Implications of Medicare Advantage and Part D

Diagnostic Review, Strategic Options, and Preliminary Recommendation

San Francisco · Boston · Washington, D.C. · Chicago

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[Client] Medicare Strategy

The Medicare Program is undergoing major change and [Client] must re-evaluate its strategic options.

- The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 is the biggest change in the Medicare Program since its enactment in 1965
  - ➡ MMA establishes a new Part D prescription drug benefit
  - ➡ And dramatically expands the role of private health plans in Medicare
- Enrollment in Part D is voluntary and the initial enrollment period runs from November 15, 2005 to May 15, 2006 with the drug benefit becoming effective on January 1, 2006
- The new drug benefit provides catastrophic coverage to all beneficiaries, will save the average senior $437 in out-of-pocket spending for drugs and will save low-income seniors $1,679 in out-of-pocket spending for drugs
- The enrollment process is confusing, the benefit is complex, and the program is off to a rocky start
- Part D will be disruptive because it gives beneficiaries the choice of leaving traditional Medicare and enrolling with a private Medicare Advantage plan
- At the same time that Part D is being rolled out, the State of [State] intends to expand managed care for Medicaid recipients including the elderly
- [Client] has a major commitment to the growing senior population, including low-income seniors and dual eligibles, and wants to identify opportunities to maintain and even enhance services and programs during this time of change

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Potential Impact of Part D and Medicaid Reform on [Client]

How will the implementation of the new drug benefit, introduction of new Medicare Advantage plans, and Medicaid Reform affect [Client] Hospitals and Physicians?

- Will the private plans offering local Medicare Advantage HMOs and Regional PPOs persuade a significant number of beneficiaries to switch from traditional Medicare coverage?
- Will [Client] lose Medicare patients if they don't participate in private plans?
- Does MMA provide [Client] an opportunity to increase services to seniors and grow its market share without jeopardizing financial performance?
- What actions does [Client] need to take to prepare for implementation of Medicaid Reform?
- Who should [Client] partner with if it decides to participate in private Medicare Advantage plans and Medicaid managed care plans?

[Client] Medicare Strategy Options

BDC Advisors, LLC was engaged to assist [Client] with the development of a new Medicare strategy.

- The project focused on the [City] market, [Client]'s primary service area encompassing [Counties]
  - The impact of MMA will be felt sooner in the more competitive [City] market
  - But eventually the changes in Medicare will affect the surrounding [State] counties
- The project included the following activities:
  - Rapid diagnostic
    - Data collection and analysis
    - Interviews of [Client] leadership
  - Analysis of Part D choices
    - Standalone prescription drug plans (PDPs)
    - Medicare Advantage plans
    - Comparison of price and benefits
    - Estimated enrollment
  - [Client] strategic options
    - Don't participate in private plans at this time
    - Participate in Medicare Advantage plans that agree to [Client] terms and conditions
    - Sponsor a private label Medicare Advantage plan in partnership with an insurance company
  - High-level evaluation of options
  - Preliminary recommendation

Key Study Questions

A. Market Summary
   1. What are trends in demographics, utilization, market share in the [City] region that will impact [Client] performance, particularly in the Medicare segment?
   2. What is [Client]' relative position in the marketplace?

B. Market Structure
   1. Health plans – Which plans dominate the region and payer segments? Which are poised to enter the MA market?
   2. Hospitals – What competitor moves must [Client] counter?
   3. Physicians – What are the opportunities for [Client]?

C. [Client] Performance
   1. How well has [Client] performed recently?
   2. What factors will present the greatest challenges to meeting the strategic goals?

D. Medicare Part D
   1. What is the size and segmentation of the Medicare market?
   2. How does Part D change the structure of the market and what are likely responses of the major players and resulting scenarios?
   3. What regulatory changes affect these scenarios?
   4. How will consumers react to the available choices?

E. Other
   1. Does [State]'s Medicaid Reform affect the strategic choices?
   2. What are potential strategies and their risk / reward in the short and long term?

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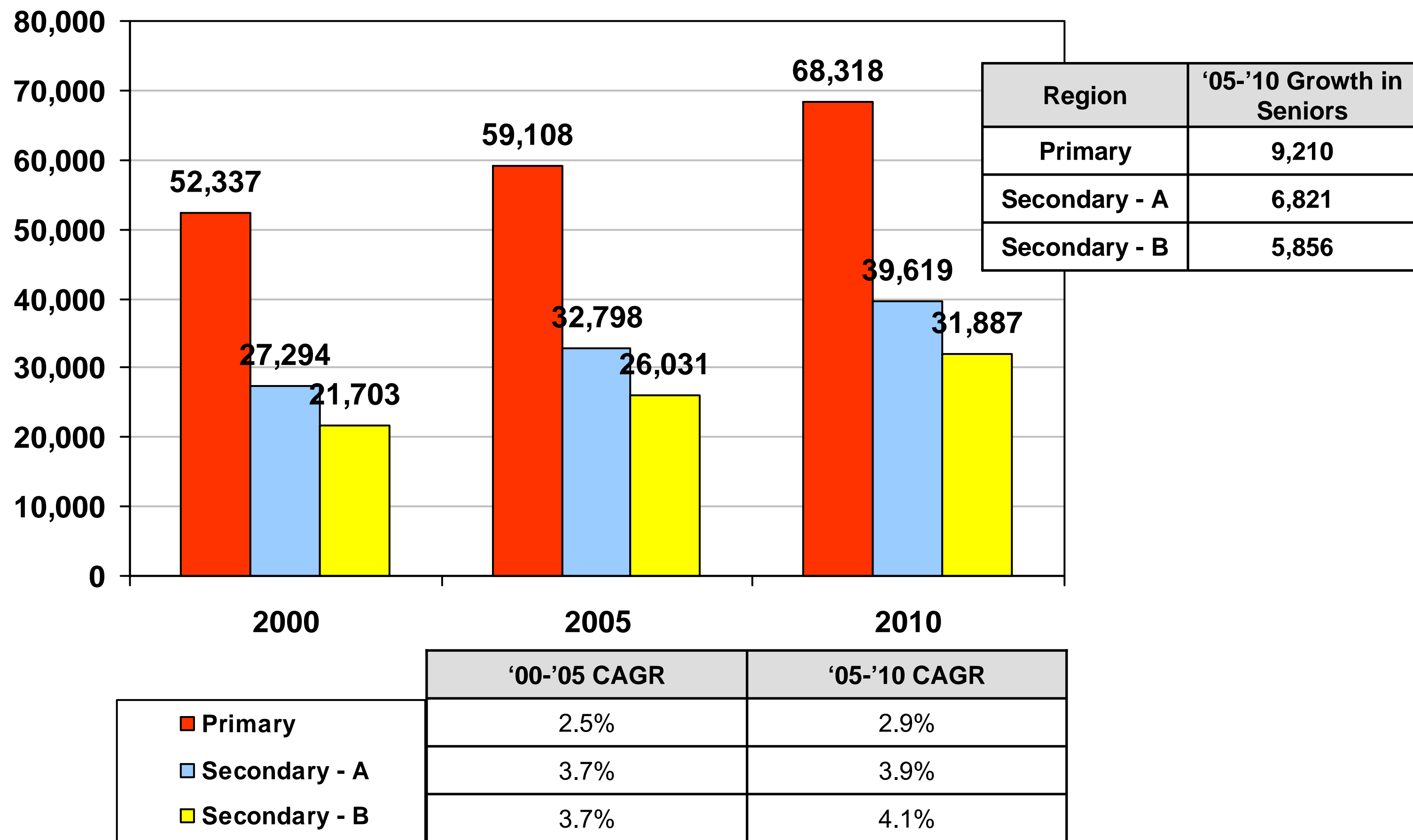
A. [City] Area Market Summary

- Population growth in the [State] is steady, but greater in regions beyond the [City] MSA
- Recent healthcare utilization rates have declined, especially with inpatient services
- Early indicators of managed Medicare volume show that gains in managed care will effectively reduce utilization further
- Among [City] area hospitals, [County] has grown share of the senior population while [Client]'s share has flattened, with a decline from outlying areas
- [Client] also has a weaker position in overall outpatient services and conceded much of the managed Medicare volume to (Hospital)
- Although [Client] has made significant gains in overall share in the last 8 years, recent gains have shifted toward a poorer payer mix for the overall patient population

Market Summary: Service Area Demographics

The [Client] primary service area has the least growth in the greater [City] area for seniors as well as the general population. [County] will outpace [City] growth by 1% CAGR.

Senior Population – Greater [City] Service Area (2000-2010)



Region	'05-'10 Growth in Seniors
Primary	9,210
Secondary - A	6,821
Secondary - B	5,856

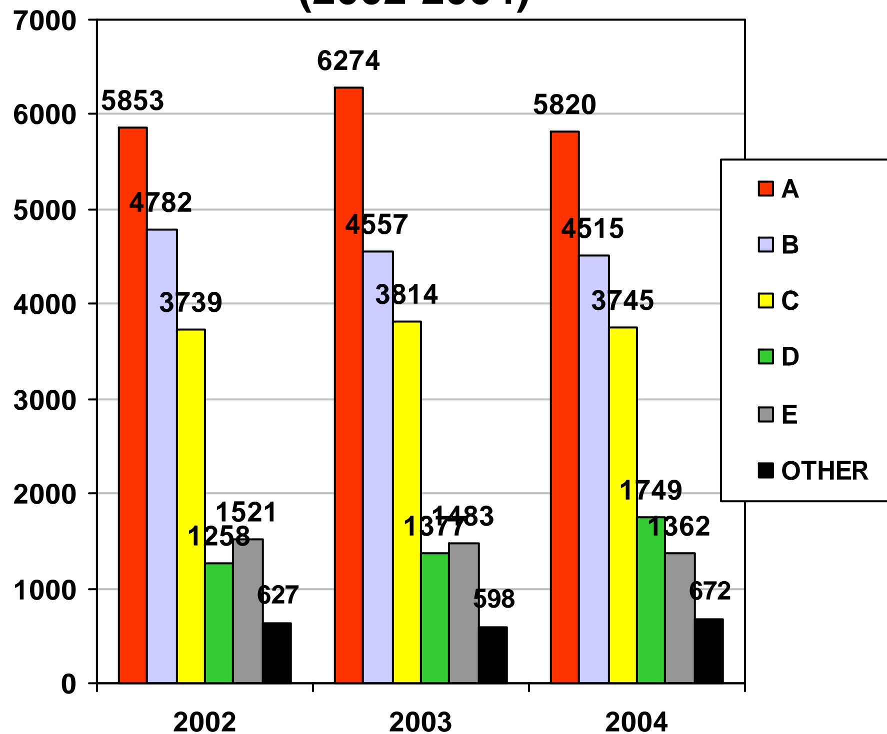
	'00-'05 CAGR	'05-'10 CAGR
Primary	2.5%	2.9%
Secondary - A	3.7%	3.9%
Secondary - B	3.7%	4.1%

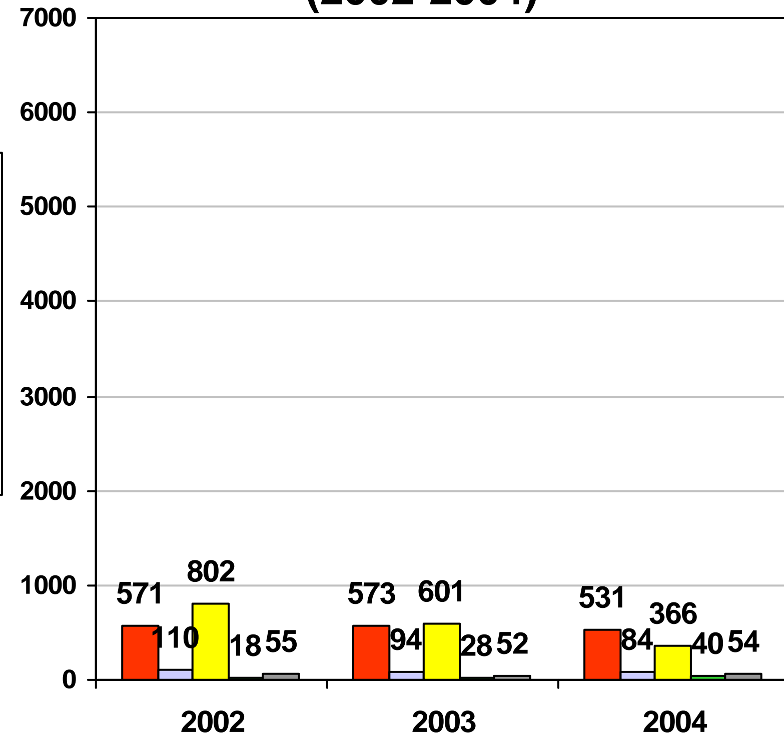
Notes: Senior population is age 65+; "Primary – [City]" includes [County], "Secondary – A" includes [County]; Secondary – B" includes [County].

Sources: [State] Dept. of Health; Univ. of [State] Center for Business and Economic Research; BDC Advisors, LLC Analysis.

Service Area Utilization

Despite continuing population growth, regional inpatient utilization in discharges for seniors[1] has been flat.





Note: (1) IP Discharges for those aged 65+; (2) "Primary" region includes [County]; (3) "Other" region includes [County].

Source: Solucient Market Planner – [Client] Service Area Discharges 2002-2004; BDC Advisors, LLC Analysis.

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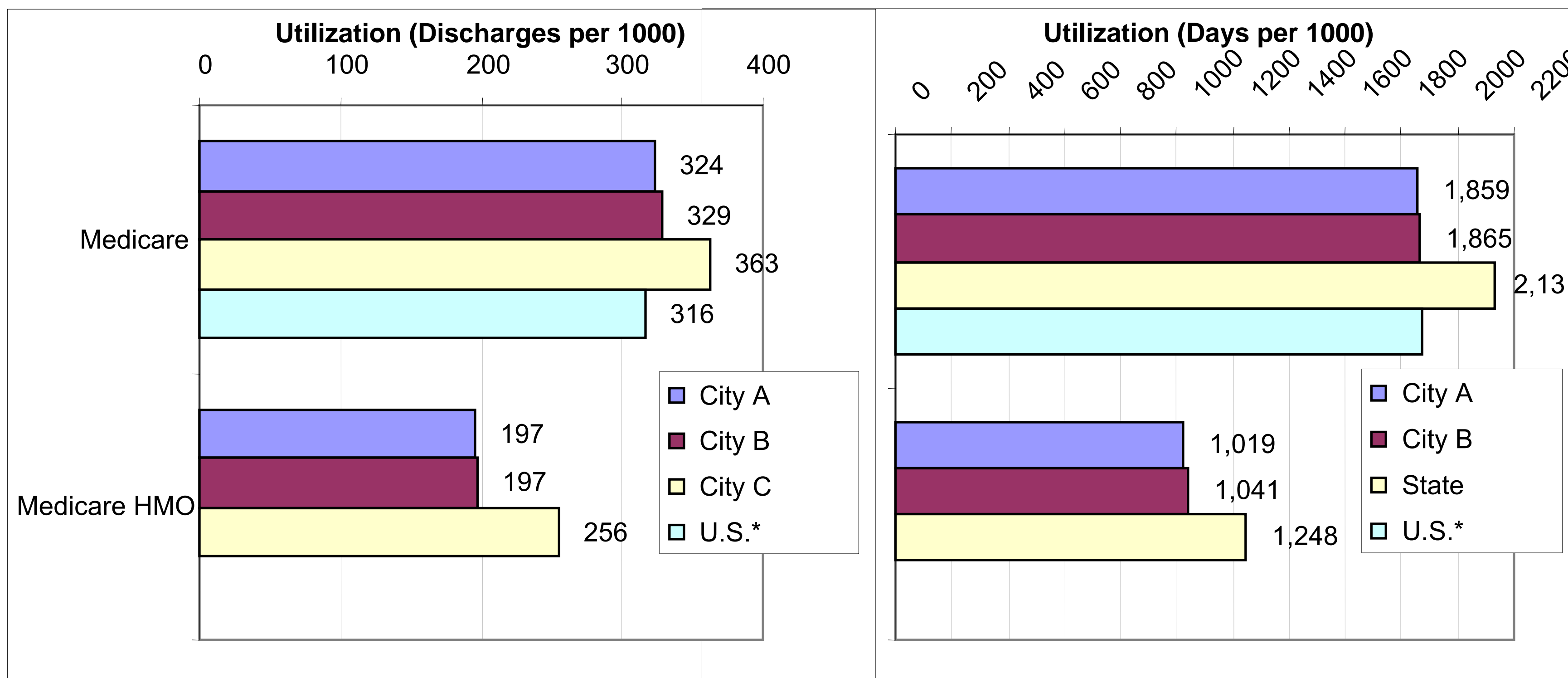
Medicare Utilization Rates

With the introduction of managed Medicare to the [City], Health Plan B has managed low utilization among its enrollees compared to the traditional Medicare population.

Medicare Population Utilization Rates FY2003



Sources: CMS 2003 Medicare eligibles and managed care enrollees for [City] MSA and [State]; [State] Healthstat Total IP discharges by payer and county 2003; BDC Advisors, LLC Analysis.

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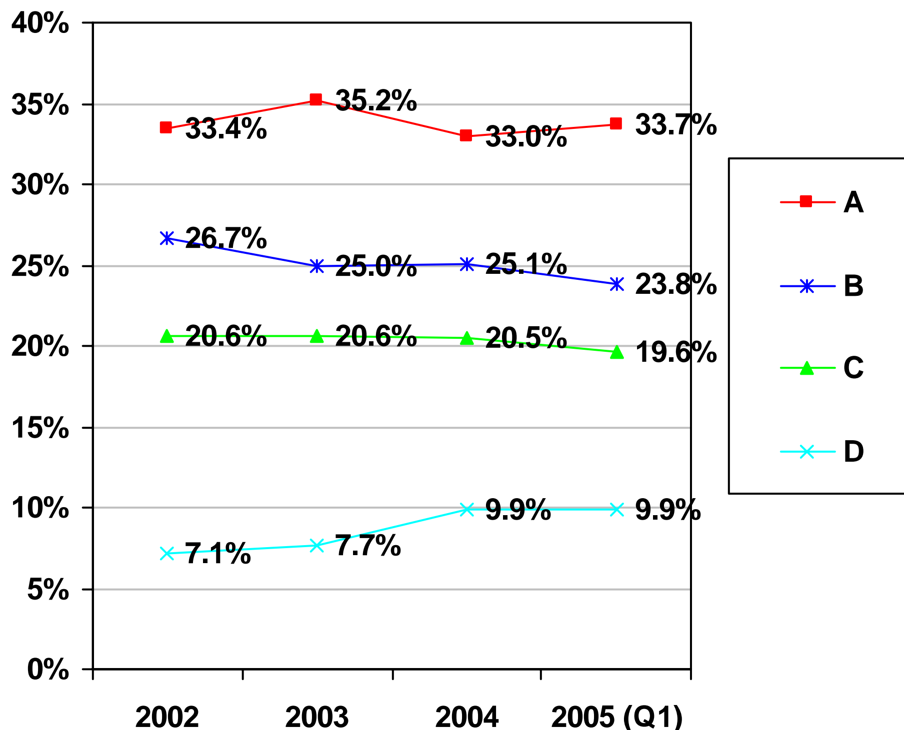
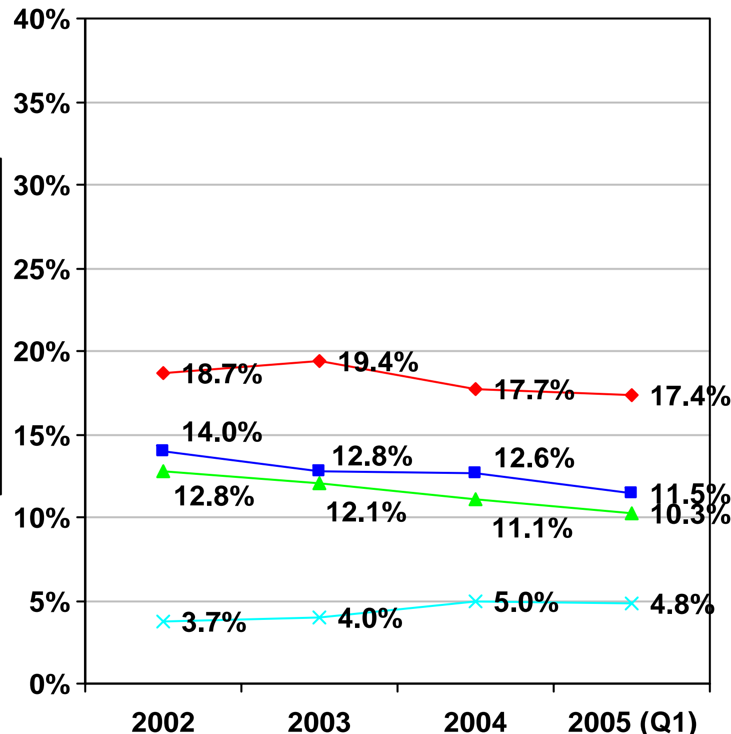
Market Share Trends

In the last three years, [Client] has had flat share growth of the senior population in the primary region and declines from regions beyond [City].





Note: (1) "Primary" region includes [City] MSA; "All" region includes [City] MSA as well as [County]; (2) Inpatient discharges for patients age 65+, all payers, and excluding all psych and substance abuse cases in the market.

Source: Solucient Market Planner – [Client] Service Area Discharges 2002-2004 and 2005 Q1; BDC Advisors, LLC Analysis.

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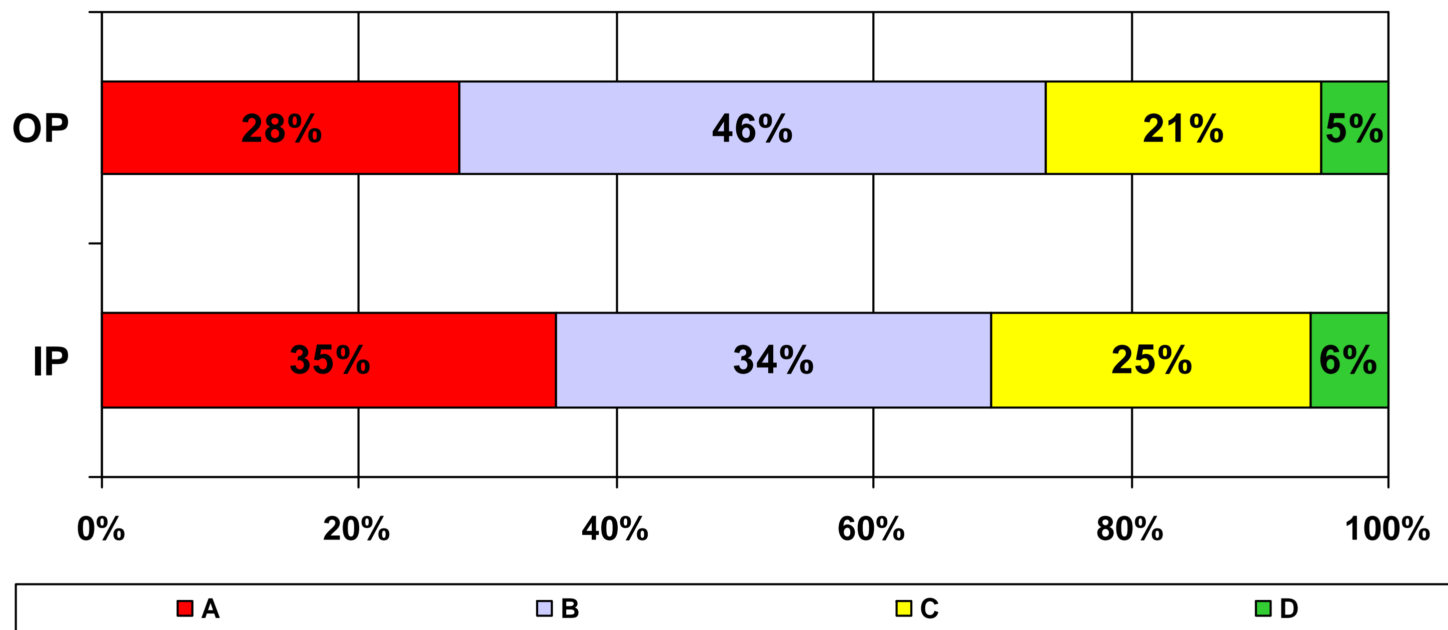
Market Share by Service

While the market leader in inpatient care for Medicare patients, [Client] has significantly lower share of outpatient revenue.

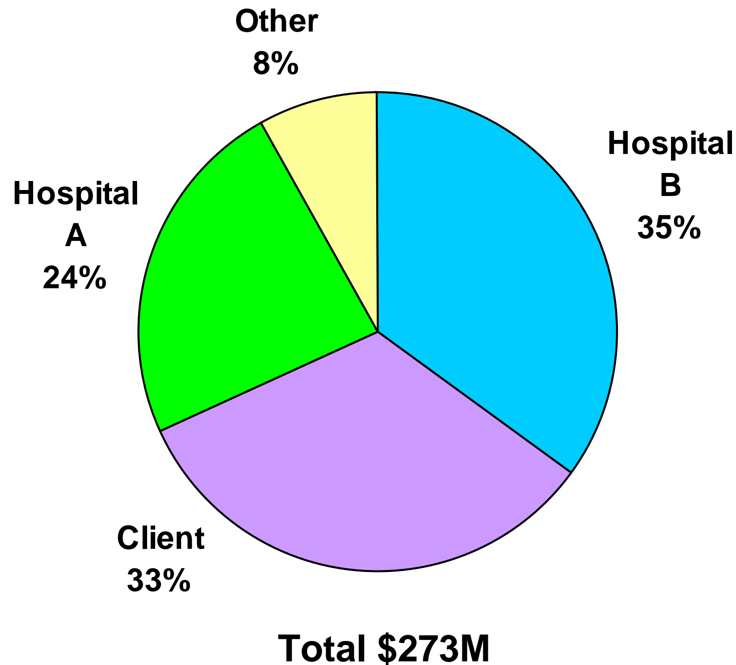


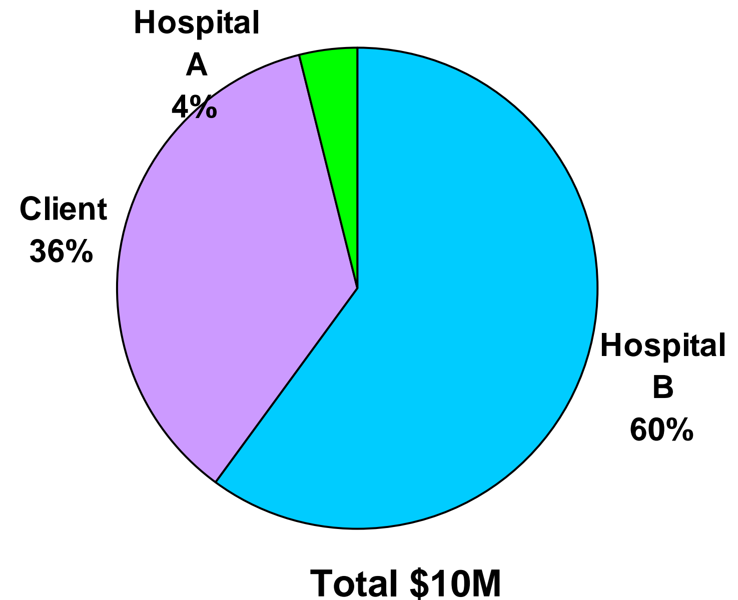
Note: (1) Includes [Campus] and [Hospital]; (2) Medicare FFS and HMO patient gross revenue as reported by each hospital for FY2004. Cost report periods slightly vary: [Hospital], 2004 FYE is Sep 04, [Client] FYE is Jun04, and West [State] FYE is Dec 04. Note that [Client] had 15% price increases effective July 2005.

Source: AHCA 2004 Hospital Cost Reports; BDC Advisors, LLC Analysis.

[Client] Medicare Market Position

[Client] has similar share as [Hospital] in [City] for Medicare patients, but has conceded the majority of the managed care volume to [Hospital].





Source: [State] Agency for Healthcare Administration (AHCA) FY2004 Hospital Cost Reports.

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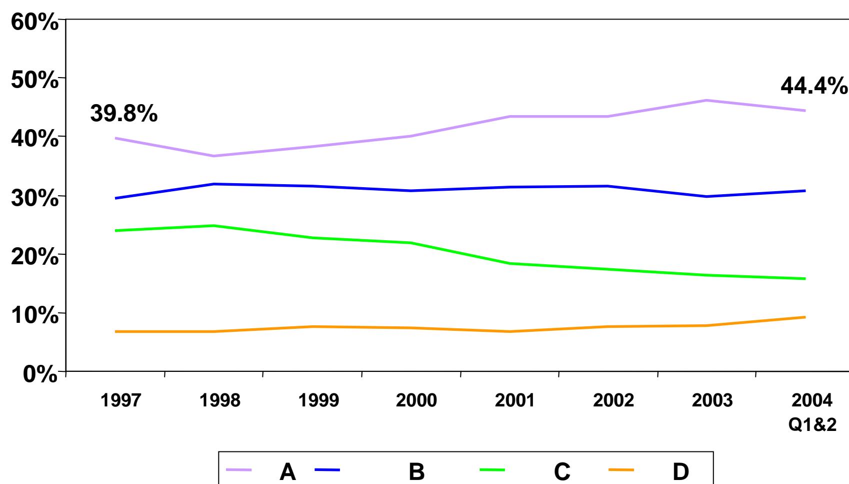
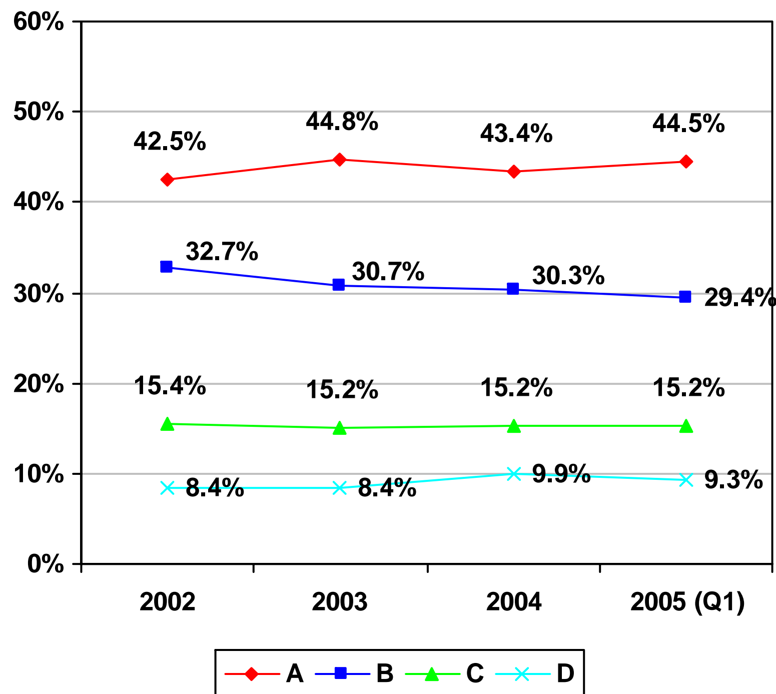
Market Share Trends – Overall

[Client] Hospital [City] has made significant gains in share over the last decade, but reached a peak in 2003.



Solucient, *The MarketPlannerPlus* Discharge Data

Definition: Excludes Psych, SA, Rehab, Nursery & SNF



Note: (1) Inpatient discharges for patients originating from [City] MSA, all payers, and excluding all psych and substance abuse cases.

Source: [Client] FY2006-2010 Integrated Strategic and Financial Plan; Solucient Market Planner – [Client] Service Area Discharges 2002-2004 and 2005 Q1; BDC Advisors, LLC Analysis.

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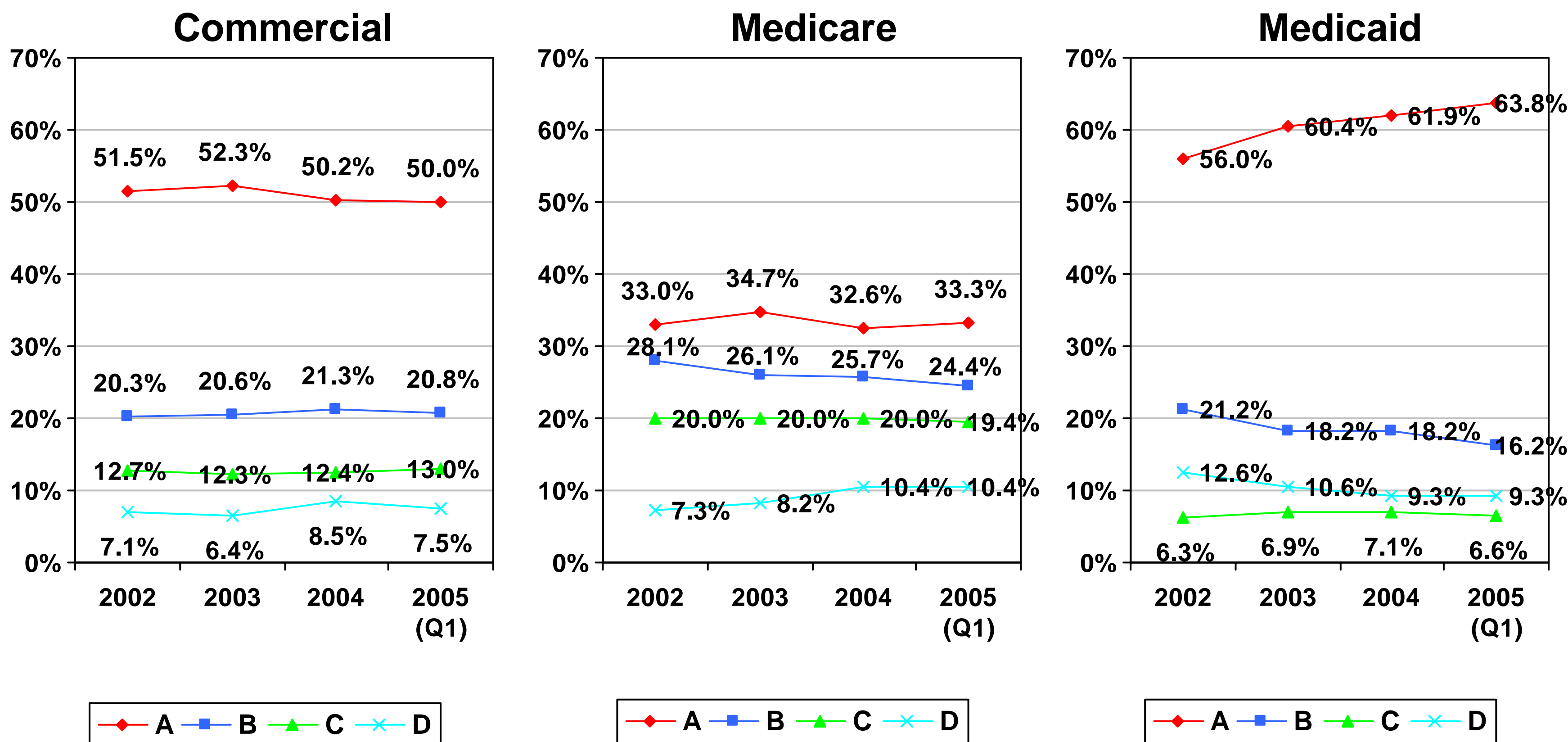
[Client] Overall Market Position by Payer Segment

Between 2002 and Q1 2005, [Client]-[City] lost some share of commercial cases, maintained share of Medicare cases, and significantly grew share of Medicaid.



Note: Inpatient discharges for all patients originating from the Primary [City] region, excluding all psych and substance abuse cases in the market.

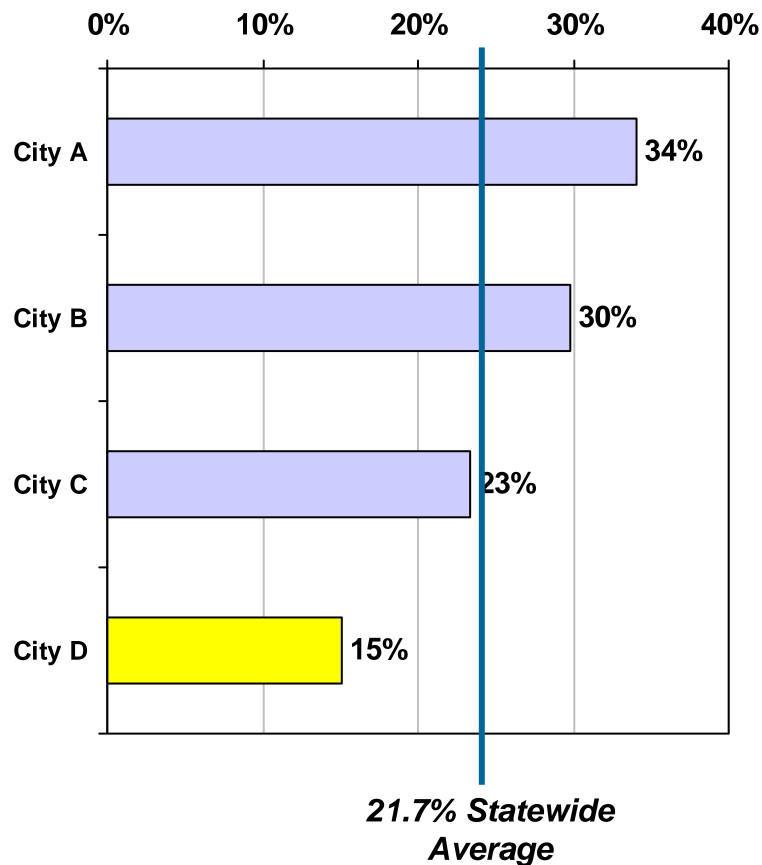
Source: Solucient Market Planner – [Client] Service Area Discharges 2002-2004, 2005Q1; BDC Advisors, LLC Analysis.

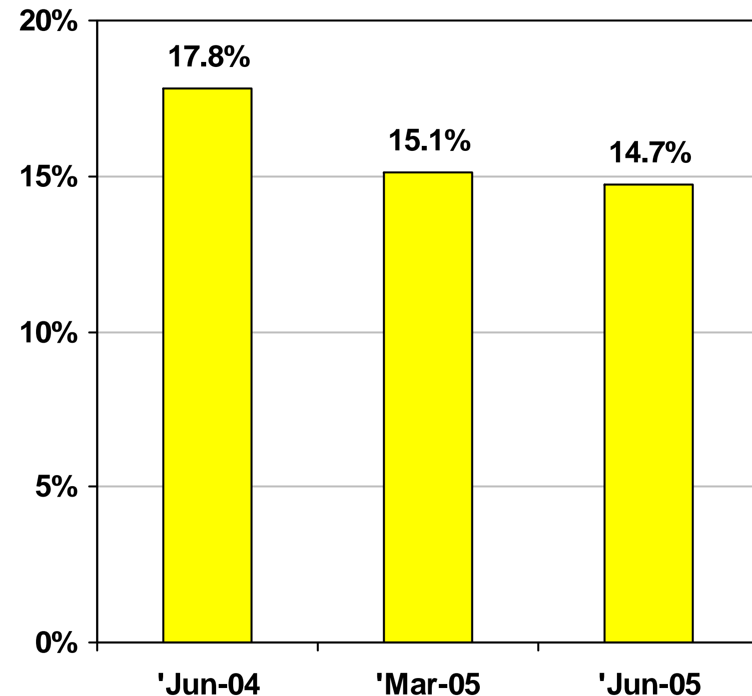
B. Market Structure

- Health Plans are de-emphasizing or exiting commercial HMO products, but will pursue growth in Medicare and Medicaid managed plans, backed by Part D subsidies and state reform of Medicaid
- Regional hospital competitors are investing in outpatient facilities and medical office buildings in growth areas and expanding capacity
- Several key physician groups are not strongly aligned to specific hospitals and are undergoing change in organization

Market Structure: Managed Care in [City]

Managed care penetration is low overall in the [City] market compared to the rest of [State], and has continued its decline in the last year.



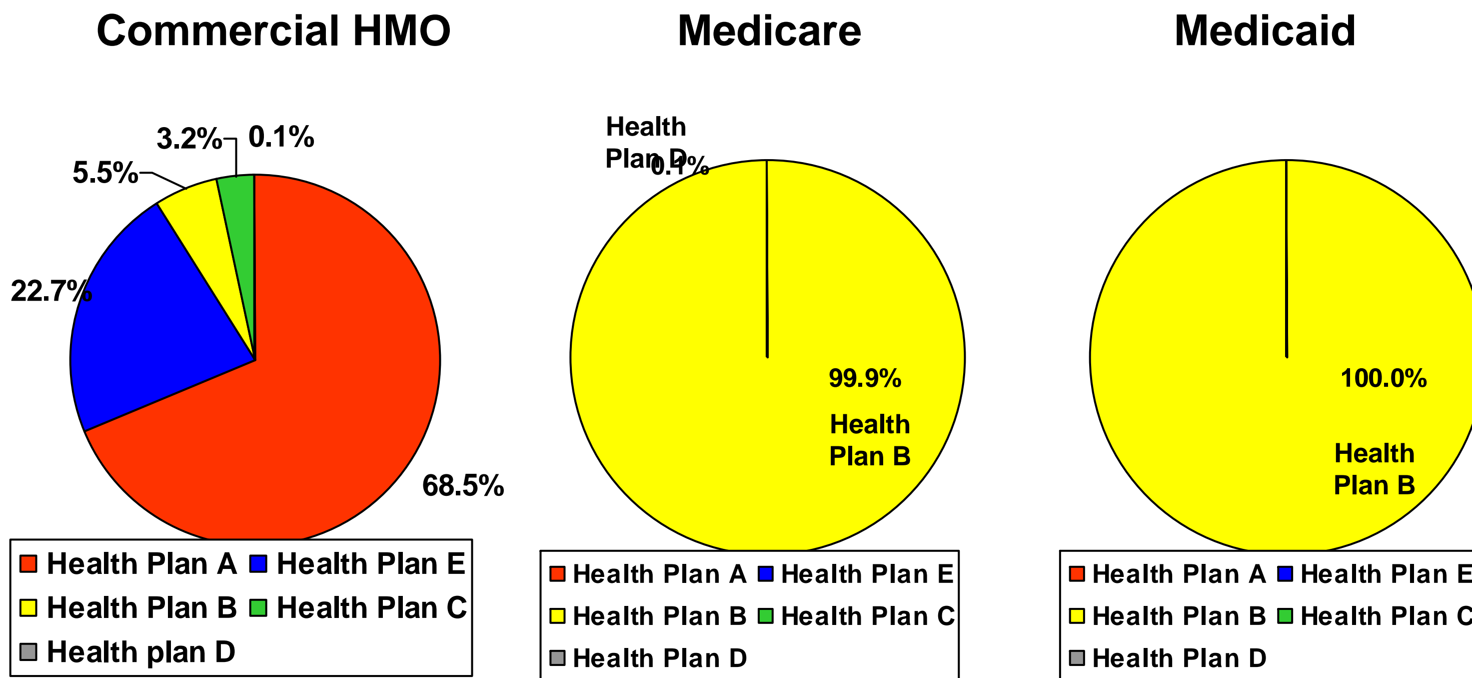


Note: All references to "[City]" and its MSA includes the primary [County].

Sources: [State] Hospital Association (FHA) Eye on the Market: HMO Indicators Report, Dec 2005.

Market Structure: Managed Care

Of the existing managed care plans, the commercial segment is dominated by Health Plan A, while the government segments are exclusively served by Health Plan B.



Jun 2005 Membership:	*29,241*	*4,493*	*19,400*

Sources: [State] Hospital Association HMO Indicators Report, Dec 2005.

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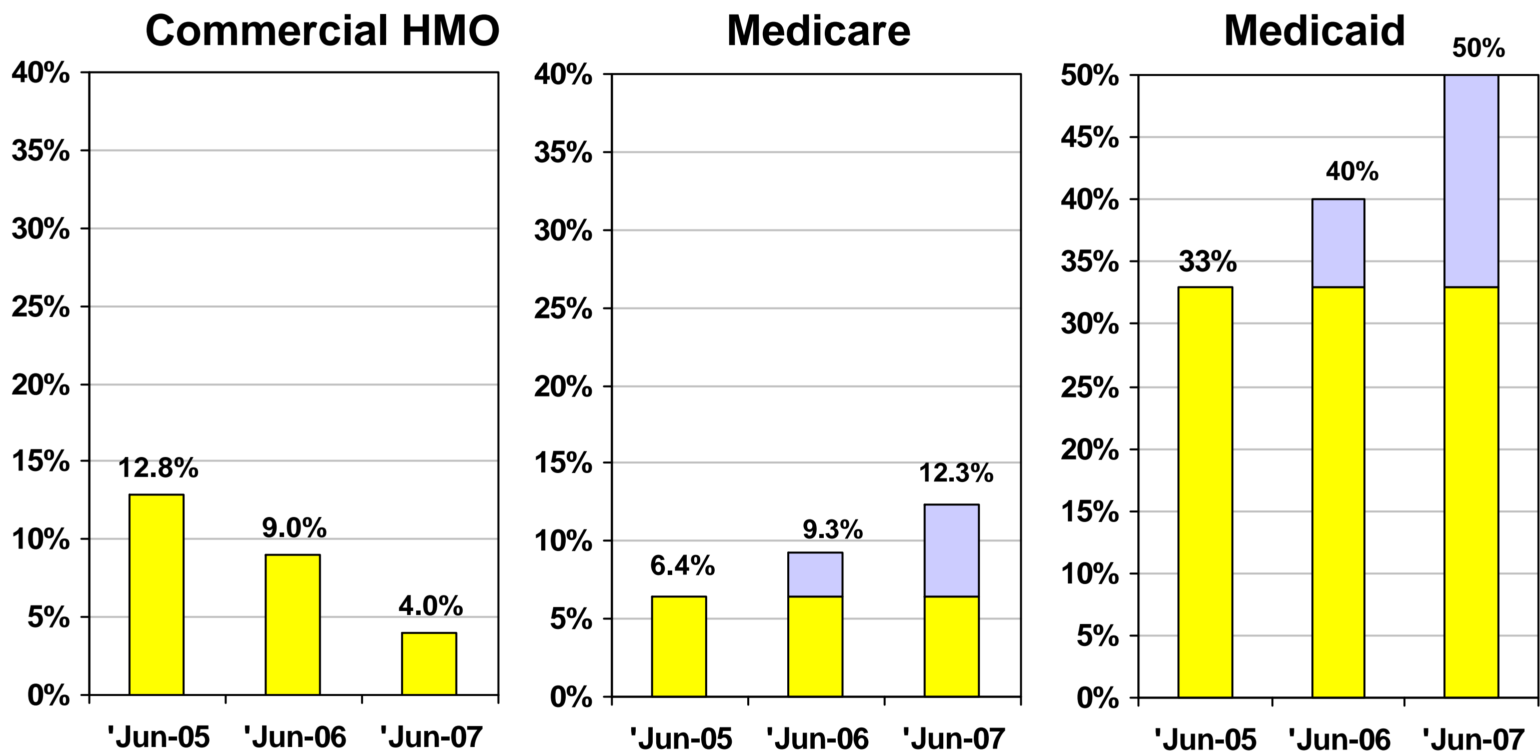
Market Structure: Managed Care

Managed care penetration will continue to decline in the commercial segment while Medicare and Medicaid will likely grow.



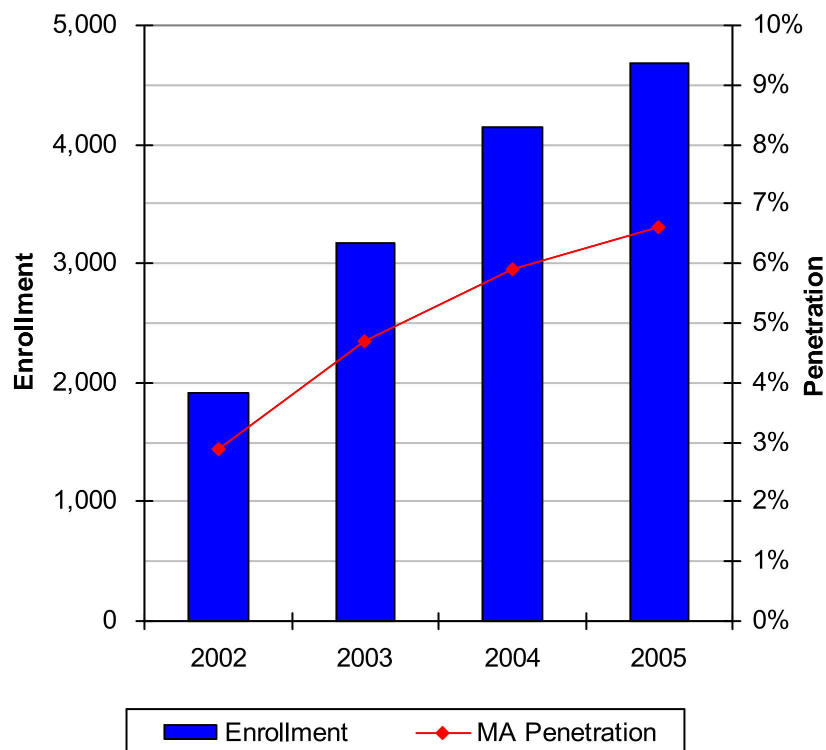
Gain / (Loss) of Members:	*(29,241)*	*665 – 3,325*	*3,921 – 9,803*

Note: (1) Health Plan A enrollment of 29,241 in [City] will be gradually transferred to PPO; (2) Medicare HMO gains if MA plans capture 1% market share, which is roughly average of the prior 2 year's gain for Health Plan B and up to 5%; (3) If Medicaid waiver allows enrollment of 10% to 25% of remaining eligibles.

Sources: [State] Hospital Association HMO Indicators Report, Dec 2005.

Market Structure: Managed Medicare

Since the closure of Health Plan C's Medicare HMO, Health Plan B is [City]'s only existing MA plan but there are potentially 2-3 new entrants in 2006-2007.



2006 MA Plans Available in [City]

	Plan Type			
Health Plan Company	**HMO**	**PFFS**	**Regional PPO**	**SNP**
Health Plan B	X			
Health Plan D		X	X	
Health Plan C			X	X
New Entrant*	X			X
Other	?		?	

Note: * New Entrant to file application with CMS in March 2006.

Sources: [State] Hospital Association HMO Indicators Report, Dec 2005.

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Plans to Watch

Health Plan D, Health Plan C, Health Plan A, and Health Plan B are the plans to follow

Existing Health Plans in the Market

- Health Plan B
  - Heavily marketing its Medicare HMO and PDP plans to the local market through (Clinic) and local media
  - Health Plan F, the largest Medicaid HMO and subsidiary of Health Plan B, is poised to take advantage of Medicaid Reform
- Health Plan A of [State]
  - Not offering MA-PD, but continuing its Medigap plans and offering PDP plans
  - Phasing out commercial managed care, transitioning to PPO

New Entrants

- Health Plan D
  - Health Plan D is the largest Medicare HMO in [State] by far with over 400K members
  - Offering PDPs and MA-PDs local PFFS and regional PPO, initial focus on [State]
  - Rolled out statewide regional PPO in January but [City] provider network is limited and under development
- Health Plan C
  - Largest Medicare plan in the country since acquisition of Health Plan G
  - History of failed Medicare HMO in [City]
  - Administers PDP and Medigap supplement plans
  - Offering PDPs and MA-PDs, local, regional PPOs, and SNPs
  - Rolled out statewide regional PPO in January but [City] provider network is limited
- Other new entrants have expressed intent to enter market

Market Competitors

Local competitors are investing in capital projects to enhance services and attract physicians.

- [Hospital]
  - Opening $30.3M institute with multispecialty ambulatory surgery, OP rehab and diagnostic imaging
  - Solucient Top 100 among community hospitals for cardiovascular care
  - Received the Malcolm Baldrige National Quality Award for its campuses
- [Hospital]
  - $100M renovation project on public spaces and patient rooms, 12 new OR, new laboratories, 26-room post-surgery wing
  - Opening 2 primary care offices 2005-2006
- [Hospital]
  - Building new surgery and endoscopy suites
  - Recruited more than 25 new physicians in last 3 years to accommodate 10-15% annual patient volume growth in local markets
  - Opened 2 MOB in 2005
    - 12,000 ft MOB with radiology and lab for primary care physicians, OB / Gyn, gen surgeon, other specialists
    - MOB for primary care

Physician Groups

Physician groups in the [City] region are fragmented and are not strongly aligned to hospital systems.

- [Clinic], once aligned with [State], once had 200 physicians, but has declined to 45 after financial losses and bankruptcy of PhyCor
  - May emerge as Surgical specialty or Neuro / Neurosurgery practice
- [Clinic], a physician-owned IPA created to compete against [Clinic], has been the major provider to managed care plans (B) and (A)
  - Focus on managed care has led physicians to admit more to [Hospital]
  - Health Plan B has grown but has low penetration; Commercial HMO (A) will be phased out, leaving (Clinic) with government programs
  - (Clinic) is aggressively pursuing growth opportunities in MA and Medicaid Reform to offset loss of HMO (A) lives
- [Client] is largest group of primary care physicians, but few specialists
  - Benefits from [Client] Provider-based billing
  - Has good relationship with Health Plan A[State], receiving one of highest P4P awards last year
- Specialists in the market are independent or are in single-specialty groups
  - Cardiology, GI, Oncology tend to be splitters in admissions
  - Pulmonology / Critical Care and Orthopedics tend to be aligned
  - Hospitalists / intensivists model has been adopted at most hospitals

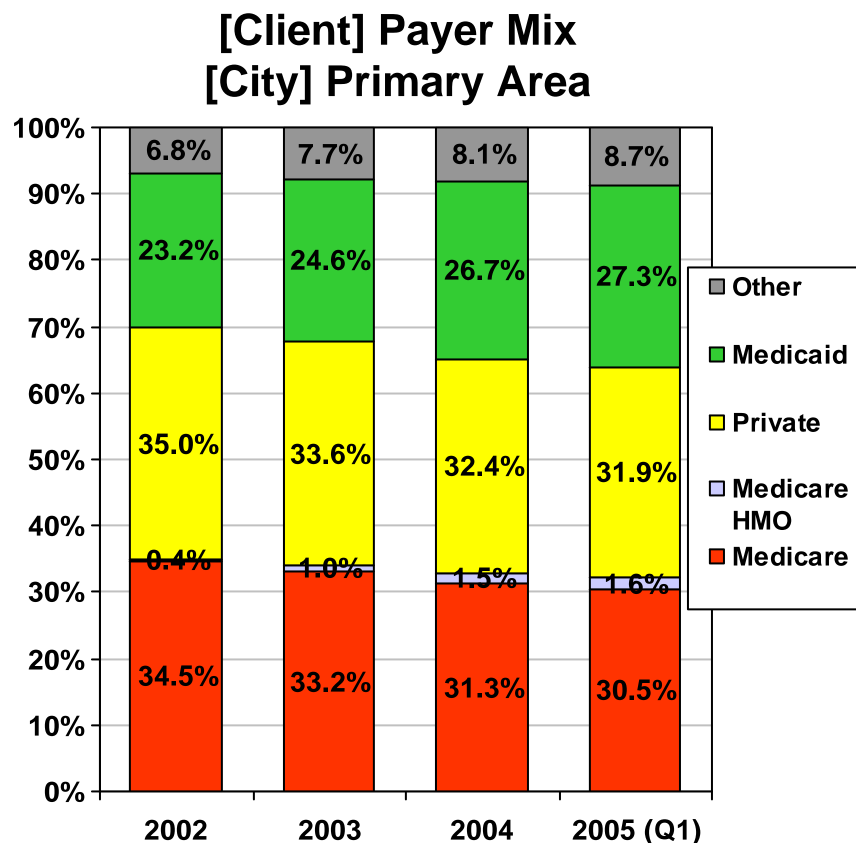
Source: [Client] interviews.

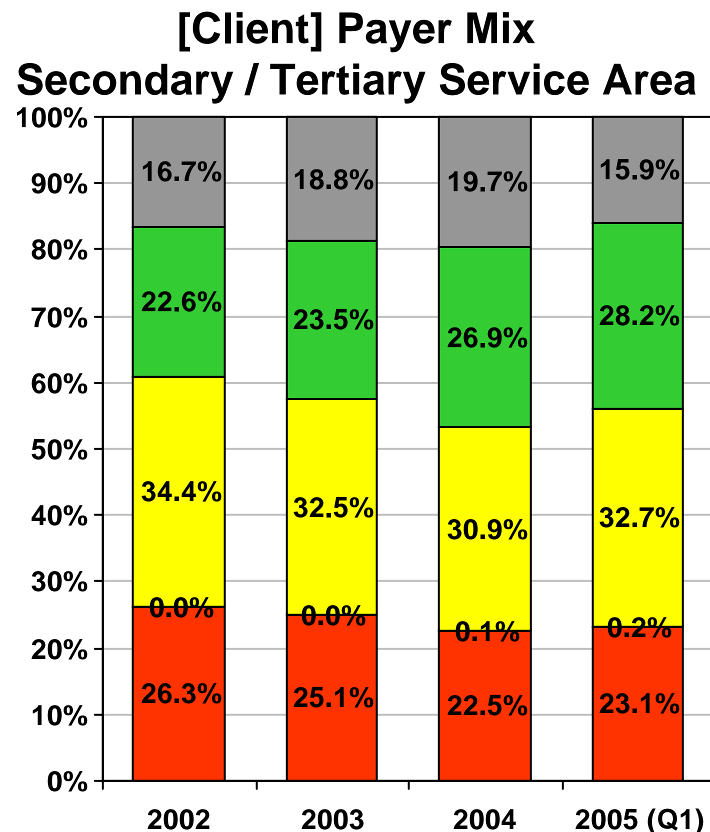
C. [Client] Performance

- Recent gains in share may have been at the cost of favorable payer mix
- Medicare is a critical component of [Client] financial performance, generating 37% of total revenues and 36% of contribution margin in FY05
- Managed Medicare with Health Plan B has been significantly more profitable than traditional FFS for the hospital
- [Client] has a low share of HMO lives in the region, and is not currently positioned to capture growth from enrollment in either Medicare or Medicaid managed plans
- Parent has very high expectations for [Client]' FY06 financial performance that will be difficult to meet based on mid-year results

Recent [Client] Performance: Payer Mix

[Client] has been experiencing declining quality in payer mix, losing Medicare and Commercial cases while growing Medicaid from the primary service area as well as those migrating in.





Note: “[City] Primary” area includes [County]; “Secondary/Tertiary” service area includes [City] Secondary, Primary, and Outside of Service Area.

Sources: [Client] Decision Support; Solucient Market Planner – [Client] Service Area Discharges 2002-2004, 2005 Q1; BDC Advisors, LLC Analysis.

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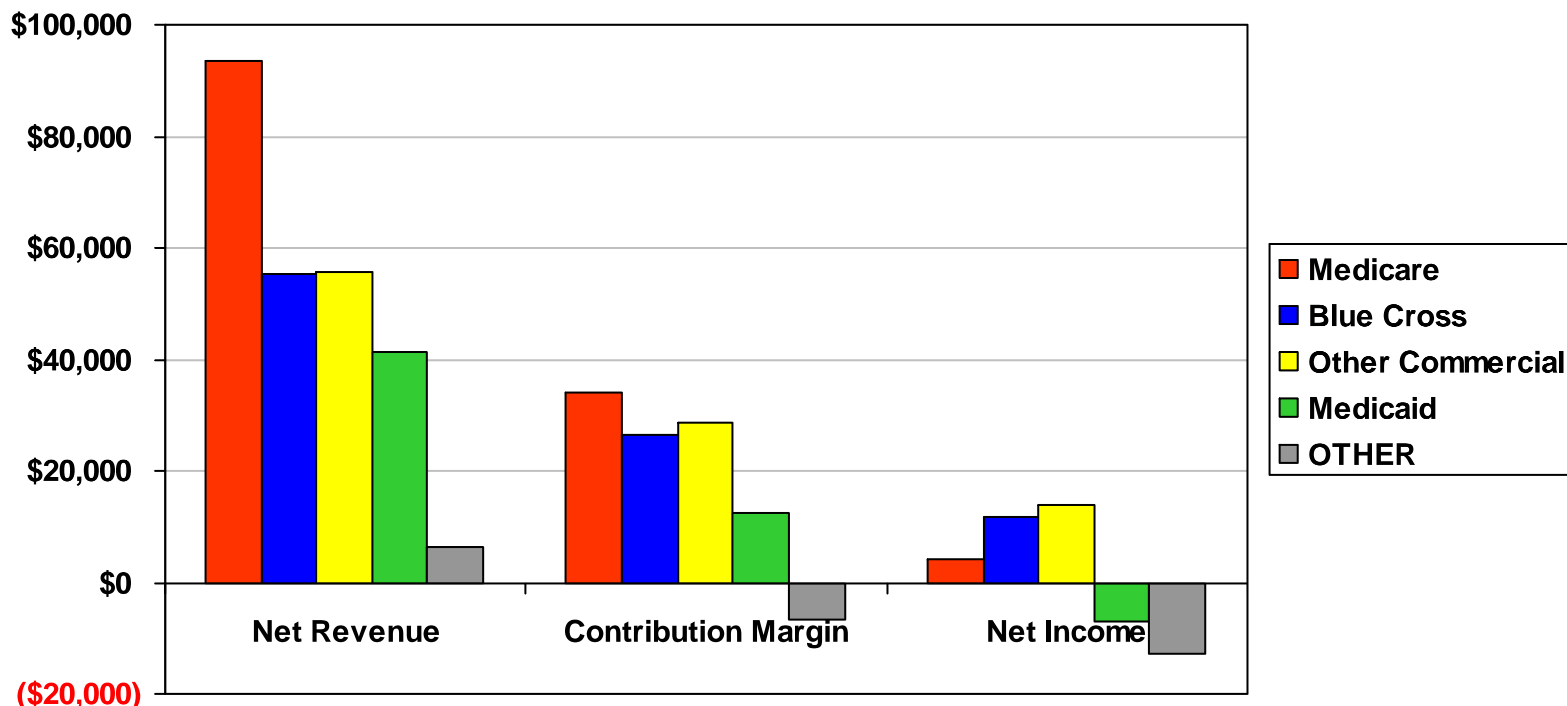
[Client] Medicare Performance

Medicare is a critical payer to [Client], providing 37% of total hospital net revenue and 36% of total contribution margin in FY05.



Medicare Share of All Payers	Net Revenue	Contribution Margin	Net Income
2005	37%	36%	43%
2004	38%	35%	31%
2003	39%	39%	49%

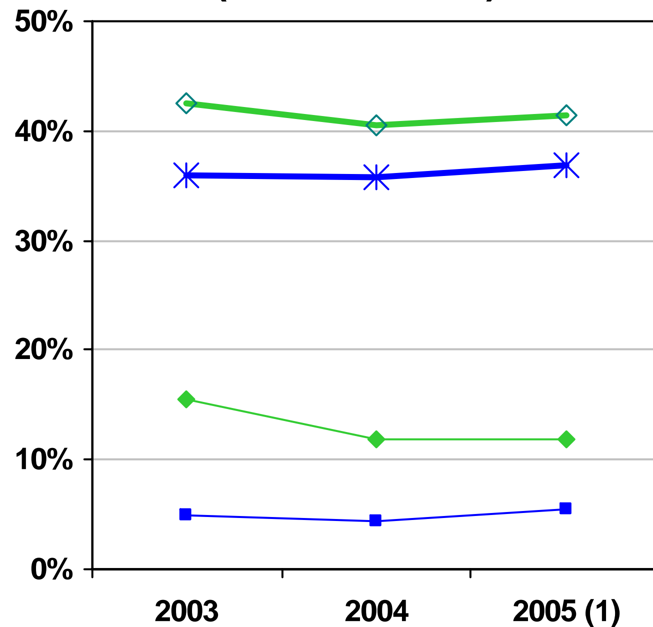
Note: [Client] Hospital [City] FY05 IP and OP encounters excluding normal newborns, all accounts.

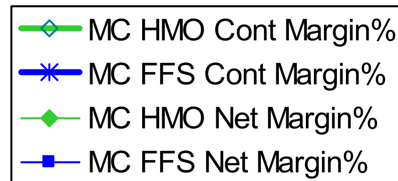
Source: [Client] Hospital Department of Finance; BDC Advisors, LLC Analysis.

[Client] Medicare Performance

Medicare FFS and HMO are both profitable and stable, with somewhat higher returns in both inpatient and outpatient HMO business.

Total Hospital Medicare Margins (FY2003-2005)





[Client] Medicare Case Rate FFS vs. HMO (FY2005)

	Medicare Payer	FY05 Per Case Average Rate			Overall Margin	
		Net Revenue	Cont Margin	Net Margin	CM %	NM %
IP	FFS	$9,106	$3,373	$412	37.0%	4.5%
	HMO	$10,108	$4,211	$1,119	41.7%	11.1%
OP	FFS	$217	$79	$19	36.3%	8.8%
	HMO	$229	$94	$32	41.0%	14.0%

Note: (1) [Client] Hospital FY05 IP and OP encounters excluding normal newborns, including only accounts with zero remaining balance.

Source: [Client] Hospital Department of Finance; BDC Advisors, LLC Analysis.

[Client] Market Position

[Client] has a low share of HMO lives in the [City] area.

[Client] HMO Share of Lives (2005)

Company	Health Plan	2005 [Client] Enrollment[1]	Total Lives in Market[2]	Share of Lives
Health Plan A	HMO (A)	3,725	29,241	13%
Health Plan E	Health Plan E	1,102	9,678	11%
Health Plan B	MA B	147	4,493	3%
	Health Plan F[3]	~5,000	19,400	26%
State program	Healthy Kids	63	3,486	2%

Source: (1) Clinic enrollment by [Client] PCP as of November 1, 2005; Healthy Kids program enrollment for [County]; (2) State HMO Market Share Report 2Q2005. (3) Health Plan F [Client] enrollment not published by State includes the [Client] contract with University of [State] Pediatrics residency program.

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[Client] – [City] Hospital Financial Performance

After 2 years of declining operating margins, it will be difficult for [Client] to reach its 5% operating margin goal.

Preliminary

[Client] Key Financial Statistics 2003-2008

[City] Hospital	Actual			*Projected*	*Budget*		
	2003	2004	2005[1]	2006 Annualized Dec YTD	2006	2007	2008
IP Discharges	24,658	24,872	24,304	23,570	26,034	26,555	27,086
ALOS	5.22	5.08	4.97	4.84	4.97	4.92	4.87
Census	353	346	331	313	355	358	362
OP Visits	295,598	304,997	306,821		323,366	333,067	343,059
Beds	431	449	449	449	449	449	449
Occupancy %	81.9%	77.1%	73.7%	69.7%	79.1%	79.7%	80.6%
NPR	$ 255,156	$ 276,001	$ 283,568		$ 312,127	$ 326,647	$ 240,863
Op Income	$ 2,133	$ 12,766	$ 9,795		$ 16,608	$ 17,824	$ 18,739
Op EBIDA	$ 20,652	$ 29,597	$ 23,803		$ 37,132	$ 38,869	$ 40,310
Op Margin %	0.84%	4.6%	3.4%		5.3%	5.5%	7.8%
Op EBIDA %	8.1%	10.7%	11.0%		11.9%	11.9%	16.7%

Note: (1) FY05 had a bad debt write-off due to billing issues with Health Plan B that could have improved operating margin by 0.1%

Source: [Client] Integrated Strategic Financial Plan – [City] Hospital projections for 2003-2004; [Client] Actual FY05 and Dec YTD vs. FY06 budget volumes.

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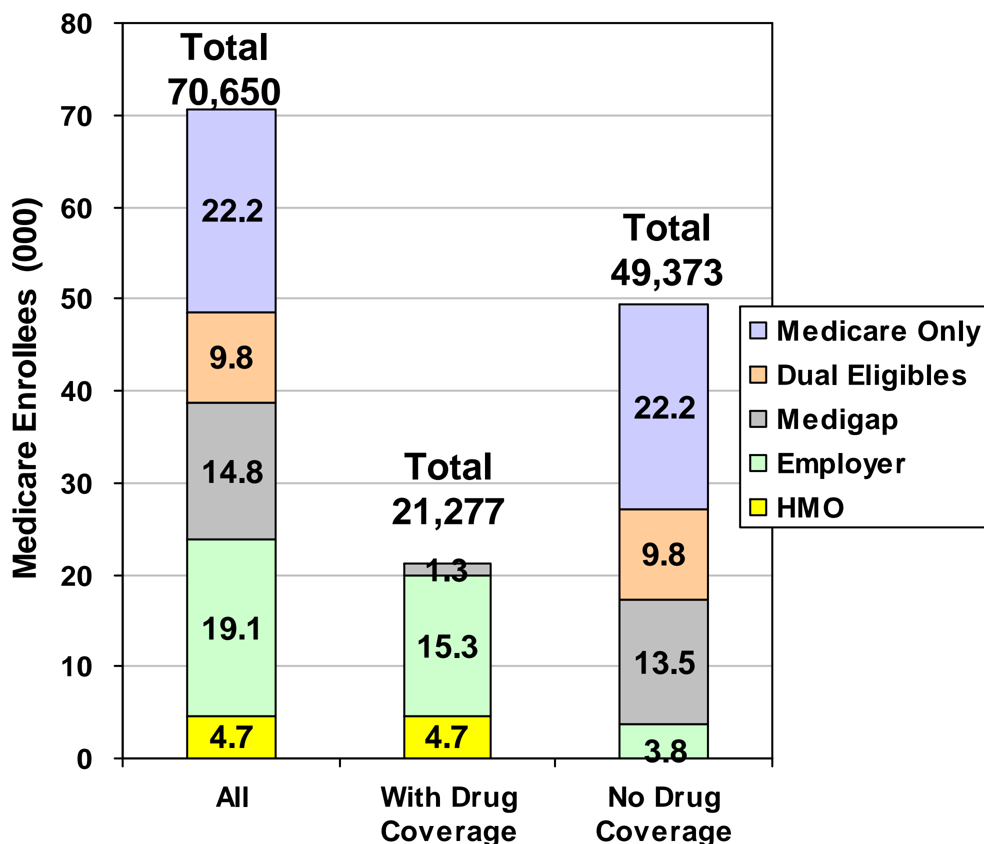
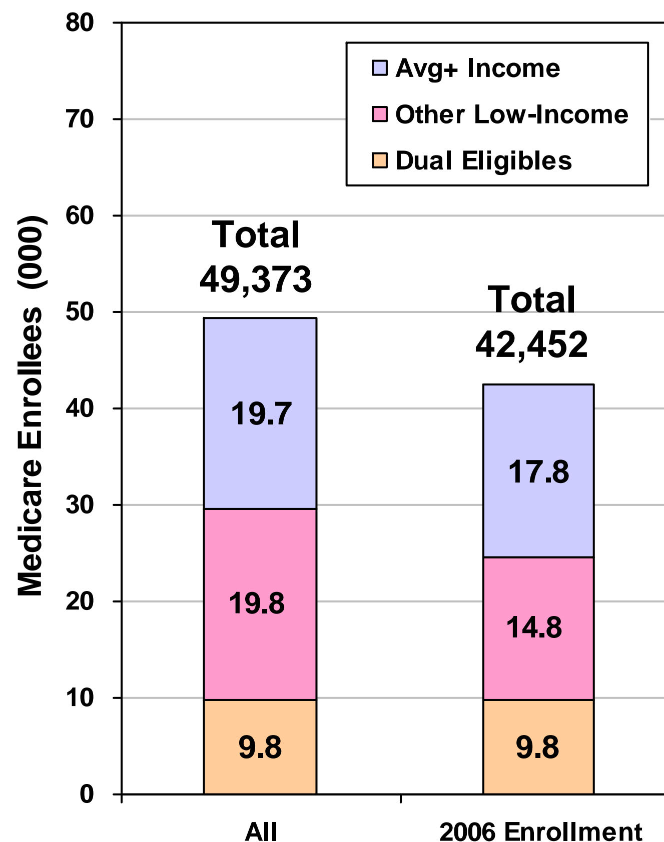
D. Medicare Part D

- Within the [City] primary market, there are 70,000 Medicare eligibles, most of whom will need and benefit from the Part D prescription drug plan
- Standalone PDP plans will be attractive compared to existing MA plans
- Among currently available MA-PD plans, there are choices that on the basis of cost-share and benefits, will be better plans than the current package of traditional FFS with Medigap and PDP
- However, consumers are leery of managed plans from previous market failures, highly value the physician network, and are unlikely to enroll in great numbers
- Some of the leading companies (e.g., Health Plan C and Health Plan D) are offering very competitive stand-alone PDP plans as a lead-in or transition product to their MA-PD plans
- Regulatory changes in Medicaid will only grow managed Medicare and Medicaid, which are segments that [Client] must seek participation

Medicare Population Segmentation

Of the 70,000 Medicare population in [City], about 50,000 will seek new drug coverage, with 86% of these likely to enroll in some Part D plan in 2006.





Source: CMS MA penetration 2002-2005, Kaiser Family Foundation survey of [State] seniors' drug coverage sources, [City] area Medicaid administration; BDC Advisors, LLC Analysis.

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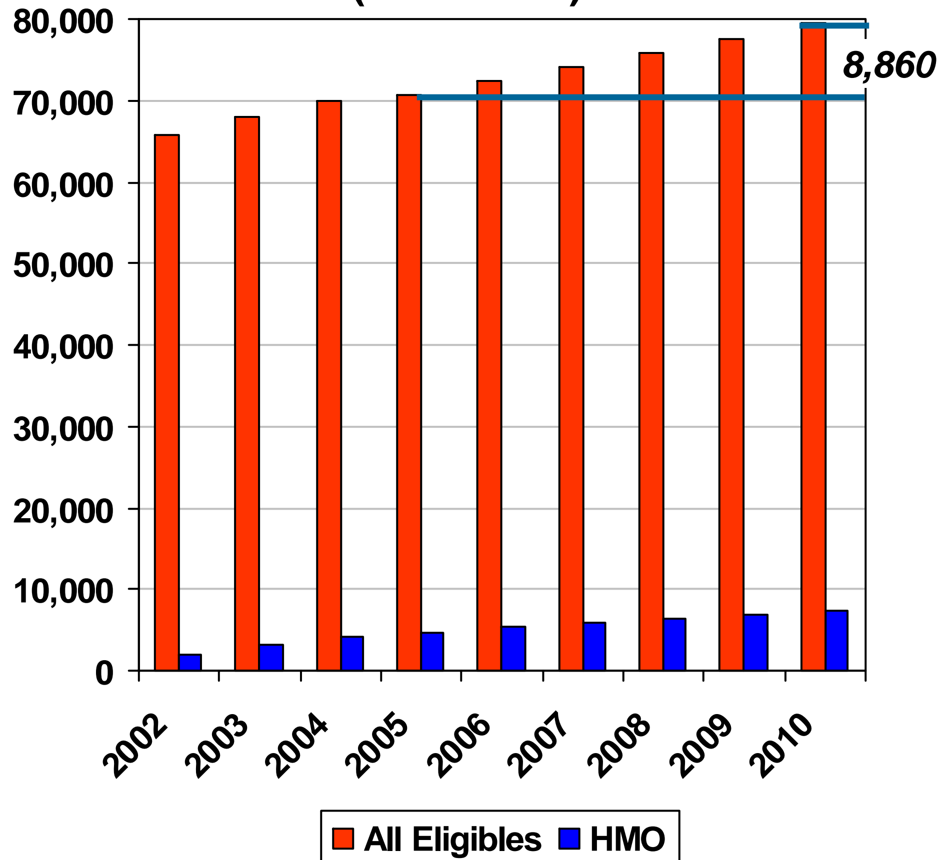
Medicare Market Growth

The Medicare-eligible population is projected to grow by 12.5% over the next five years, by nearly 9,000 new beneficiaries.



Population Growth by Segment (2005-2010)

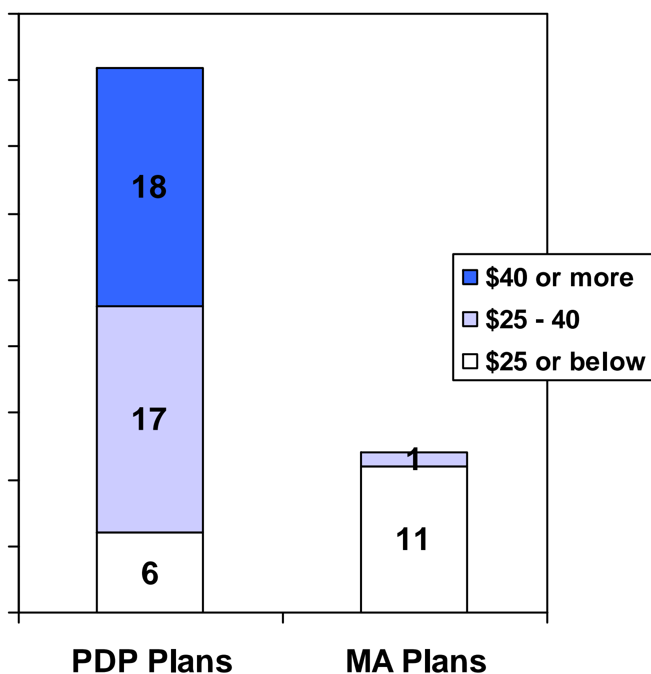
Health Plan Company	2005 Enrollment	Change ('05-'10)
HMO	4,681	+2,723
Dual Eligibles	9,839	+1,234
Employer Sponsored	19,076	-2,379
All Other	37,054	+7,282
Total Medicare	70,650	+8,860

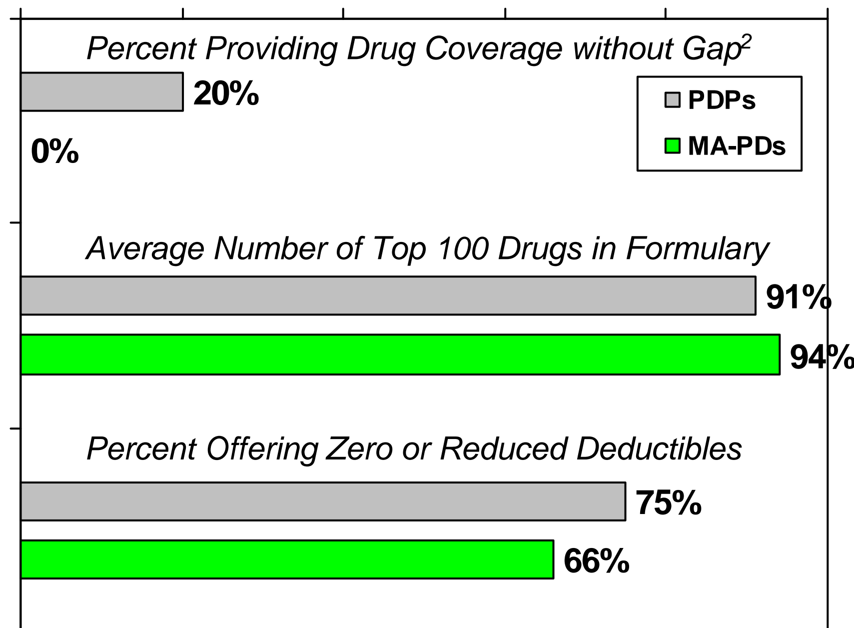
Notes: Population growth by segment based on 2005 distribution of income levels, expected employer sponsored plans, and current HMO penetration.

Source: CMS MA penetration 2002-2005, Kaiser Family Foundation survey of [State] seniors' drug coverage sources, [City] area Medicaid administration; BDC Advisors, LLC Analysis.

Drug Benefit Comparisons

Standalone PDP plans have higher premiums, offer nearly a comparable formulary, and can provide coverage between the $2250-$3600 range where MA plans do not.





Note: (1) Four of the MA plans' drug portion of the total monthly premium was $0 (2) Health Plan D plans only.

Source: CMS PDP Landscape for [State] and MA Plan Landscape for [County].

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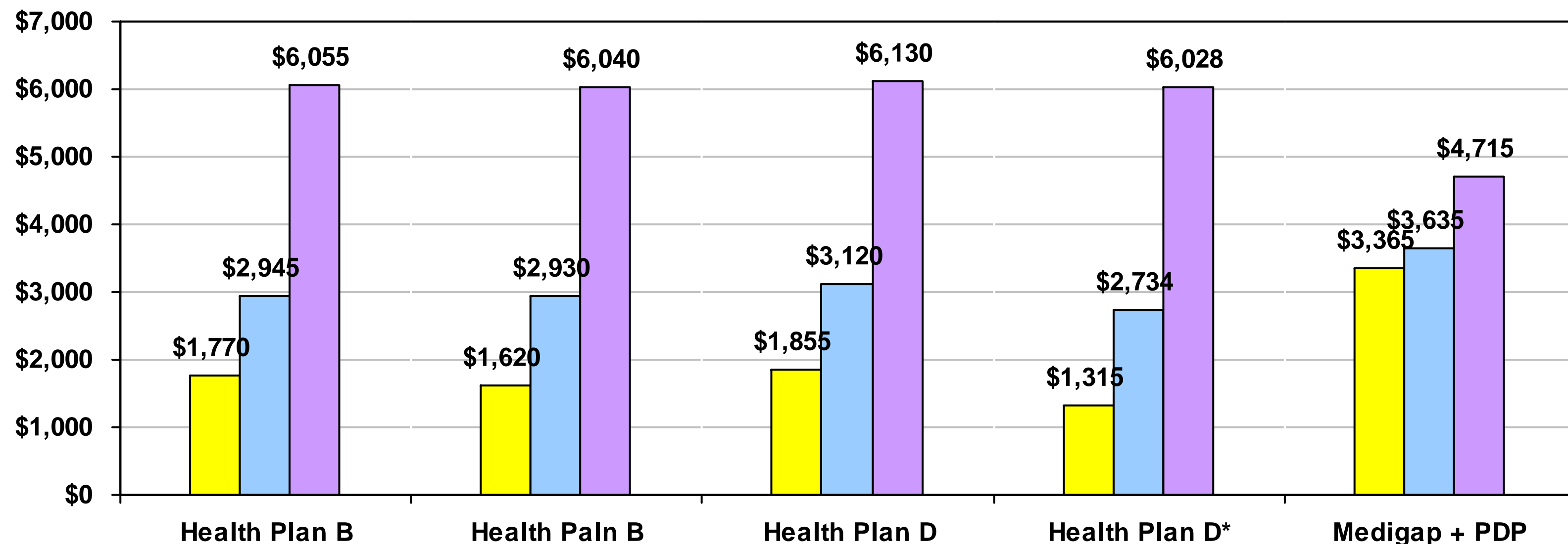
Medicare Plan Packages – Coverage Comparisons

Total annual costs[1] across available MA-PD plans compare favorably versus traditional Medicare with Medigap and a standalone PDP for those in fair to good health.



Utilization	Good Health	Fair Health	Poor Health
Number of Doctor Visits	4 (2 Primary, 2 Specialists)	12 (4 Primary, 8 Specialists)	24 (8 Primary, 16 Specialists)
Urgent Care / ER Visits	1/0	0/1	0/2
IP Admissions (Days)	0 (0)	1 (4 Days)	3 (12 Days)
Prescriptions (30days)	6	24	72
Routine Physical Exam	1	1	1

Notes: (1) Total cost share includes all premiums (including Part B), co-pays, and co-insurance for one year as published on the CMS Medicare Personal Plan Finder, December 2005.

Sources: CMS Medicare Personal Plan Finder as of Dec 21, 2005; [Client] Medigap plan table of premium quotes, Feb 2005; CMS MA Plan Landscape for [County]; Medicare News Watch 2006 Medicare Advantage Cost Share Report; BDC Advisors, LLC Analysis.

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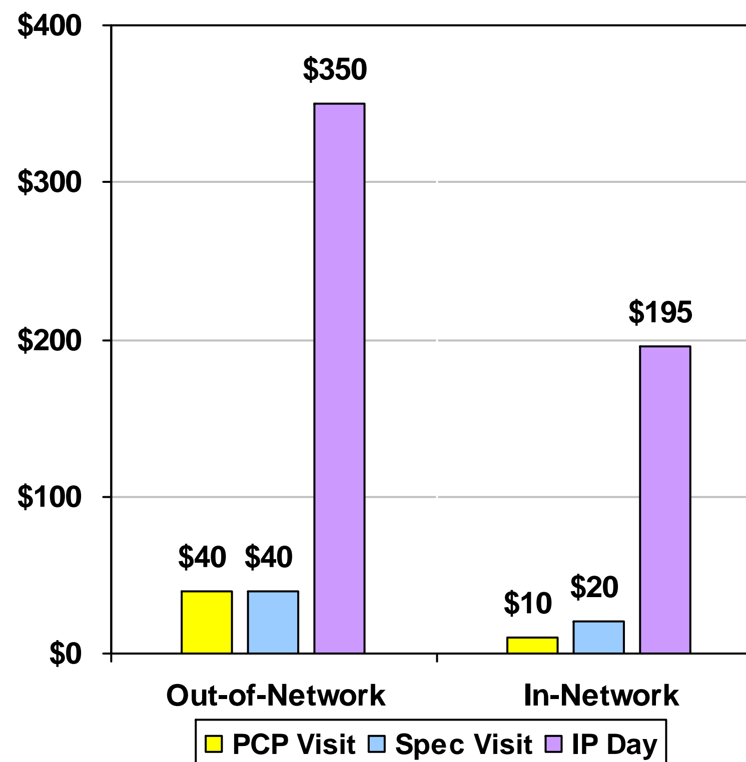
Medicare Plan Packages – Coverage Comparisons

However, the in-network restrictions on hospitals and providers at the initial enrollment period are likely to deter most [City] seniors from joining these new MA-PD plans in favor of standalone PDP plans.

In-Network Comparison (2006)

	H Pl B	*H Pl D*	*H Pl C*	*Traditional Medicare with Medigap*
Hospitals	ALL	NONE	Limited	ALL
Providers PCP	Limited	Limited	Limited	ALL
Providers Specialists	Limited	Limited	Limited	ALL
Pharmacies	PDP Plan	PDP Plan	PDP Plan	PDP Plan



Sources: CMS Medicare Personal Plan Finder; [Client] Medigap plan table of premium quotes, Feb 2005; CMS MA Plan Landscape for [County]; Medicare News Watch 2006 Medicare Advantage Cost Share Report; BDC Advisors, LLC Analysis.

Standalone PDP Selection: Winners and Losers

Who will benefit and have their prescription drug costs lowered?

	Beneficiaries Segment by Current Coverage
Winners	**No Current Drug Coverage** Medicare beneficiaries in [State] will average $758 in savings The average senior now spends $1,708 per year for prescription drugs This will decline to $950 per year after enrolling in Part D **High drug utilization** – Part D now covers catastrophic drug costs And an estimated 14 percent will exceed the catastrophic threshold **Low income levels that qualify for subsidy** Low income seniors in [State] now spend $1,825 per year for prescription drugs This will decline to $198 per year after enrolling in Part D for an average $1,627 in out-of-pocket savings
No Impact / Unclear	**Private Coverage** (e.g. Employer plans, Government / Military Retirees) - offers richer drug benefit
Potential Losers	Beneficiaries with drug costs that cause them to spend deep in the doughnut hole may or may not benefit depending on their prior coverage An estimated 38 percent of enrollees will hit the no coverage zone or doughnut hole (Riding the Rollercoaster, Health Affairs)

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MA-PD Plans: Factors that Influence Enrollment

There are a number of factors that will influence the consumer's decision whether to enroll in MA-PD plans and which plan to select.

Factor	Description
Price / Benefits	Early Medicare HMO experience demonstrates that a price / benefit differential of 20 to 25 percent is sufficient to attract seniors to enroll even if it means that they will have to change physicians
Network Composition	Broad networks that provide choice and don't require seniors to change physicians will attract enrollment Limited networks must have a substantial price / benefit advantage and will appeal especially to the price sensitive senior
Brand Trust / Loyalty	The plan must have a track record of service to Medicare beneficiaries - [City] seniors have been burned before by Health Plan C's Medicare HMO - Health Plan A of [State] and AARP are the most trusted brands in the [City] market New entrants take time to establish identity and build brand loyalty [Client]'s Affinity Group has a voluntary membership of over 20,000 seniors with strong loyalty that could be used to sponsor a plan that would immediately generate trust
Inertia	Seniors are not early adopters Seniors will select the plan with the lowest risk
Lack of Clear Differentiation / Marketing Message	Part D offers too many choices It is difficult for seniors to understand the differences among plans and the potential savings Presentations by plans tend to be biased and are perceived as marketing
Late Enrollment Penalty	The threat of a late enrollment penalty may stimulate seniors to enroll

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Regulatory Changes

- [State] plans to shift more Medicaid recipients to managed care plans
- Potential impact on patient segments
  - Dual-eligibles Medicaid / Medicare: Proposed pilot project for the region would shift all dual-eligible seniors above age 60 (about 9,000 in [City]) into state-approved managed care plans
  - Medicaid: Current 33% managed penetration could rise rapidly
- Potential impact on [Client]
  - Auto-assignment into Health Plan B for dual-eligibles would significantly reduce number of FFS patients – [Client] should expand participation with Health Plan B
  - Reform will make managed Medicaid the dominant provider to this growing population – [Client] should seek participation with other potential state-approved plans or consider forming a PSO

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E. Strategic Options and Preliminary Recommendation

- The market will respond to MA plan offerings in one of at least three potential enrollment scenarios
  - ➨ Low enrollment: Health Plan B will continue moderate growth while MA plans gain only a small share of new Medicare eligibles
  - ➨ Initial enrollment growth followed by decline: MA plans develop attractive provider networks and provide significant savings to enrollees, but after several years of growth federal subsidy is eliminated and enrollment declines
  - ➨ High enrollment: If MA plans gain traction, new entrants as well as Health Plan B will benefit from the high level of interest in these plans, and will significantly reduce the FFS market size
- [Client] has three main strategic options that are optimal for these scenarios
  - ➨ Don’t participate / enhance traditional Medicare and develop 340B PDP
  - ➨ Delay participation / late entry
    - MA plans won’t agree to acceptable reimbursement rates
    - MA plans are not willing to steer enrollees to [Client]
  - ➨ Early entry to increase market share – take leadership position in building the local MA market

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Medicare Strategic Options

What options should [Client] consider?

- **Continue current strategy of not contracting with MA plans**
  - ➡ Focus on traditional Medicare
  - ➡ Expand Senior Services Affinity program with additional services and programs
  - ➡ Continue role of providing independent advice regarding Part D
  - ➡ Monitor patient enrollment and satisfaction with MA plans
  - ➡ Risk is loss of some patients
- **Delay participation in MA plans**
  - ➡ Wait until it is clear that a significant segment of Medicare beneficiaries will enroll
  - ➡ Delay participating until MA plans are willing to offer acceptable reimbursement rates
- **Become an early participant in MA plans**
  - ➡ Opportunity to improve services to existing patients
    - Lower premiums and reduced costs
    - Better clinical integration
    - Promote benefits of enrollment to Senior Services Affinity membership
  - ➡ Opportunity to increase market share and serve new Medicare beneficiaries
    - Vehicle to grow [Client] patient volume
    - Competitive alternative to (Clinic) and Health Plan B
    - With early entry more likely to obtain desired contract terms and reimbursement rates
  - ➡ New Regional PPO plans are more compatible with [Client] / [Client] culture
  - ➡ Risk is instability of MA program and future compression of reimbursement rates
  - ➡ Assets [Client] brings to the table
    - [Client] primary care capacity and willingness to recruit new physicians
    - Loyal Senior Services Affinity Group

Strategic Option 1: No Participation

Market Conditions:	***Favorable***	***Unfavorable***
Consumer Enrollment	Low – seniors prefer traditional Medicare with Medigap and [Client] sponsored standalone PDP	Seniors value overall MA savings over PDP MA plan enrollment exceeds 20% penetration by 5 years
Health Plans	Health Plan D and Health Plan C fail to sign providers in [City] Health Plan A does not enter the MA market	Health Plans aggressively pursue provider networks (Clinic) grows PCPs and signs MA plans to replace HMO A Health Plan A enters the market
Physicians	Physicians show little interest in joining MA Regional PPOs and reimbursement rates are less than traditional Medicare	Physician groups consider MA plans a growth market and reimbursement rates meet or exceed traditional Medicare
Federal / State Regulations	Federal subsidies of plans and pharmacies are curtailed	Federal subsidies continue

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Strategic Option 2: Delay Participation

Market Conditions:	*Favorable*	*Unfavorable*
Consumer Enrollment	Low – seniors still prefer traditional Medicare with Medigap	Seniors value savings over physician choice Enrollment exceeds 20% of plan members by 5 years
Health Plans	Health Plan D and Health Plan C fail to sign providers in [City] Health Plan A does not enter the MA market	Health Plans aggressively pursue provider networks (Clinic) grows PCPs and signs MA plans to replace HMO A Health Plan A enters the market
Physicians	Physicians show little interest in joining MA Regional PPOs	Physician groups consider MA plans a growth market
Federal / State Regulations	Federal subsidies of plans and pharmacies are curtailed	Federal subsidies continue

Strategic Option 3: Enter Market with Early Participation

Market Conditions:	*Favorable*	*Unfavorable*
Consumer Enrollment	High – reaches 30-35% penetration (~20-25K members) through 5 year period	High enrollment that peaks, then declines
Health Plans	Plans view [Client] as asset, offers favorable rates MA plans perform well financially MA plans' premiums and benefit package are favorable vs. FFS H Pl A enters and includes [Client]	MA plans plan broad network that do not shift share MA plans do not perform financially and limit reimbursement to providers Health Pl A does not participate
Physicians	[Client] regional network grows	[Client] has to cancel participation
Federal / State Regulations	Federal subsidies continue	Federal subsidies curtailed

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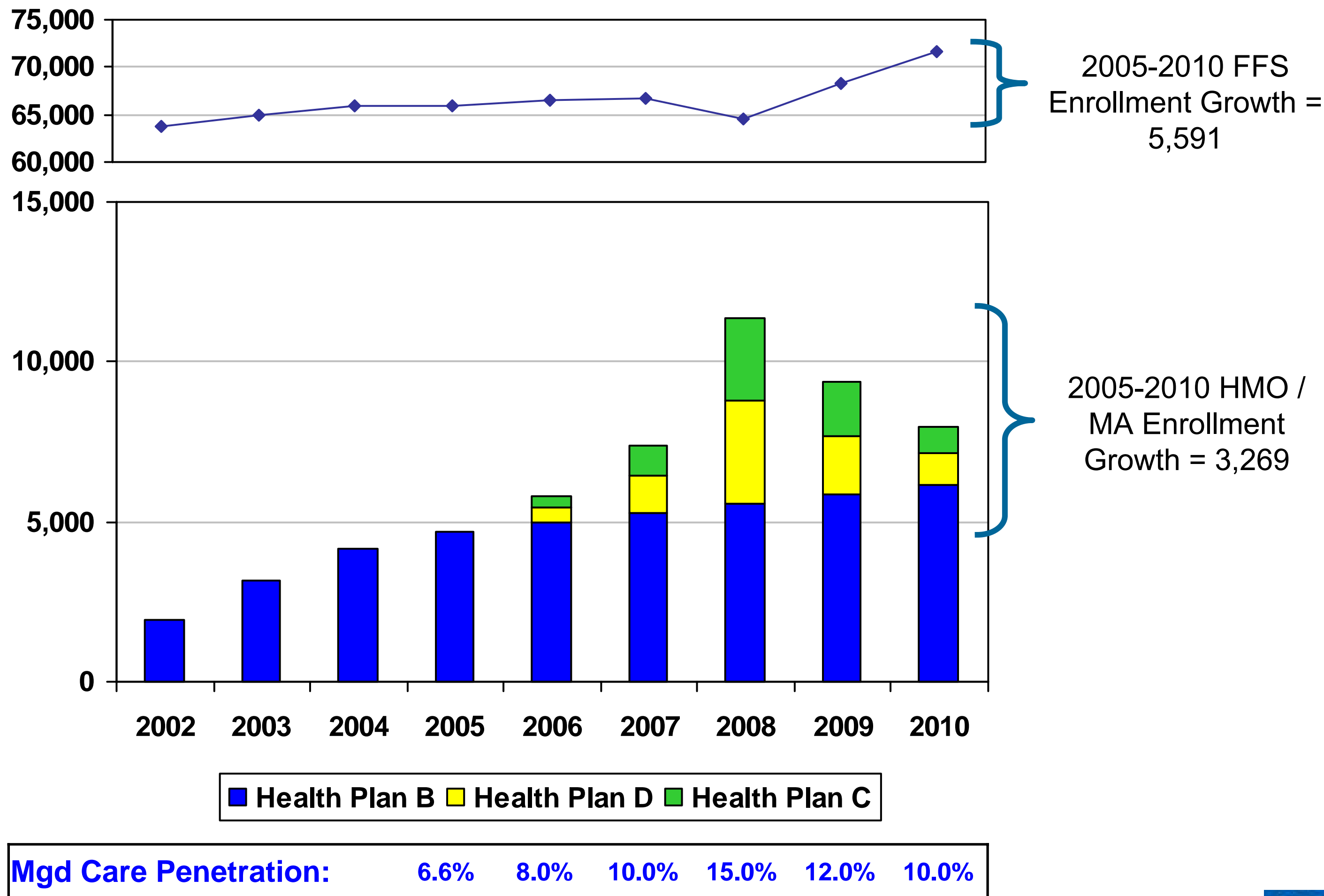
Enrollment Scenario 1: Low Growth, then Decline

Low level of interest and slow uptake of MA plans, with an expected eventual decline, would indicate that growth of the FFS segment would outpace that of MA plan growth.



2005-2010 FFS Enrollment Growth = 5,591

2005-2010 HMO / MA Enrollment Growth = 3,269

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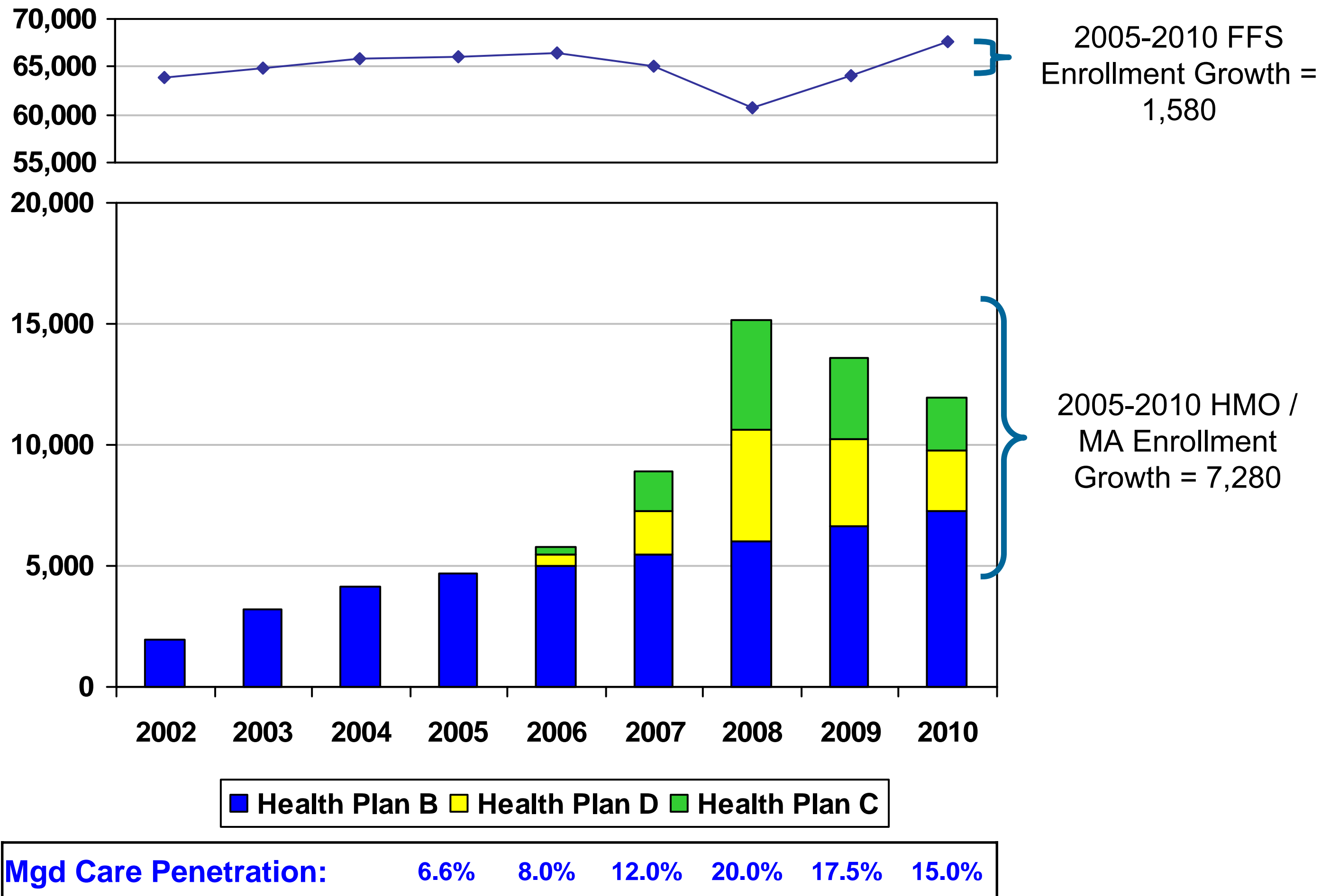
Assumptions for Low Growth

MA plans do not establish a presence in [City] region.

- [Client] doesn't contract with MA plans (with the exception of dual eligibles)
- Medicare beneficiaries continue to favor traditional Medicare plus standalone PDPs and MediGap
- Federal subsidy of MA plans is eliminated
- Private health plans don't push MA plans in [City] market
- Most competing physician groups don't participate in MA plans
- (Clinic) does pursue MA plan contracts and views this as a way to replace HMO A membership but has limited IM capacity and has difficulty retaining physicians
- MA plans don't perform well financially and provider reimbursement is reduced to below traditional Medicare rates
- MA plans fail to establish momentum and after a few years membership declines
- Health Plan A doesn't develop a MA plan offering
- Five-year enrollment projections indicate that [Client] will lose a modest number of Medicare patients to lower priced MA plans
  - Losses will peak after two to three years and [Client] will regain some patients when the product fades
  - Health Plan B will continue to grow but weakness in the (Clinic) will be a limiting factor

Enrollment Scenario 2: Initial Growth, then Decline

Initial enrollment grows quickly, but peaks and falters as subsidies are reduced.



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Assumptions for Initial Growth Followed by Decline

MA plans do establish a presence in [City] region but then fade.

- [Client] enters into early contracts with MA plans and becomes a participating provider when it is early enough to shift market share
- Enrollment in MA plans starts to pick up in late 2006, accelerates in 2007 and 2008, reaches a peak market share of 20 percent and then declines
- [Client] contracts with MA plans that agree to desired reimbursement rates and contract terms and agree to build their provider network around the [Client] regional network
- Private health plans aggressively pursue enrollment growth and view the participation of [Client] regional network as a major asset
- To assure access [Client] regional network is enhanced by adding other providers but [Client] has input into their selection
- Federal subsidy of MA plans is phased out after three years
- MA plans perform well financially and provider reimbursement is equivalent to or exceeds traditional Medicare for the first two to three years and then declines
- [Client] initially gains market share but cancels contracts with MA plans when reimbursement declines
    - [Client] sponsors a standalone PDP
    - [Client] encourages its MA plan patients to transfer back to traditional Medicare and enroll in its PDP

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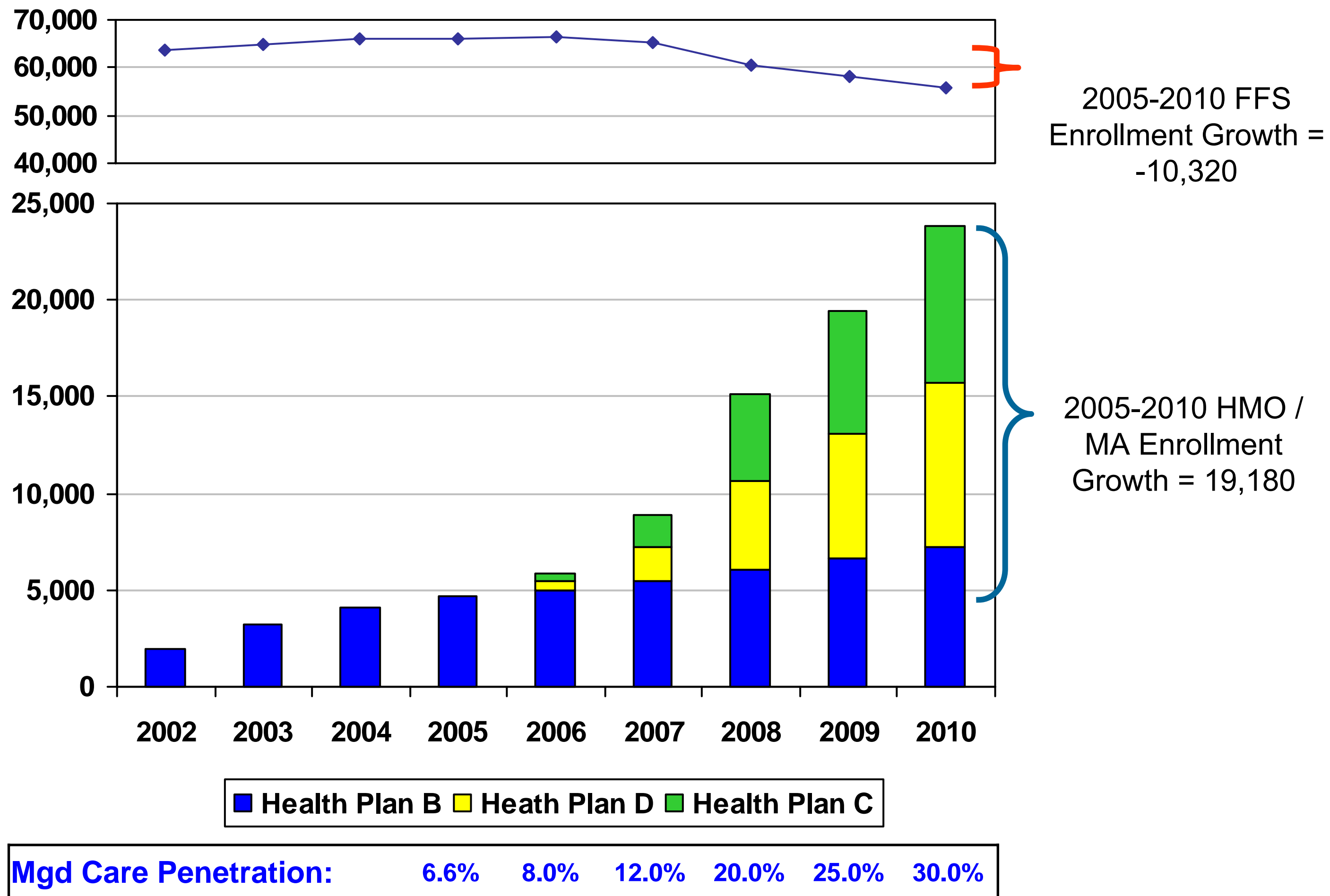
Enrollment Scenario 3: High Enrollment

If MA plans gain traction and federal subsidies continue, managed care plans could reach 30% market penetration and significantly shrink the FFS market.



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Assumptions for High Growth

MA plans establish a presence in [City] region and appeal to all segments.

- [Client] enters into early contracts with MA plans and becomes a participating provider when it is early enough to shift market share
- Enrollment in MA plans starts to pick up in late 2006, and then grows rapidly achieving a 30 percent market share within five years
- [Client] contracts with MA plans that agree to desired reimbursement rates and contract terms and agree to build their provider network around the [Client] regional network
- Federal subsidy of MA plans continues
- Private health plans aggressively pursue enrollment growth and view the participation of [Client] regional network as a major asset
- To assure access [Client] regional network is enhanced by adding other providers but [Client] has input into their selection
- MA plans perform well financially and provider reimbursement is equivalent to or exceeds traditional Medicare (including PBS)
- MA plan premiums and benefits are substantially better than traditional Medicare
- Health Plan A does develop an MA plan offering around its commercial PPO and agrees to pay [Client] the equivalent of Medicare rates
- Five-year enrollment projections indicate [Client] could increase its market share and operating margin

Medicare-Medicaid Dual Eligibles

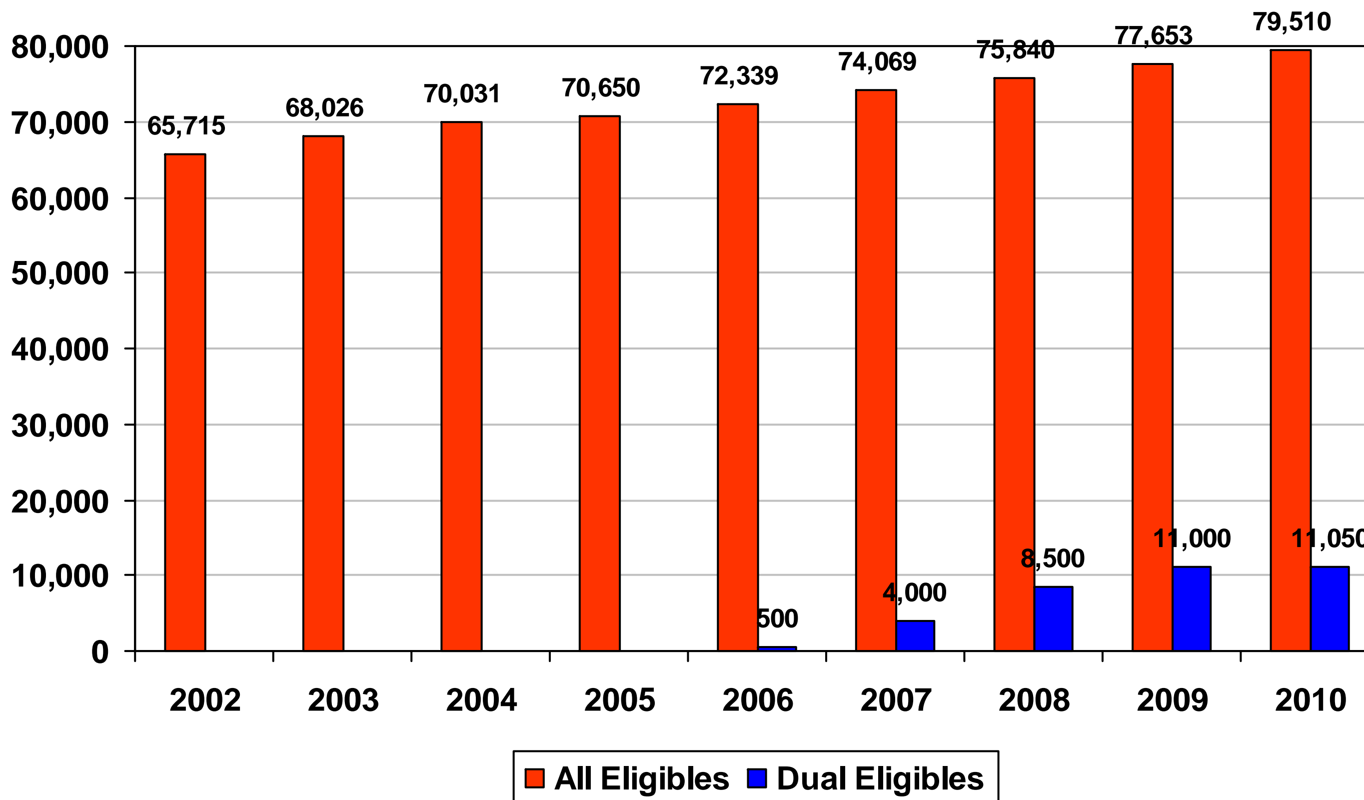
With [State] Medicaid reform, the dual-eligible population in [City] will likely be fully enrolled in some managed care plan in the next 5 years.

- Federal Waiver for Medicaid
  - The objective is to reduce the rapidly increasing cost of Medicaid
  - The plan is to shift more Medicaid recipients into managed care plans
- Proposed Medicaid pilot project for the region
  - The pilot would target Medicaid recipients 60 years of age and older, which would include the estimated 9,000 beneficiaries dually eligible for Medicare and Medicaid
  - [State] and the impacted counties would contract with two or more Medicaid managed care plans
    - Plans would accept partial or full risk for the care of the members
    - Recipients would be required to select of one the plans for their care (mandated enrollment) and would not be allowed to use the fee for service Medicaid program
    - The earliest possible date of implementation is July 1, 2006
    - A transition plan will have to be developed for dual eligible beneficiaries that have selected or been assigned to Medicare Part D plans
- Provider networks
  - Currently [Client] has several physician groups and programs that provide service to Medicaid recipients and dual eligible beneficiaries
    - U. of [State] residency program
    - Community Clinic
    - Pediatric group
  - To continue to provide service to this population, [Client] providers will need contracts as participating providers with the plans selected for the pilot project
  - Health Plan B have already indicated interest in applying
  - It is not clear at this point who the other plan(s) might be
- [Client] should consider expanding its participation with Health Plan B to be sure that its interested providers can continue to serve this population
- [Client] could also find another insurance partner or sponsor a Provider Sponsored Network

Enrollment of Dual Eligibles

By 2010 the [City] market will have 11,000 dual eligible seniors who will likely be fully enrolled in an MA plan with Medicaid reform.

Medicare Dual Eligibles Enrollment Projection in [City] (2005-2010)



Enrolled Dual Eligibles Share of All Eligibles:	0%	1%	5%	11%	14%	14%

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Forecast

Which scenario is most likely to happen?

- Scenario 2, initial growth of MA plans followed by decline is the most likely to occur
  - Scenario 2 will be driven by the major Medicare health plans (Health Plans C and D) who see an opportunity for profitable growth through the federal subsidy of private plans
  - Depends on the willingness of MA plans to pay providers at or above traditional Medicare rates
  - If [Client] does not participate in MA plans this will increase the probabilities for Scenario 1
  - But it will provide an opening for the (Clinic) and other providers to attempt to leverage Medicare Advantage
  - MA plans are focused on more populated regions of [State]
  - Sometime during 2006 they will turn their attention to the [City] region
- Difficult to predict due to political nature of the policy to privatize Medicare
  - Mid-term elections could lead to change
  - 2008 Presidential election could lead to change
- Key variables [Client] should consider
  - Focus on short-term decision--what to do for the next two to three years
  - If rules change [Client] may have to change course
  - Is this an opportunity to gain market share and increase margin?
  - Is this a threat to lose market share and margin?
- Recommended Strategy to achieve targeted increase in Medicare market share and margin
  - [Client] contracts with MA plans that can attract enrollment and will meet [Client] terms
  - When MA plans run into trouble [Client] provides a soft landing by shifting MA enrollment back to traditional Medicare and a [Client]-sponsored PDP plan
  - MA plan experience will prepare [Client] for [State]'s Medicaid Reform

Scenario Financial Outcomes Models

Declining share of a small MA market will still allow organic growth and return a modest operating margin benefit, but pursuing growth will increase the gain by additional 0.3% to 0.5% margin by 2010.

	Scenario 1		Scenario 2		Scenario 3	
	FFS	MA[1]	FFS	MA	FFS	MA
Baseline Incremental Change 2005-2010						
Segment Share	0.0%	-3.0%	0.0%	13.6%	0.0%	16.0%
IP Case Volume	556	195	157	908	(1,026)	2,399
Incr. Patient Days	2,930	1049	827	4,885	(5,407)	12,907
Incr. OP Visits	6,300	2,489	1,779	11,589	(11,625)	30,619
Overall Medicare Market Share Gain	**-0.1%**		**+1.6%**		**+4.4%**	
Incremental Financials (2005-2010)						
Contribution Margin ($000)	$3,286		$4,748		$6,230	
Operating Margin Change	+0.6%		+0.9%		+1.1%	
Operating Margin (FY05)	4.0%		4.3%		4.5%	

Note: For baseline incremental change calculations "MA" includes Health Plan B HMO cases reimbursed at current Health Plan B rates and new MA enrollment reimbursed at FFS rates.

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Scenario Sensitivity Analysis

Loss of dual eligibles volume would have a significant negative impact compared to an erosion of Health Plan B share in the growth scenarios. Potential additional contributions from higher reimbursement rates and higher MA utilization could mean 0.1% to 0.5% operating margin gain.

	Scenario 1		Scenario 2		Scenario 3	
	FFS	MA	FFS	MA	FFS	MA
Sensitivity Analysis – Incremental Financials						
Impact of Losing Dual Eligibles						
Contribution Margin ($000)	$(1,402)					
Operating Margin Change	-0.4%					
Operating Margin (FY05)	3.0%					
Impact of Health Plan B share declining 2% each year (2007-2010), ending at 26%						
Contribution Margin ($000)			$4,180		$5,563	
Operating Margin Change			+0.8%		+1.0%	
Operating Margin (FY05)			4.2%		4.4%	
Impact of MA plans reimbursing at Health Plan B rates						
Contribution Margin ($000)			$5,815		$7,553	
Operating Margin Change			+1.1%		+1.6%	
Operating Margin (FY05)			4.5%		5.1%	
Impact of MA enrollees at utilization rates equally between Health Plan B HMO and FFS						
Contribution Margin ($000)	$3,325		$5,023		$7,075	
Operating Margin Change	+0.6%		+0.9%		+1.2%	
Operating Margin (FY05)	4.0%		4.3%		4.6%	

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Assumptions for Projecting Impact

Compare five-year impact on patient volume and operating margin for each scenario.

- For all scenarios
  - Same organic growth rate of senior population
  - Market segment utilization rate (IP cases per 1000 pop.) expectation: FFS remains at 324; Health Plan B at 197 and and other MA plans at 239
  - Expected incremental OP visit volume per incremental IP case to stay constant at 11.3 per FFS discharge and 12.8 per HMO discharge, per FY05 actual rates
  - Impact is compared to FY05 results
  - New MA enrollment contribution margin based on current FFS rates
  - Dual eligibles are enrolled in state approved managed care plans; [Client] maintains its share
  - Additional working capital requirements with increasing patient volume: IP - $250,000 per incremental ADC of 10.0; OP - $100,000 per incremental 10,000 patient visits
- Scenario 1, Low growth, [Client] does not participate and loses some patients
  - In 2006 [Client] loses 5% of incremental MA volume
  - From 2007-2010, [Client] loses 10% of incremental MA volume as enrollment grows (gaining this share when enrollment begins to decline)
  - *Sensitivity analysis includes impact of losing existing share of dual eligibles at FFS rates if not participating with designated MA plan for this segment*
- Scenario 2, Initial growth and decline, [Client] participates early and gains share
  - 2006-2008 [Client] captures 65% of all new MA enrollees
  - [Client] maintains share of remaining FFS population
  - *Sensitivity analysis evaluates impact of MA plan volume reimbursed at current Health Plan B rates*
- Scenario 3, High growth, [Client] participates early and gains share
  - 2006-2008 [Client] captures 65% of all new MA enrollees
  - 2009-2010 [Client] captures 45% of all new MA enrollees (as Health Plan A enters with broad network)
  - [Client] maintains share of remaining FFS population
  - *Sensitivity analysis evaluates impact of MA plan volume reimbursed at current Health Plan B rates*

Ranking of Strategic Options

On a scale of one to five (best) how well do the options perform?

Criteria	Medicare Advantage Strategic Options		
	Don't Participate 340 PDP	***Delay Participation***	***Early Participation***
Increase Mkt Share	***2***	***3***	***5***
Increase Margin	***2***	***3***	***5***
Retain Patient Base	***2***	***4***	***5***
Alternative to HFN	***2***	***3***	***5***
Long-term Stability	***4***	***3***	***2***
Total	***12***	***16***	***22***

Branching Decision Tree

MA plans are the key variable.

- **If MA plans are willing to match or exceed Medicare reimbursement rates**
  - Contract with MA plans that will provide [Client] acceptable financial results, can attract substantial enrollment and agree to meet other desired terms
  - Could result in [Client] participating with several MA plans
  - Continue to develop PDP plan to attract Medicare beneficiaries that choose to remain in traditional Medicare and as a fall-back option if MA plans become unattractive
  - Enhance programs for seniors including preventive services and chronic disease management
  - Monitor patient satisfaction with MA plans
  - Monitor federal subsidy of MA plans and continued acceptability of reimbursement rates
- **If MA plans aren't willing to match or exceed Medicare reimbursement rates**
  - Don't contract with MA plans at this time
  - Focus on traditional Medicare program and develop alternative to MA plan offerings
  - Accelerate development of PDP and use it to compete with MA plans
  - Partner with a company that can attract substantial enrollment to the PDP program such as H PI A
  - Enhance programs for seniors including preventive services and chronic disease management
  - Monitor enrollment in MA plans
  - Monitor reimbursement rates in MA plans
- **Should [Client] limit participation to a single new entrant MA plan**
  - Limits growth potential and ability to shift market share
  - Limits short-term financial risk
  - Increases [Client] level of endorsement of MA concept and requires long-term commitment
  - Recommendation: [Client] should contract with MA plans that agree to desired terms without endorsing the MA concept or committing to the long-term viability of the product

Desired Contract Terms

What terms and conditions should [Client] request?

- Long-term contract (five years is desirable)
- Providers are reimbursed on a fee-for-service basis with no downside risk
- Reimbursement rates
  - Agreement to match provider based Medicare reimbursement rates for [Client]
  - 110 percent of Medicare for specialists
  - 110 percent of Medicare for inpatient hospital
  - Equivalent of 110 percent of Medicare for outpatient hospital and agreement to use discounted charges instead of APCs
- Opportunity to share in savings if targets are met
- MA plan provides medical management services
- Agreement not to develop a capitated Medicare Advantage HMO in the [City] area
- Agreement to build provider network around [Client] and to consult [Client] regarding addition of other providers to supplement regional network
- Agreement not to contract with (Clinic)

Appendix

- The Medicare Advantage program
  - ➡ National enrollment projections
  - ➡ The standard prescription drug benefit
  - ➡ Part D drug benefit: Example of plan options
  - ➡ Seniors with chronic disease rely on prescription drugs
  - ➡ Local MA-PD and PDP Plans
    - [City] counties' MA plan landscape
    - [State] PDP plan landscape
- 340B outpatient prescription drug program
- [City] regional service areas

The Medicare Advantage Program

MMA contains a number of provisions that shift responsibility for Medicare to the private sector.

- The prescription drug benefit in not provided directly by Medicare. It can only be obtained from stand-alone PDPs or MA-PDs--private contractors that are typically insurance companies or health plans
- MMA creates two types of Medicare Advantage plans, regional and local
  - The local plans continue the M+Choice program and serve individual counties
  - Local plans are typically HMOs but can also include local PPOs and private fee-for-service plans (PFFS)
- A major MMA initiative is the creation of Regional PPO plans
  - They must serve all parts of a geographic region
  - Regional PPOs were created to increase choice for beneficiaries and provide access to private plans to rural beneficiaries
  - Regional PPOs must have a network of contracted providers but must also reimburse for all covered benefits regardless of whether such benefits are provided within the network
- To foster the development of Regional PPOs, MMA provides the following incentives and protections:
  - Risk sharing (up and down) with plans for the first two years
  - A $10 billion stabilization fund to protect plans from losses
  - A network adequacy fund to assist plans in contracting with rural hospitals
  - Increased payments by having plan bids affect the calculation of benchmark amounts
- Payments of Medicare Advantage plans of all types will change to a competitive bidding system against a benchmark beginning in the 2006 contract year and the risk adjustment system that has been phased in over the past several years will be fully implemented by 2007

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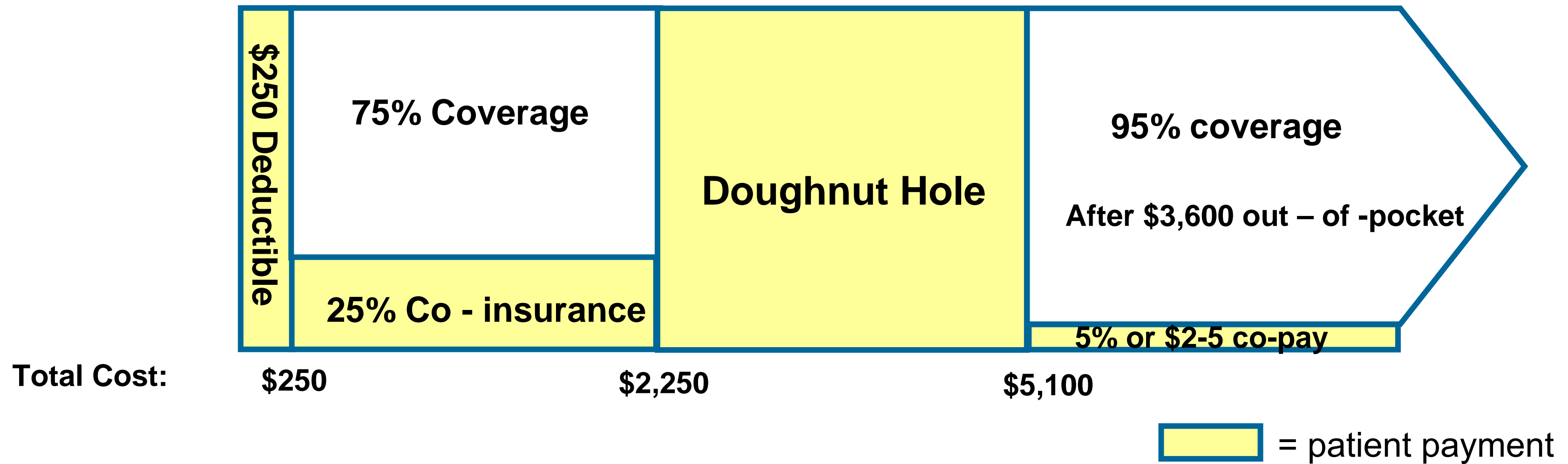
National Enrollment Projections

The Administration projects that almost 70% of beneficiaries will enroll in Part D.

- In 2006, 29.3 million Medicare beneficiaries (or 68 percent of the estimated 43.1 million Medicare beneficiaries) are projected to enroll in the Medicare prescription drug program
- Another 9.8 million or 23 percent are expected to get prescription drug coverage from an employer plan
- 14.5 million or 34 percent are estimated to be eligible for low income subsidies and 10.9 million are expected to receive them
- The net federal cost of the Medicare drug benefit is estimated to be $37 billion in 2006 with approximately 25 percent of the financing paid by beneficiary premiums
- The net federal cost is projected to be $724 billion between 2006 and 2015

The Standard Prescription Drug Benefit



- All plans must offer at least this much “actuarially equivalent” coverage
- Plan offerings vary in premiums, deductibles, co-pays, coverage gaps, drug formularies, and in-network pharmacies
- Insurance companies typically offer three levels of benefits at varying costs
- These threshold limits are indexed to rise with the growth in per capita Medicare drug spending

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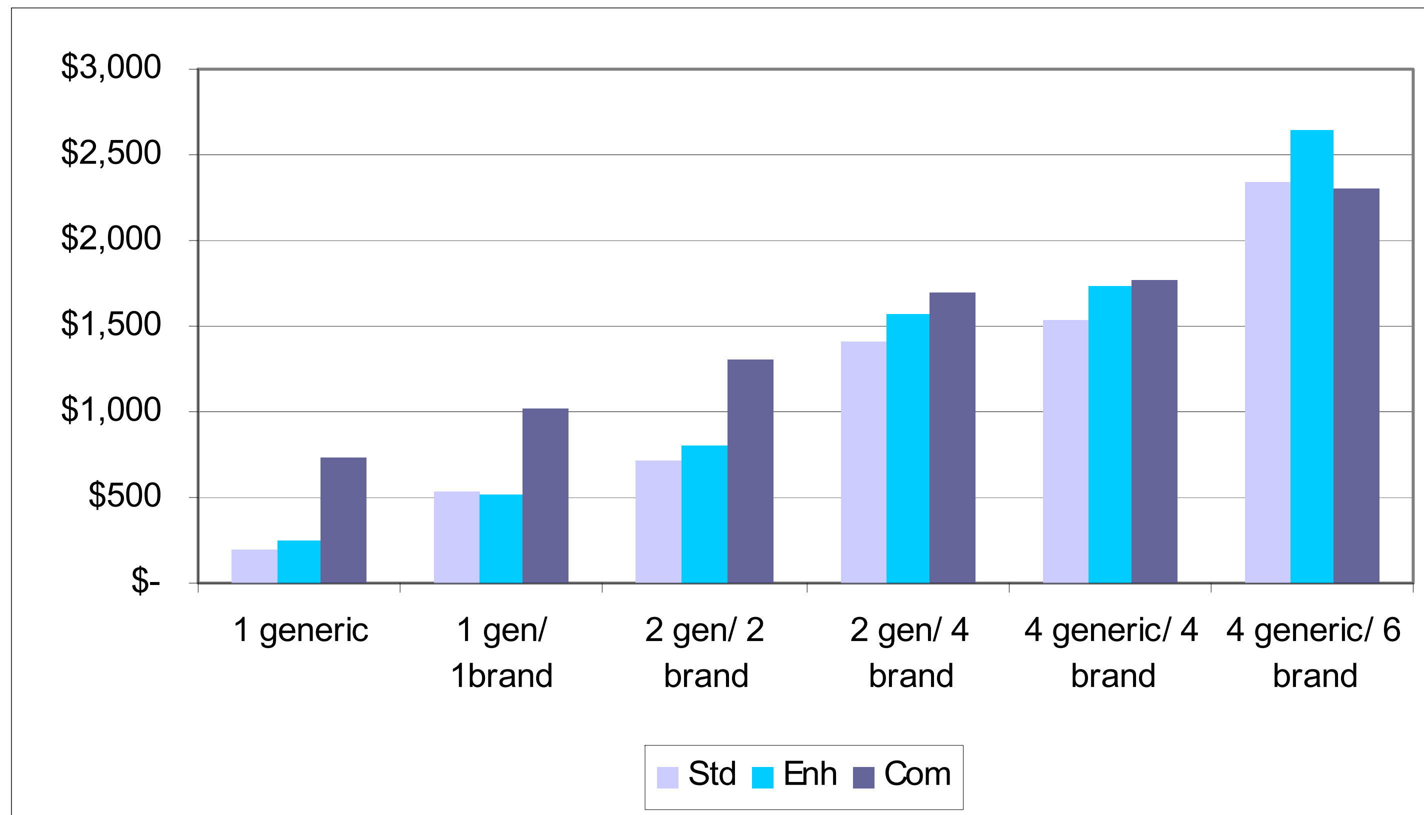
Part D Drug Benefit: Example of Plan Options

Standalone plans within a health insurance company's offerings are available at multiple levels of benefits.



Source: Health Plan D PDP plan on-line calculator, December 2005; BDC Advisors, LLC Analysis.

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Seniors with Chronic Diseases Rely on Prescription Drugs

Drug spending is highly skewed.

- Average per capita drug spending among the Medicare population is projected to be $2,864 in 2005
  - 10 percent of beneficiaries have no drug costs
  - Another 10 percent are projected to have expenses of $250 or less
  - In contrast, 18 percent of beneficiaries are projected to have total drug costs of $5,100 or more in 2005, accounting for 57 percent of total drug spending on behalf of Medicare beneficiaries
- The cost of healthcare for seniors continues to rise
  - In 2002 beneficiaries total per capita medical and long-term care expenses was $11,714 and Medicare covered only 45 percent
  - Beneficiaries paid, on average, 19 percent of total expenses or $2,223 out-of-pocket with most of this spending for services and benefits not covered by Medicare or with coverage limits including long-term care, prescription drugs and dental services

MA Plan Landscape – [City] MSA

Description							Cost					Coverage				Convenience
		Type of Medicare Advantage Plan							Drug Deductible				Additional Drug Coverage in Gap			
Organi-zation Name	Plan Name	HMO	Local PPO	Regional PPO	P-FFS		Beneficiary Total Premium* (Incl Drug Premium)	Beneficiary Drug Premium*	Zero	Reduced	Std ($250)	Includes Tiered Copayments for Drugs	Generics Only	Generics & Brands	Number of Top 100 Drugs on Formulary	Mail Order Offered

Note: Plans available for [County]. Includes contracts / plans approved as of October 10, 2005. The data does not reflect PACE organizations, employer sponsored plans, or HCCP Cost Plans.

* The beneficiary total premium for Medicare Advantage, Cost Plans and Demonstrations covers Medicare medical and hospital benefits, and prescription drug benefits and supplemental benefits, where offered. The beneficiary drug premium is the portion of the total premium that covers prescription drugs only; plan premiums vary for these benefits. Beneficiaries generally are also responsible for the Part B premium.

Dashes (-) indicate Medicare Advantage only plans (no Part D drug coverage).

Source: CMS – December 2005.

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Standalone PDP Plan Landscape – [State]

Description		Cost					Coverage				Convenience
		Beneficiary Total Drug Plan Premium*	No Premium with Full Low Income Subsidy	Drug Deductible			Includes Tiered Copay-ments for Drugs	Type of Additional Coverage Offered in Drug Coverage Gap		Number of Top 100 Drugs on Formulary	Mail Order Offered
Organization Name	Plan Name			Zero	Reduced	Standard ($250)		Generics Only	Generics and Brands		

Note: The beneficiary drug premium covers prescription drugs only and does not cover medical or hospital benefits. Beneficiaries are also responsible for their Part B premium and any premiums for Medigap coverage to meet their individual needs. Includes contracts / plans approved as of October 10, 2005. The data does not reflect information for PACE organizations, Employer sponsored plans, or plans that were not approved by the "As of" date of the chart.

Source: CMS – December 2005.

[City] Regional Service Areas

[Map]