PSERS — HOP HEALTH OPTIONS PRORAM — WWW.HOPBENEFITS.COM

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Date: April 14, 2010

Subject: Medicare Advantage and Companion Pre-65 Plans for 2011 – Disposition of Legacy Plans

To: Board

From: Mark Schafer

As a result of a request for proposal (RFP) issued in April 2008, PSERS selected Highmark as the sole Medicare Advantage and pre-65 managed care plan available through the Health Options Program (HOP) effective January 1, 2009. HOP members enrolled in other Medicare Advantage and companion pre-65 plans prior to January 1, 2009, were permitted to continue their participation in these plans (referred to as "legacy" plans), but new members and those members wishing to change their coverage during an annual option selection period had the following options:

For Individuals Eligible for Medicare	For Individuals Not Yet Eligible for Medicare
▪ HOP Medical Plan	▪ HOP Pre-65 Medical Plan (without prescription drug coverage)
▪ Enhanced Medicare Rx Option	▪ HOP Pre-65 Medical Plan (with prescription drug coverage)
▪ Basic Medicare Rx Option	
▪ HOP Managed Care Plan by Highmark	▪ HOP Pre-65 Managed Care Plan by Highmark

At the time of the Highmark selection, Medicare Advantage Private Fee for Service (MA PFFS) plans were permitted to operate without contracted network providers. We were also expecting that Highmark would merge with Independence Blue Cross (IBC). Since then two things occurred which changed the health insurance situation within Pennsylvania. First, Congress passed a law requiring MA PFFS plans to establish networks of contracted providers by January 1, 2011 and second, the expected merger between Highmark and IBC failed to materialize. While these two factors impacted Highmark's ability to provide a single Medicare Advantage and companion pre-65 plan, there was a further development which potentially mitigated their effect. The national Blue Cross Blue Shield Association (BCBSA) implemented a network-sharing program for Medicare Advantage PPO plans sponsored by Blues groups across the country. That network sharing program was introduced as a pilot test in 2010 and is planned to go into full effect in 2011 as the network requirements become effective.

Considering the network sharing initiatives of the National Blue Cross Blue Shield Association, PSERS decided to keep the legacy plans operational for the 2010 plan year. While these plans were still closed to new members, HOP members enrolled in these plans were not required to change to one of the above noted options.

In March 2010, Congress passed the "Patient Protection and Affordable Care Act" and the "Health Care and Education Reconciliation Act of 2010." These laws change the funding of the Medicare Advantage program. Simply stated, the Center for Medicare and Medicaid Services (CMS) will be reducing payments to Medicare Advantage plans over the next several years.

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CMS has already impacted Medicare Advantage program funding by keeping federal payments to these organizations virtually static for 2010 and now for 2011, while medical care costs continue to increase 6% or more per year. Industry observers expect this shift in funding to dramatically increase the premiums paid by those enrolled in Medicare Advantage plans as the carriers pass along the lower subsidy levels from CMS. Managed care organizations offering Medicare Advantage plans have already cut benefits and increased premiums for 2010 and now may retreat from unprofitable service areas or terminate some or all of their Medicare Advantage products.

With this as background, we are at a decision point for the 2011 plan year. The alternatives are:

A. Proceed with the implementation of a single Medicare Advantage plan and companion pre-65 plan by Highmark and terminate the legacy plans of Aetna, Amerihealth, Humana, Keystone - Central (Capital Blue Cross), Keystone – East (IBC), and University of Pittsburgh Medical Center (UPMC). The mechanics of this approach would require us to notify approximately 4,000 HOP participants (10,000 if we include those enrolled in the Highmark Keystone West HMO) that they must select a new HOP plan for coverage effective January 1, 2011. Individuals failing to select a new plan would be auto-enrolled in Highmark.

   - The 2,700 HOP members enrolled in Keystone – Central and Keystone – East should experience minimal provider disruption with the BCBSA network sharing agreement in effect. This assumes, however, that Blue Cross and Blue Shield organizations do not reduce their PPO service areas or terminate their PPO products entirely. Members moving to Highmark may pay higher premiums and/or higher out-of-pocket payments for services.

   - The 1,000 HOP members enrolled in Aetna, Amerihealth, and Humana will likely experience significant provider disruption, especially in New Jersey where there is no Blue Cross and Blue Shield Medicare Advantage PPO product. Members moving to Highmark may pay higher premiums and/or higher out-of-pocket payments for services.

   - The 200 HOP members enrolled in UPMC will not experience any provider disruption as UPMC providers are a subset of the Highmark PPO network. They may, however, possibly experience significant premium increases.

   All Medicare Advantage participants will likely incur higher premiums and/or higher out-of-pocket payments for services as a result of the cutback in federal funding. Some of the premium increases and/or benefit reductions, experienced by legacy plan participants moving to Highmark, would occur even if the legacy plans were maintained.

B. Abandon the implementation of single Medicare Advantage plan and companion pre-65 plan by Highmark and provide legacy plans and other managed care organizations that qualify with the opportunity to contract with PSERS to provide a Medicare Advantage and pre-65 plan through HOP. The mechanics of this approach would be to develop a “standard” contract and give managed care plans (including the frozen legacy plans) a mechanism to participate in HOP for new and existing members. Managed care plans would need to apply for approval under the stated criteria to be included in the standard contract and that would apply to all approved plans. Legacy managed care plans that will not enter into a contact with PSERS will be terminated and their enrollees given the opportunity to select another HOP plan or default to Highmark.

- While the longer-term outlook for Medicare Advantage plans is cloudy, there are still solid plans available in the marketplace at good values for retiree participants. Some managed care organizations appear to remain committed to the Medicare Advantage product line. By maintaining Medicare Advantage plans for as long as they remain viable, PSERS helps to fulfill its mission to offer reasonable plan options to eligible retirees.

- The functionality of the BCBSA's network sharing program, while well-conceived in theory, and while tested during 2010 for most of the Blues organizations across the country, nevertheless will still be new for 2011 for Independence Blue Cross and may not offer a seamless transition of HOP managed care plan participants in the Independence Blue Cross five-county market area around Philadelphia.

- The standard contract approach would put all qualified managed care plans under a common set of contract provisions, performance standards and operating procedures. Even if the type of plans to be offered under such a contract had to change as the Medicare Advantage market place changes, PSERS would have an ongoing structure and approval process to help keep all participating carriers engaged in fair competition.

The recommendation of the staff, which is supported by the Segal Company, is to provide Highmark, the other legacy plan carriers, and other managed care organizations the opportunity to contract with PSERS to provide a Medicare Advantage and pre-65 plan through HOP effective January 1, 2011. This recommendation is supported by the following:

1. CMS' reduction in the funding of the Medicare Advantage program is likely to cause a reduction in the availability of plans. It is impossible to predict with any certainty the number, type and service areas of Medicare Advantage plans going forward. Offering several Medicare Advantage plans should increase our ability to continue to offer HOP participants throughout the Commonwealth a Medicare Advantage alternative while these plans are still available.

2. While the BCBSA network sharing initiative addresses the CMS requirement that Medicare Advantage (MA-PFFS) plans have provider networks, the initiative only impacts PPO (Preferred Provider Organization) plans. If a Blue Cross organization has a Medicare Advantage HMO but not a PPO, there would be no network sharing capability. Since the PPO plans are not as cost effective as HMO plans, the PPO plans would likely be among the first plans to be dropped by managed care organizations as funding for Medicare Advantage is cut.

3. The "legacy' plans have been frozen to new participants for two years; 2009 and 2010. When a plan cannot add participants who may bring a lower cost level to the program, its costs will increase as the average age of the group increases. Keeping these plans frozen for an extended period of time will cause the premiums paid by our members to increase to a point that the plans will have to be terminated.

Attached is a draft proposed resolution to approve contracting with Medicare Advantage and companion pre-65 managed care plans to participate in HOP effective January 1, 2011.

We look forward to reviewing this matter with you at the upcoming Health Care Committee meetings.

Attachment

Proposed
PSERB Resolution 2010 - _____
Re: Health Options Program
Medicare Advantage and Companion Pre-65 Plans for 2011
April 29, 2010

RESOLVED, that the Health Care Committee of the Public School Employees' Retirement Board (the "Board") hereby recommends that the Board approve contracting with Medicare Advantage and companion pre-65 managed care plans to fully participate in HOP effective January 1, 2011 in accordance with the attached recommendation of Mark Schafer as presented at the April 29, 2010, Health Care Committee meeting.