet CMS's provider access requirements without the high-cost administrative burden of setting up networks in each county, the report said. Therefore, the MIPPA network requirements for PFFS plans and cuts in MA reimbursements may ''dampen group PFFS enrollment,'' the report said.

Frank McArdle, a principal and manager of Hewitt's Washington research office, said that another option for employers dealing with retiree health care costs that may be up and coming are defined contribution plans in which employers use a facilitator to offer retirees choices.

PFFS Conversion. PFFS plans that are able to meet the MIPPA network requirements may become local PPO products, Avalere's Washington said.

Her company reported in November 2008 that local PPOs were also on the rise in rural areas that have been a traditional stronghold of PFFS plans. ''Rural areas have traditionally been under served by network-based managed care plans, given the difficulty in setting up adequate provider networks,'' Avalere said.

Although most new local PPO enrollment was in urban areas, Avalere found that 62 percent or 4,502 plans were set up in rural areas as opposed to 38 percent in urban areas.

Specifically for regional PPOs, since the start of the MA program, they have not entered the market evenly or in large numbers, with five of the 26 regions having none. However, 2009 will mark the first time that a regional PPO will enter one of the five regions that did not previously attract one, MedPAC analysts noted.

In 2007 and 2008, eight organizations offered regional PPOs. One of them, United Healthcare, the company with the highest overall MA membership, said that in 2009 it will offer a regional PPO in Connecticut, Rhode Island, Massachusetts, and Vermont.

Enforcement. Over at CMS's Center for Drug and Health Plan Choices, observers see a more tightly controlled MA regulatory and enforcement environment.

''Enforcement probably will go up and audits will increase,'' Kongstvedt said.

George Strumpf of EmblemHealth said that ''increased auditing and compliance activity by CMS and the states should be expected in late 2009 accelerating in 2010 when CMS's budget is increased to support those actions.''

He predicted that ''MA plan assessments will probably be increased to support more oversight.''

In addition, states will be given more responsibility for overseeing marketing and enrollment functions while CMS will increase audits of coding of claims forms, Strumpf said.

Sales and Marketing. Galvin noted that pursuant to MIPPA, provisions related to sales and marketing as well as broker and agents commissions resulted in CMS issuing a new interim final rule in November 2008. A comment period for this rule closed Dec. 15, 2008, so

there could be adjustments in 2009 for the 2010 contract year, she said.

In fact, on Dec. 24, 2008, CMS established fair market value ceilings for compensation rates that can be paid in 2009 to Medicare Advantage and Part D sales agents and brokers (*see related item in the Federal News section*).

Based on the newly defined fair market values, CMS said in the memo that half of all stand-alone prescription drug plans and 30 percent of all MA plans had set 2009 agent and broker compensation amounts in excess of the maximum rates and that those plans would be required to revise their compensation structures.

Washington predicted a greater degree of plan oversight in marketing and other regulations.

She said that CMS may allow less leeway by plans in their variation of cost sharing. Plan designs have to be actuarially equivalent to the traditional Medicare benefit in that they may charge beneficiaries larger copayments, for example, but make it up in other areas. However, CMS may limit this flexibility with stricter confines, she said.

She also speculated that CMS may require plans to collect full encounter data. After the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 was passed, to reduce burden on plans, CMS moved from collecting extensive data to collecting risk adjustment data through a streamlined or abbreviated process.

A rule published in August 2008 on data collection said that CMS planned to discuss with MA plans their concerns about data collection requirements.

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