

In This Issue

In this seventh issue of the McGraw Wentworth Benefit Advisor, we will review the new coverage options under Medicare as created by the Budget Reconciliation Act of 1997.

The Medicare Part C options we will review include:

- *Traditional private and employer-sponsored supplement plans*
- *Existing Medicare Risk HMO's*
- *Additional managed care options, including Point of Service (POS) models, PPO's and Provider-Sponsored Organizations (PSO)*
- *Medical Savings Account (MSA) plans*
- *Private Fee For Service Plans (PFFS)*

Additional copies of the Benefit Advisor and the "Medicare & You" booklet are available on the McGraw Wentworth web site at www.mcgrawwentworth.com.

New Medicare Options

THE BUDGET RECONCILIATION ACT OF 1997

The Budget Reconciliation Act of 1997 (P.L. 105-33) creates new coverage options for most individuals covered under the current Medicare Parts A and B. Under the new Medicare Part C, or "Medicare + Choice", all beneficiaries except those covered because of End Stage Renal Disease (ESRD) will be eligible to select from the following coverage options:

- Traditional private and employer-sponsored supplement plans
- Existing Medicare Risk HMO's
- Additional managed care options, including Point of Service (POS) models, PPO's and Provider-Sponsored Organizations (PSO)
- Medical Savings Account (MSA) plans
- Private Fee For Service Plans (PFFS)

All of the Medicare + Choice coverage options listed above will become available on January 1, 1999. However, a scaled down

information campaign for beneficiaries and late notice to potential service providers make it likely that there will be limited movement to new Medicare + Choice options in early to mid-1999.



THE OPTIONS

Status Quo

Medicare beneficiaries who wish to do so can continue to get their health care under the ex-

isting Part A/Part B fee for service system. However, this approach may not be advantageous to retiree plan sponsors, many of whom provide for self-funded Medicare supplements that "wrap" around Medicare to provide retirees with a defined level of medical coverage. Especially if the employer-sponsored supplement is wrapped around a rich level of traditional plan coverage, employers will at least want to consider encouraging covered Medicare beneficiaries to consider the new Medicare + Choice options.

CONTINUED ON PAGE 2

Medicare Risk HMO's

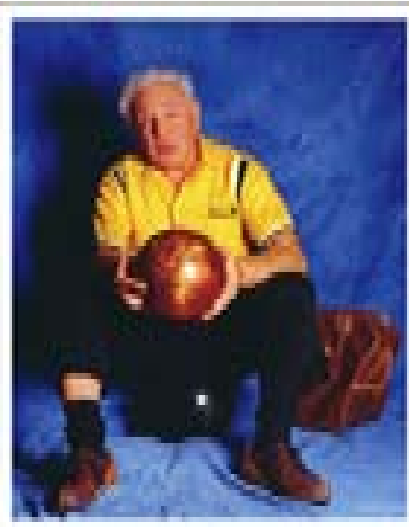
Over 6 million senior citizens have already enrolled in Medicare Risk HMO's. As one of the options under the new Medicare + Choice arrangement, the Medicare Risk HMO remains an alternative for these and prospective new enrollees. For years, Medicare Risk HMO's have offered an attractive alternative for employers looking to limit exposure for retiree health care benefits. The combination of aggressive marketing by managed care organizations and HCFA restrictions on what the Medicare Risk HMO could charge to employers offering group coverage resulted in the availability of inexpensive plans with often generous coverage.

The attractiveness of the Medicare Risk HMO, however, may lessen in the future. Many of the national managed care systems offering Medicare HMO contracts have announced plans to scale back their benefits, especially the attractive (and expensive) prescription drug coverage. In addition, HCFA limits on what a Medicare Risk HMO can charge employers for group coverage will disappear in January 1999. The opportunity to charge "market rates" for coverage could result in significant cost increases for some plans.

OTHER "COORDINATED CARE" OPTIONS

Managed Care Options

In addition to the private and employer-sponsored traditional Medicare supplements and HMO Risk contracts, the new Medicare + Choice regulations will allow for Point of Service (POS), PPO, and Provider-Sponsored Organization (PSO) coverage options. All of the new plan models will be subject to regulations monitoring guaranteed issue and re-



newal status, provision of comparative information to prospective enrollees, election procedures under each plan, the procedural rights of enrollees under the plans (including appeals procedures) and a disclosure of the risk for a Medicare + Choice organization to terminate its contract.

Medical Savings Account

Medicare beneficiaries can also opt to establish a Medical Savings Account (MSA). Initially available to 390,000 Medicare recipients, the MSA option will allow participants to enroll in a high deductible health care plan. Medicare pays the premium for the MSA plan and makes a deposit to the Medicare MSA established by the participant. At the end of each year, unused MSA deposits can be carried forward to the next plan year or withdrawn as taxable income. Annual sign-up for the MSA option will be in November and beneficiaries are required to stay in this plan option for a full year.

Private Fee For Service Plan

The Private Fee For Service Plan (PFFS) allows participating Medicare beneficiaries to go to any doctor or hospital that they choose. The selected insurance plan, rather than Medicare, determines reimbursement levels for services received by beneficiaries. Because providers are allowed to bill beyond what the plan pays, beneficiaries may be subject to balance billing under this plan option. As with the other Medicare + Choice options, some PFFS plans may offer additional benefits not covered under standard Medicare Parts A and B.

NOTABLE THOUGHT

"It is hard for an empty bag to stand upright."

- Benjamin Franklin

GENERAL MEDICARE + CHOICE PROVIDER GUIDELINES

In general, the Medicare + Choice plans must cover at least the range of services normally covered under fee for service Medicare. In addition, the plans may offer beneficiaries the option to purchase supplemental health care benefits approved by the Health Care Financing Administration (HCFA). Specific Medicare + Choice plan limitations include:

- The Medicare + Choice plans do not have to provide for Hospice care.
- Medicare + Choice MSA plans may not offer supplemental benefits that cover the plan deductible.
- Medicare + Choice Private Fee For Service (PFFS) plans may offer supplemental benefits that cover all deductibles and balance billing amounts.

The Medicare + Choice plans are subject to specific guidelines with regard to claim processing, including prompt consideration of emergency treatment needs, clearly defined appeals processes and prompt follow-up treatment by physicians when appeals indicate that it is warranted. The plans are, however, exempt from state insurance mandates as to benefit requirements, coverage determinations and related appeals and grievance procedures.

The Medicare + Choice plans

will be required to maintain and provide enrollees with access to accurate medical records. The plans cannot restrict physicians from fully discussing with their Medicare patients issues related to their health status and all available treatment options, whether or not the options are covered under the Medicare + Choice plan. Finally, the plans may not offer financial incentives to reduce or limit medically necessary services.



MANAGED CARE PROVIDER LICENSING REQUIREMENTS

The 1997 Balance Budget Act placed a set of specific requirements on managed care organizations seeking to become licensed Medicare + Choice providers. These requirements include the following:

- Current Medicare Risk HMO contracts will be consolidated under the Medicare + Choice legislation by no later than January 1, 2000. Medicare beneficiaries enrolled in risk sharing HMO's as of December 31, 1998 will be considered to be enrolled under Medicare + Choice if the HMO has a Medicare + Choice contract on January 1, 1999.
- A Medicare managed care contractor must be organized under the laws of the state in which it operates and be a federally qualified

HMO or Competitive Medical Plan (CMP), such as a Point of Service (POS) or Provider Sponsored Organization (PSO).

- The managed care contractor is paid a predetermined amount regardless of the frequency, extent or type of services delivered to individual members.

- The plan assumes full financial risk, on a prospective basis, for providing covered services, except as mitigated by outside stop-loss protection.

Providers Sponsored Organizations (PSO) can obtain three-year waivers to state licensing requirements, but will still have to meet federal solvency and capital adequacy standards, as well as state consumer protection and quality standards.

With regard to minimum enrollment requirements, HMO's and CMP's must have an enrollment of at least 5,000 members in suburban and metropolitan areas and at least 1,500 members (no more than half of which may be Medicare beneficiaries) in rural areas. Except for PSO's, all Medicare + Choice organizations are subject to the same enrollment requirements. PSO's were able to qualify for a risk sharing contract effective January 1, 1998 with at least 1,500 enrollees in urban areas and 500 enrollees in rural areas. The 1997 Budget Act eliminates the

requirement that no more than half of rural plan participants be Medicare beneficiaries effective January 1, 1999.

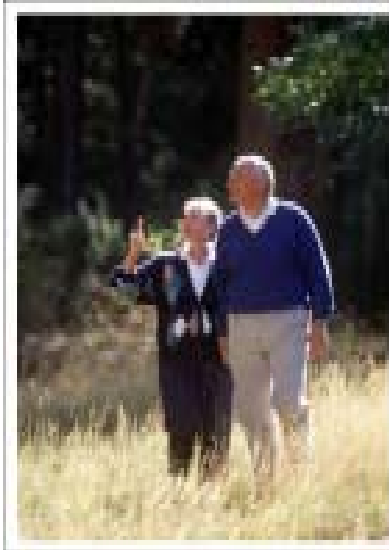
PROVIDING INFORMATION TO POTENTIAL ENROLLEES

Providing a comprehensive overview of the choices available to potential Medicare + Choice enrollees in 1999 will prove problematic for employer plan sponsors. Initially, the federal government pledged to send a handbook detailing the Medicare + Choice options, including a description of each available plan in an enrollee's service area, to all 38 million Medicare beneficiaries. In June, the Clinton Administration announced that it would scale back the information campaign to a "test mailing" covering 5.5 million beneficiaries in the states of Arizona, Florida, Ohio, Oregon and Washington. The remaining 32.5 million potential Medicare + Choice enrollees will receive a short form newsletter providing a general overview of the new plan options.

At the same time, information to potential Medicare + Choice providers was also delayed. Initially due out on June 1, interim regulations spelling out requirements for health plans seeking Medicare authorization under Part C were released on June 18 and published in The Federal Register

the following week. Because of the delays, it is likely that few new Medicare + Choice plans will gain federal approval in time for a January 1999 open enrollment. As a result, while employers may receive inquiries from concerned retirees, most of the substantive questions regarding plan enrollment for 1999 will continue to revolve around traditional supplemental coverage and Medicare Risk contracting.

While much of the enrollment activity in the new Medicare + Choice options is likely to occur later in 1999 or in the year 2000, some information to assist beneficiaries and plan sponsors in understanding the plan options is available



today. On the internet, the Medicare website (www.medicare.gov) includes a 40 page booklet entitled "Medicare & You".

The booklet provides potential Medicare + Choice enrollees with an overview of their current Medicare benefit levels and costs, describes the new Part C options and discusses the information that each plan

option must make available to potential new enrollees.

If you have questions regarding the impact of the new Medicare + Choice legislation on your retiree health care plan, please contact your McGraw Wentworth Account Director. As information regarding new plan options become available, we will share it with you.

Our technical bulletins are written and produced by the McGraw Wentworth staff and are intended to inform our clients and friends on general information relating to employee benefit plans. They are not intended to provide either legal or tax advice. Consult your legal counsel or tax advisor in matters that directly affect your benefit plans.

McGraw Wentworth
3310 West Big Beaver Road Suite 105
Troy, MI 48084
Telephone: 248-822-8000 Fax: 248-822-4131
Internet: www.mcgrawwentworth.com