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MEDICARE AND SOCIAL SECURITY TOPICS

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- o Emerging trends in government financing, availability and scope of public programs.
- o Medicare supplement products implications.
- o New opportunities for the private sector (e.g., Medicare Health Maintenance Organizations).
- o Future Federal Insurance Contributions Act Tax.

MR. RICHARD S. FOSTER: The term social security often means different things to different people. I use the term to mean old-age and survivors insurance (OASI), disability insurance (DI), hospital insurance (HI), and supplementary medical insurance (SMI). The first three of these programs are financed primarily by the social security payroll tax, currently 7.05 percent on earnings up to a maximum of 39,600 dollars and payable by employees and employers. Of the total tax rate, OASI receives 5.2 percent, DI receives 0.5 percent, and HI (Part A of medicare) receives 1.35 percent. The SMI program (Part B of medicare) is financed primarily from general revenues and premiums paid by the program participants.

In 1985, the social security program will pay 260 billion dollars to its various beneficiaries. The program promises to continue paying benefits so long as participants remain eligible for them - usually for the rest of their lives. The program promises to increase benefits according to cost-of-living and medical care costs. Currently, there are many legislative proposals to scale back these promises.

If current workers continue to work and pay social security taxes, they and their families will receive benefits when they retire or become disabled or die. A person starting work at age twenty retiring forty-five years later, and then living another thirty years implies continuing obligations for the next seventy-five years and more. The

Office of the Actuary at the Social Security Administration and the corresponding office at the Health Care Financing Administration must ensure that the program can make good on its promises.

Projections of program costs under alternative sets of actuarial assumptions indicate how the program would operate in the future under a wide range of reasonably expected economic and demographic conditions. The substantial uncertainty inherent in such endeavors virtually guarantees that any specific forecast will be inaccurate, even in the short range. The projections are valuable for planning and measuring future financial obligations, but their limitations must be remembered.

The Boards of Trustees for the social security trust funds issue annual reports to Congress on the funds' financial status. The information in charts 1 through 5 is drawn from the material in the 1985 reports.

Chart 1 shows OASDHI income, expenditures, and trust fund assets in dollar amounts from the beginning of the program through the present, and projected future amounts based on the intermediate "II-B" assumptions from the 1985 Annual Reports. It is difficult to distinguish income and expenditure curves, illustrating the "current cost" or "pay-as-you-go" financing that has been in effect for the program. Most people would no longer characterize the long-range financing for the OASDI program as current cost.

Prior to the mid-1970s, trust fund assets were maintained level with annual expenditures. With the adverse economic conditions of the last decade, however, asset levels declined and only recently have begun to increase as a result of the social security amendments of 1983. With current cost financing, trust funds are contingency reserves. When outgo temporarily exceeds income, as in an economic recession, trust fund assets should meet the shortfall. If economic or other trends prove worse than assumed when financing was established and short falls occur for an extended period, the trust funds can allow time for legislation to restore financial balance to the program. To date, there has been no accumulation of large funds equal to accrued liabilities - the goal for private pension plans.

The table in Chart 1 shows that during the first forty-eight years of the program's operation, total OASDHI income amounted to 2,041 billion dollars, and total expenditures were 1,995 billion dollars. The difference of 46 billion dollars was the trust fund amount at the beginning of 1985. In the next five years, the OASDHI trust funds will take in and pay out amounts almost as large as the totals for the prior forty-eight years.

Chart 2 shows the recent operations of one trust fund. At the beginning of January 1982, the OASI trust fund held 21.5 billion dollars in assets. Approximately 11.0 billion dollars in benefits were paid out on January 3, 1982, dropping the remaining assets to 10.5 billion dollars. During the balance of January as tax income was received from employers, assets built back up to about 20 billion dollars. This level dropped sharply with the payment of benefits in February, and

the trust fund progressed in a zig-zag fashion but with a generally downward trend during 1982.

At the beginning of November and December, asset levels dropped to almost zero following the payment of each month's benefits. This resulted from temporary legislation to postpone the OASI financing crisis until a more permanent solution could be found. This legislation allowed the OASI trust fund to borrow assets from the DI and HI trust funds, but limited the borrowing at any time to the amount needed to cover shortfalls for six months. Also no loans could be made after December 31, 1982. At the beginning of November and December, just enough assets (0.6 billion dollars and 3.4 billion dollars, respectively) were borrowed to enable OASI benefit payments to be made. At the end of December, another 13.5 billion dollars was borrowed to cover anticipated deficits for January to June 1983.

Chart 2 shows through the first part of 1983, assets continued downward. The 1983 amendments changed the whole picture. Beginning in May 1983, the OASI and DI trust funds are now credited with most tax income estimated on the first day of each month, rather than uniformly throughout the month. Thus, the curve takes a sharp upward jump in May 1983 with the receipt of 10 billion dollars in advance tax transfers. This money was held for a few days then drawn down to pay May benefits. Assets no longer build up during the remainder of the month, since most tax income for the month has already been received. Also in May 1983, the curve takes a large upward movement of 17.5 billion dollars reflecting lump-sum payments from general revenues for military service wage credits. Prior to the 1983 amendments, the funds were reimbursed in installments for the cost of these credits. Reimbursement was modified to expedite providing immediate income to the trust funds (from general revenues), since tax and benefit changes required more time to take effect than was available.

For the balance of 1983, assets continued to decline but with the tax rate increases, coverage changes, and 1984 amendments, assets finally began to increase.

Chart 3 summarizes the current short-range financial outlook for each of the four social security trust funds. These graphs show the ratio of assets to annual expenditures or "trust fund ratios" under the four alternative sets of assumptions used in the Trustees Reports. OASI assets are expected to remain at relatively low levels through about 1987, partly because of the repayment of interfund loans during this period. With the tax rate increases scheduled in present law for 1988 and 1990, the trust fund will increase rapidly, depending on the rate of economic growth. By the early 1990s, OASI trust fund ratios will substantially exceed the levels normally associated with pay-as-you-go financing, barring adverse economic conditions. Under most kinds of economic conditions, the OASI trust fund should operate satisfactorily in the short range; until the anticipated growth in assets has occurred, however, the fund could be vulnerable to extremely adverse economic conditions.

The situation of the DI trust fund is uncertain. Under most economic conditions, the trust fund is expected to operate satisfactorily. Depending on the effect of recent disability amendments, the trust fund could experience difficulties - particularly if the economy performs poorly. Under the adverse "alternative III" assumptions, the trust fund would be unable to pay benefits on time beginning late in 1987. The actual effect of the amendments and other recent experience on disability incidence and termination rates will have to be monitored very closely.

Total OASI and DI trust fund income is projected as adequate to cover total program expenditures under each of the alternative sets of assumptions. After 1987, however, there is no authority to transfer assets from one fund to another, except to repay prior interfund loans, which must be repaid before 1990. While the DI deficit under alternative III could be offset by projected OASI surpluses, new legislation (such as a reallocation of tax rates between OASI and DI) will be required.

Chart 3 indicates that HI income and assets are expected to be adequate during the next ten years under all but the pessimistic assumptions. Under all but alternative I, however, the HI trust fund would be depleted by the end of this century. Based on the alternative III assumptions, this depletion could occur as early as 1992.

The HI projections based on alternatives I, II-A, and II-B are substantially more favorable in the short range than those shown in the 1984 Annual Report. Primarily this improvement is because the Secretary of Health and Human Services has tentatively set hospital prospective payment rates for fiscal year 1986 at the same level as for 1985. Also, the Deficit Reduction Act of 1984 reduced the "limiting annual increase" in such rates to the increase in the hospital input price index plus .25 percent (rather than the increase in the index plus 1 percent). For alternatives I, II-A, and II-B, the payment rate "freeze" in 1986 is assumed; for alternative III, the Health Care Financing Administration (HCFA) actuaries assumed that the "freeze" would not occur, and the increase in payment rates would be based on the price index plus .25 percent, as is assumed for all later years under each set of assumptions.

The resulting improvement in the short-range financial status of the HI program prompted a headline in the Washington Post reading "Medicare's Hospital Fund is Now Sound." The article stated "The giant Medicare hospital trust fund, which the Reagan administration last year predicted would go bankrupt by 1991, now looks financially sound until near the end of the century."

Few actuaries will be comforted by this seven-year postponement of the trust fund's depletion. The long-range problems of the HI program will not be eliminated by lower payment rates.

Chart 3 shows trust fund ratios for the SMI program. The financial status of SMI receives little attention because of the "automatic" nature of the program's financing (whereby premiums and general revenue

income are redetermined annually) which results in fairly close balance each year between income and outgo. Currently, SMI assets are more than sufficient to cover estimated levels of incurred but unpaid claims, which is the primary test used by the trustees to judge the financial status of SMI. It surprises many people, that the annual cost of the SMI program recently surpassed that of the DI program and is expected to exceed the latter by forty percent in only three years. While longer-range projections for the SMI program are not available, this rapid level of growth in expenditures is not likely to diminish of its own accord soon.

Chart 4 shows long-range OASDI and HI projections of income and expenditures as a percentage of taxable payroll, based on alternative II-B assumptions. It is clear that past "income rates" and "cost rates" have generally been close. Future OASDI income rates (comprised of the scheduled employee-employer payroll tax rates, plus income from the taxation of OASDI benefits) are projected to exceed OASDI cost rates substantially for a number of years. After about 2020, the reverse will be true, and substantial deficits will occur. The implications of this massive surplus/deficit pattern may be put in perspective by considering that the recent worrisome financing problems, receiving such great news media attention, were largely attributable to the relatively small deficits that are indicated on the graph between 1975 and 1982.

If the pattern of large OASDI surpluses followed by even larger deficits is allowed to occur in the future, then average income would be about 12.9 percent of payroll under alternative II-B and average costs would be about 13.3 percent. The resulting average deficit of 0.4 percent is within the tolerance for "close actuarial balance"; the long-range financing is considered acceptable according to the usual criteria. The somewhat unusual manner in which the criteria are met, however, and the strong possibility that any OASDI surpluses would be needed to offset HI deficits, suggests that the long-range status of the OASDI program should be watched carefully.

The HI projections shown in Chart 4 indicate that after about 1990 expenditures will greatly exceed scheduled tax income. While the limitation on prospective payment rates for 1986 would help to restrain expenditures, such a "freeze" would probably be required about every five years to eliminate the deficits projected under alternative II-B. On average, over the seventy-five year projection period, HI cost rates would be about 5.7 percent of taxable payroll compared to 2.9 percent for scheduled tax income. The resulting deficit of 2.8 percent implies that, on average, HI tax rates would have to be doubled or benefits cut in half.

Combining the projections in Chart 4 for OASDI and HI, total expenditures currently represent about 14 percent of taxable payroll. Under alternative II-B, this cost would increase to about 23 percent. Using the more optimistic assumptions from alternative I, total costs would initially decline to about 11 percent before returning to about 15 percent. Under more adverse conditions of alternative III, costs would rise steadily to over 40 percent of payroll. The total tax income

scheduled under present law for OASDI and HI would be adequate to cover combined program expenditures in the long range only under alternative I.

A comparison of the projected numbers of workers and beneficiaries is shown in Chart 5 under the alternative sets of assumptions. Currently there are about thirty OASDI beneficiaries per one hundred covered workers. This ratio has declined slightly in recent years, as the baby-boom generation has entered the labor force. In addition, birth cohorts from the Depression years will soon be reaching retirement age; since these cohorts are smaller in size than the generations on either side, the number of new beneficiaries will be relatively low during 1990-2000. Thus, demographics will have an unusually favorable effect for the balance of this century.

After the turn of the century, the size of the workforce will stabilize (due to the recent low birth rates) and the baby-boom generation will begin to retire. The ratio of beneficiaries to workers is expected to increase substantially. Even under extremely favorable demographic conditions (alternative I), this ratio would increase by about 40 percent relative to today's levels. If birth rates fall somewhat from recent levels, and life expectancy continues to improve quickly, then the ratio could climb to over eighty beneficiaries per one hundred covered workers (alternative III). These projections reflect the partially offsetting effect of the higher retirement ages enacted with the 1983 amendments. The range shown clearly indicates the level of uncertainty inherent in such long-range projections. Nonetheless, substantial increases in this ratio would occur under present law, regardless of the particular demographic conditions in the future.

The various charts and figures presented in this summary are merely an overview of the information that is available to the diligent reader in the 1985 Trustees Reports. A careful study of the reports will provide sufficient information to allow an individual to reach his or her own legitimate conclusions concerning the financial status of the social security program.

MR. ROBERT J. MYERS: PRESENT FINANCING STATUS OF OASDI

Many public critics of the OASDI program assert that it is doomed to failure and bankruptcy soon. Unfortunately, many, especially younger people, are convinced of this.

The social security amendments of 1983 were intended to solve the financing problems of OASDI, both over the short range and over the long run. The short-range estimates (for the 1980s) were used for developing the financing of the system and were based on several different sets of assumptions about future economic conditions. However, the actual financing provided was developed on the basis of pessimistic ones. Economic conditions have been better than the intermediate estimate. As a result, the balance of the combined OASI and DI trust funds as of September 30, 1984, was .5 billion dollars higher than the original pessimistic cost estimate, and 2 billion dollars higher than the intermediate cost estimate.

Thus OASDI probably will have no financing problem in 1985-87. Then no problems should arise for at least several decades thereafter. This is because the OASDI tax rate increases substantially in 1988, and again in 1990, and the demographic situation will be favorable for some years to come because the number of persons reaching retirement age each year is ceasing the steady rise that has occurred (due to the annual number of births in 1925-39 being lower than in preceding and succeeding years).

Another evidence of the favorable financial status of OASDI is that, in January 1985, OASDI was able to repay part of its loans from DI and HI (2.5 billion dollars to DI and 1.8 billion dollars to HI), much earlier than thought likely.

Precise cost estimates cannot be made for many decades into the future. However, the intermediate cost estimate for the next seventy-five years seems reasonable. According to it, OASDI will be in close actuarial balance over this period.

CURRENT PROPOSALS FOR INDEXING OASDI BENEFITS

Both OASDI benefits and private pensions should be indexed to maintain the purchasing power they had when initially granted. This is equitable and desirable, as long as it is financially feasible and supportable. In some instances, this may seem too costly, especially if the initial level of pension benefit is too high or is made available at too young a "retirement" age. The high cost is then blamed on the other factors, not on indexing per se.

OASDI benefits have been indexed by the changes in the CPI ever since 1975 and will continue to be, except possibly when the trust-fund balance is unduly low. The CPI may not be a perfect tool for indexing, but it is certainly the best now available.

The indexing of OASDI benefits should not be done under any and all circumstances. If there is a financing problem in doing this, then indexing should be lessened, or even temporarily suspended. The legal provision for such reduction could be more stringent than at present.

However, I do not agree with those currently suggesting lowering or reducing the cost-of-living adjustment (COLA) for December 1985 solely for reducing the general-budget deficit. The OASDI program is not responsible for this deficit and should not be required to help solve it. Furthermore, the trust funds have sufficient resources to finance this COLA.

OTHER CURRENT DEVELOPMENTS AND PROPOSALS FOR OASDI

Although the short-range financial experience of OASDI has been satisfactory, that of the DI portion has taken a turn for the worse. This is because the enforcement of disability reviews for those on the rolls is easing-up and eventually will be ceased. Such reviews had been legislated in 1980 but were initially too vigorously enforced by the Reagan Administration. Legislation in 1983-84 provided for less

vigorous reviews, and it appears that there has been less strict initial determination of disability in recent months.

Disability cost estimates are difficult to prepare with any precision. The 1985 Trustees Report indicates that, if the DI experience worsens significantly, it will be necessary to reallocate more of the OASDI tax rate to the DI trust fund to maintain solvency. This can be done without adversely affecting the OASI trust fund.

The 1983 amendments made a great step forward in providing adequate financing for OASDI aggregately over the seventy-five year valuation period. The financing theory under present law is to build up a large fund during 1990-2020 and then liquidate it to meet the excess of outgo over income in subsequent years. Under the intermediate-cost estimate, the relative peak of the fund balance (in about thirty years) will be as much as five times annual outgo. Such a situation, involving a fund balance of about 7-8 trillion dollars (or 2 trillion dollars in 1985 dollars), is unrealistic and hardly proper to finance a national social insurance program. This undesirable buildup should be prevented by an automatic-adjustment procedure that would lower the OASDI tax rates when the fund balance exceeds 50-60 percent of annual outgo. Similarly, the tax rates would be increased when the fund balance falls under this range.

PRESENT FINANCING STATUS OF MEDICARE

Even though OASDI is in good financial condition, the hospital insurance portion of medicare is not. All estimates for HI indicate that income from payroll taxes will be insufficient to finance outgo, and that the balance currently accumulated in its trust fund will be exhausted.

The supplementary medical insurance portion of medicare has no direct financing problems, because the enrollee premium rates and the matching amounts from the general fund of the Treasury are established on a year-by-year basis and can be increased as future costs arise. Of course, these costs (to the enrollees and the federal government) might increase to levels which are too burdensome; but this is a financial matter, not a financing one.

Estimates differ when the HI trust fund will be exhausted under the present benefit and tax-rate provisions. According to the 1984 Trustees Report, this point of crisis will be during 1991 under the intermediate estimate, 1989 under the pessimistic estimate, and 1995 under the optimistic estimate. The 1985 Trustees Report presents a much brighter picture -- 1998 for the intermediate estimate, 1992 for the pessimistic estimate, and 2025 for the optimistic estimate. The more favorable expected future experience is largely due to reductions in assumed reimbursement rates for hospitals. Whether this can be achieved by producing greater operating efficiency and reduction of "unnecessary" services, or whether it will result in poorer medical care is a question.

But what if hospital costs increase so much over the long run that either HI benefits will have to be sharply reduced or unbearable HI tax

rates will be required?

If the solution is to reduce benefit protection, then how will the difference be made up? It is inconceivable that we will ration or refuse medical care of high quality to anybody. If medicare does not meet a substantial portion of the cost, the burden will have to be borne by individuals, their former employers, and the government through medicaid (i.e., by the general taxpayer).

Certainly, some greater efficiency and lower costs in the medical-care delivery system can be developed, but there is little room for significant improvement. Changes in the method of delivery--such as greater use of ambulatory surgical centers and requiring more second opinions as to surgery--will help to hold down rises in medical-care costs. However, new, beneficial but costly procedures will continue to be developed.

What if the tax rates for OASDI and HI would have to rise to a very high level some four or five decades hence? This load would be unbearable if it went into effect in a few years. Because the increase would go into effect gradually, it could readily be borne by the working populace, and they would still have increasing real earnings - thus a rising standard of living.

Earnings will almost surely increase more rapidly than prices over the long-distant future, just as in the past. Part of this increase could be devoted to meeting the higher HI taxes. The benefit protection arising therefrom would represent an increase in the standard of living. The remainder of the increase in the real wages would result in a higher standard of living in areas other than retirement and health-care benefits.

Part of the increase in ultimate tax rates could be obviated by a slow corresponding reduction in OASDI benefit gross replacement rates, while at the same time keeping net replacement rates (initial benefit amount as percentage of final gross pay minus OASDI-HI taxes) at the same current level. Under present law, the gross replacement rate for a steady worker with average earnings who first claims benefits at the normal retirement age will always be about 41 percent. At present, when the employee OASDI-HI tax rate is 7.05 percent, the net replacement rate is 44.1 percent (41 percent divided by .9295).

If the employee tax rate increases to 20 percent (12 percent for OASDI and 8 percent for HI) and no change is made in the OASDI benefit structure, the gross replacement rate will rise to 51.2 percent (41 percent divided by .8). It would be possible to reduce the general OASDI benefit level by 12.5 percent relatively - to a replacement rate for the average earner of 35.9 percent - so that the OASDI tax rate would be 10.5 percent, and the OASDI-HI tax rate would be 18.5 percent. At the same time, the net replacement rate would be the same as currently, 44.1 percent (35.9 percent divided by .815). Thus, some part of the increased financing if pessimistic conditions prevail for OASDI and/or HI would be met by gradually reducing the benefit level relative to gross pay, although maintaining it relative to net pay (after deducting OASDI-HI taxes).

MR. GORDON R. TRAPNELL: In predicting the future, it is always tempting for an actuary to project the trends of the last few years. This is usually safe for about five or ten years, but longer is hazardous. Consider what we would have projected on the basis of what was happening ten years ago.

Ten years ago we were discussing not whether but what kind of national health insurance program we would have. The most heated debates about social security concerned how to make the program more equitable, and how to make it achieve social goals more effectively. The conventional wisdom among pension actuaries was that the benefit level should be projected to expand, since it always had in the past.

Social Security

We face the intractable problem of:

1. An aging population, with a need for income and services that will continue to grow rapidly for years to come.

2. Benefits promised literally into the hereafter, and a political system that will assure the retirement of most elected officials who vote to change any element of the benefit structure.

3. Chain letter financing, sometimes dignified by calling it a pay-as-you go "financing" approach (rather than simply noting that it is not financed).

Ironically, we have a situation that demands advance funding, but a political environment that precludes it. There is no realistic prospect of foregoing current consumption to fund future benefits.

Even if there was a fund, it would be invested in federal debt (a false asset since the federal government owes it to itself). Advance funding through this medium simply lowers other taxes.

What we need is capital owned by the system. Capital can be productive, and capital investments could provide some of the real income needed to pay for part of the huge income and service demands of the aged in coming decades.

Unfortunately, with the combination of the prevailing political consensus and current circumstances, an endless series of funding crises and temporary solutions that defer as much of the real problem to some subsequent generation of taxpayers can be projected. Since the next crisis is not projected for thirty years, the public and their representatives consider the problem solved.

Each crisis leads to a lower level of confidence by the working population in the prospect of receiving benefits. The long-run consequence of repeated financial crises may be to undermine the political consensus maintaining the current level of benefits.

Disability Insurance

The recent DI experience has been characterized by a politically determined cycle. Over the cycle the number of beneficiaries follows a wave motion. Near the crest of the wave, the number of beneficiaries is increasing rapidly, benefit outlays are rising and actuarial forecasts show the financing to be inadequate and new funding (i.e. new taxes) needed. This leads to system reform to eliminate malingerers. The actions to accomplish this reduce the beneficiary roles, but deny benefits to a large number of persons in each Congressional district. This leads to pressures from Congress to restore the easier benefit eligibility criteria, and the program roles grow again, leading to another financial crisis.

Medicare

Medicare appears to be on the verge of radical change, reflecting the very rapid evolution of financing medical care in the U.S. Further, the natural resistance to change built into social insurance programs by the political environment has left this program an anachronism.

Medicare originally reflected the state of the art in third party financing of medical care. The program was designed to put the aged in the same financial position for purchasing hospital and physician services as the employed population. It was supposed to be neutral about choice of providers. It thus paid the reasonable costs of a nonprofit hospital industry and the customary and prevailing charges set in a presumed market for physician services.

The financing of hospital and medical services is changing rapidly. We now have health maintenance organizations (HMOs), preferred provider organizations (PPOs), comprehensive health planning (CHP), high-low options, cafeteria plans, flexible spending accounts and countless other innovations. Rather than neutrality, each of these innovations directly involves the choice of provider and payment rates jointly or provides a direct incentive for a patient to judge the cost effectiveness of the service.

The first decade of medicare was characterized by attempts to control the prices the program paid for covered services. As early as 1967, amendments authorized limits on the recognition of physician charges. The 1972 amendments completed the conversion to maximum fees, with the economic index, with a "productivity" component derived in a way that the index would not rise as much as actual fees. Similar limits have been placed on the hospital costs that would be reimbursed, reaching a culmination in the diagnostic related group (DRG) system, an elaborate set of fixed fees for different types of hospital admissions.

The difficulty with price controls has always been that the number of services expands, offsetting part or all of the impact of the maximums. Both parts of medicare have proved to be no exception to this phenomenon. The "mix" of physician services and DRGs reported have both changed in ways that increased the cost of the programs significantly.

Recognizing problems with price controls, the private sector is moving rapidly toward various ways of capitation. In many areas, the process has advanced to the point that more persons are insured under capitation agreements than have a traditional fee for service reimbursement insurance program. It seems a safe bet that the rest of the country will ultimately follow.

A new set of technical problems is likely to dominate policy debates in the future. This is the problem of biased selection. The rewards to skimming of risks (however obtained or contrived) are still greater than the rewards to efficiency. At some point, proposals will be made to drive the residual beneficiaries in fee for service into one of the capitated arrangements. More effective ways will be sought to provide income (i.e. the adjusted average per capita cost (AAPCC)) that is commensurate with the risk of specific individuals.

Even capitated competitive plans do not provide a remedy to medical cost inflation. These are limited only by the ingenuity of our scientists to find new and more expensive ways to provide yet better care. At least as far as the government programs are concerned, it is likely that there ultimately will be a limit on the capitated amount that the government will pay, depending more on the income to the program than the potential cost of care. A voucher option, together with an assigned risk pool, may bring us to this position sooner than natural evolution.

MR. ALLEN J. SORBO: On January 10, 1985, the Department of Health and Human Services published final regulations authorizing medicare reimbursement to eligible federally qualified HMOs and competitive medical plans (CMPs) on a prospective risk basis. The regulations implement Section 114 of the 1982 Tax Equity and Fiscal Responsibility Act. This legislation ushers in a new era of competition which will have significant impact on prepaid health plans, commercial insurers, Blue Cross and Blue Shield organizations, and certainly the medicare eligibles.

An example of the budget methodology defined by the regulations and prescribed by HCFA for the medicare risk program follows. I will review this process and define some of the various terms peculiar to this program.

Base Rate - The base rate can be set at either the community rate used by the HMO for its commercial population or the average premium charged to all groups during the risk contract period. The base rate must be allocated by medical expense item, according to historical experience.

Adjustments - The adjustments reflect differences between benefits included in the commercial plan and benefits covered under medicare.

Initial Rate - The initial rate is the difference between the base rate and the adjustments and reflects the estimated cost of providing medicare-covered services to a commercial population, prior to reduction for medicare's copayments and deductibles.

Frequency/Complexity Factor - This factor represents the organization's projection of the difference in utilization and intensity of services between their medicare enrollment and the commercial enrollment. The HCFA which reviews these budget assumptions in detail requires complete documentation of each frequency and complexity adjustment factor. The documentation can be based on plan-specific experience, other plan experience, or nationally published statistics. Currently, the extreme lack of data particularly specific to organizations providing services under a risk contract makes reasonable and adequate documentation a difficult problem for new organizations.

Adjusted Community Rate (ACR) - The initial rate (usually in specific benefit segments) is multiplied by the frequency/complexity factor to arrive at the adjusted community rate for the medicare enrollment. The ACR must be split between Part A and Part B components so that a separate rate can be developed for medicare enrollees with Part B coverage only. The final step in setting the ACR for the medicare population is subtracting the actuarial value of Parts A and B deductible and coinsurance amounts as established by HCFA actuaries.

Medicare Payment Rate - The maximum amount reimbursed by medicare to the organization is calculated as the sum of the adjusted average per capita costs based on certain demographic variables for each medicare enrollee of the organization. The HCFA has established standardized per capita rates of payment by county for medicare Parts A and B and for aged and disabled enrollees. These amounts are further adjusted by additional demographic factors including age, sex, institutional status, and medicaid status. The standardized rates for each county and the adjustment factors are all published in the regulations heretofore mentioned. Each organization must project the characteristics of its enrollment according to the demographic factors and develop an average rate of payment to be received from medicare. This rate of payment is currently set at 95 percent of the projected fee-for-service costs for the area.

The excess of projected medicare payment rate over the projected adjusted community rate establishes a value for additional benefits that the organization may provide over and above medicare benefit levels. The organization can charge a supplemental premium if the value of the additional benefits exceeds the margin of difference between the payment rate and the adjusted community rate. The assumptions for each of these additional benefits must also be carefully documented.

Prepaid health plans are flocking to the medicare risk concept. Many plans and other persons in the industry see a risk arrangement as some type of panacea. The following are some of my observations and opinions regarding the medicare risk contract concept:

1. Many plans appear to be ill-equipped in terms of management information systems for determining the appropriate frequency and complexity measures of medicare cost, vis a vis, commercial cost. Failure to do so has ramifications relative to plan profits/surplus and appropriate allocation of cost between the medicare enrollees and commercial enrollees.

2. Many organizations will shift the large portions of the expense risk for the medicare program to the providers. In some cases, groups of physicians are capitated for all physician services and outpatient diagnostic tests at levels which are comparable to projected medicare payments for these services. Thus, the physician group is being capitated at a level which is probably equivalent to 50-60 percent of the group's charges. Many groups are entering into these arrangements with little knowledge of the "adequacy" of the capitation proposed.

3. Selection in a competitive arena is a major concern of the HCFA, participating organizations, and insurers marketing medicare supplement policies. The primary concern of each of these groups is as follows:

   a. The HCFA is concerned that the participating organizations will enroll a better-than-average health care risk. Various health status adjustments are being reviewed for possible inclusion in the calculation of risk program payments in the future.

   b. The closed-panel HMOs are likely to realize a better-than-average risk selection. However, individual practice associations (IPAs), with a vast majority of area physicians participating, may not fare so well with selection. In either case, there is some evidence of very high initial utilization patterns as the prepaid health plan deals with existing health problems. Most of the risk demonstration programs have not operated long enough to establish any clear patterns of the impact of selection. It would be very helpful for plans to track utilization of cohorts of members over several years to study the selection results.

   c. Carriers marketing supplemental policies in an area of high HMO penetration certainly have reason to be concerned about adverse selection. They have every reason to believe that they will retain a larger-than-average proportion of cases with intensive health care needs.

4. Payments to participating programs by the government will be affected by legislation relative to DRG payments and medicare reasonable charge allowances. Also, by 1990, the county-specific standardized per capita rates of payment largely will reflect payments under the DRG system. This should significantly narrow the differences in part A rates of payment between different areas, other than those due to utilization differences. Participating organizations will have to carefully control their cost to prevent the premium charge to the member from spiraling out of control. Small increases in DRG payments under medicare may work to the advantage of carriers marketing traditional medicare supplement policies.

5. Many individuals selecting a medicare risk program will essentially be locking themselves in for life. If they become dissatisfied with

the program and want to terminate, they may not be able to find any satisfactory traditional medicare supplement coverage unless they can pass the carrier's health screens. Some may be able to return to an employer-sponsored plan for retirees.

6. Many of the medicare risk programs are offering a comprehensive set of benefits at no or minimal cost to plan enrollees. These benefits sometimes include many services not covered by medicare such as prescription drugs, eye exams, glasses, hearing aids, and occasionally a limited dental benefit. Certain of these program have been very successful with enrollment. One plan in Florida has enrolled in excess of one hundred thousand medicare eligibles within two years. The success of this and other programs will cause much of their competition to enter a medicare risk arrangement as early as possible as a result of pressure from participating hospitals and physicians who fear losing patients to other providers.

7. Large numbers of medicare enrollees in HMOs is likely to further increase the leverage the HMO has in negotiating rates of payment to hospitals and physicians.

Commercial carriers are going to have to look very carefully at their markets for medicare supplement policies and may have to consider some creative alternatives of their own to compete with the medicare programs soon. A carrier with selected providers and a control system could be a CMP.

MR. EDWARD H. FRIEND: Chart 4 shows the twenty-five year blip between 1985 and the year 2010 or 2015 when the income to OASDI considerably exceeds the outgo. Mr. Myers expressed a concern that rather than let that huge surplus build it might be more appropriate, while waiting for the World War II baby boomers to retire, to lower the rate for fear that this huge surplus might cause Congress to liberalize benefits or perhaps not move the retirement age up to age sixty-seven which could be a problem. If the rates did come down, it seems to me that there would be a terrible problem in bringing them back up above where they had been.

Would we not be able to solve the problem of this huge surplus by offering the assets which were built up to the nation's cities? We would ask those cities to deliver plans where user fees would return to the coffers of social security sums of money which would then be available at the time of the retirement of the World War II baby boomers. We have a terrible problem in urban America, and your concern about having a lot of assets around would be taken care of by spending that money for this purpose.

In the event that we curtail the rates and bring them back down again and then eventually raise them, how high do you believe those rates would have to be in order to satisfy the problems at that time?

MR. MYERS: Your preliminary analysis was correct, and you offer a relatively unique proposal to invest the trust fund assets with state and

local governments. Your suggestions are innovative. I'd like to see social security remain neutral budgetwise; and I don't like the relation between the federal government and the state because if the state and local governments don't do the right thing, how do you force them to do it? I don't foresee any difficulty in a slight reduction of the tax rates and then building them up very slowly in the future. If you had to do it suddenly, I'd see a big problem. It wouldn't be such a sharp reduction. Some of the reduction in the OASDI rate might be needed in HI. The American public might prefer to pay higher HI tax rates and get better hospital care than a tightening up of the DRG. You need a rate of around 15 percent for an employee, which doesn't seem too high.

The very high estimates, like 40 percent of payroll, are often stated for social security, but the definition of social security is not only OASDI but also HI. The figures are way off in the future, and even if they were to result, I think they can be borne without people having lower standards of living. One thing you have to consider is that over the years it is likely that wages will rise faster than prices, and generally that difference, the increase in productivity, results in people having higher real income. The higher real income might be used for higher HI taxes so that people would be purchasing better hospital care, rather than deteriorating care.

MR. JOSEPH W. MORAN: You made the comment that you are opposed to the idea of the one-year freeze on the cost of living adjustment increases in social security income benefits, and the rationale is that the arguments for such a freeze arise entirely outside the social security system. There are valid supporting arguments within the context of social security for at least having such a freeze apply to a substantial number of current retiree beneficiaries in that there are millions of retirees who were fortunate enough to reach retirement age during the period when the law contained a substantial mistake. Whether it was a political mistake, or an actuarial mistake, is open for discussion. Wouldn't it be proper to use the cost of living adjustment freeze to help the pattern of differentials and benefits between what some of those windfall retirees are receiving and what is provided for under current law to catch up, or more specifically, catch down?

MR. MYERS: Theoretically, you have a good point, but in political as well as administrative practice, it just couldn't be done. You couldn't give COLAs to some people and not to others. People who reached age sixty-two before 1979, if they retired at age sixty-two, did not particularly get windfalls. The ones who got windfalls, were the ones who reached sixty-two before 1979 and kept on working until age sixty-five or seventy. Theoretically, it would be desirable to take away some of their windfalls through freezing the COLA for them; however, it would be impossible for the Social Security Administration to pick out ones who should get the COLA freeze and others who should not. Instead, on a big system like this, which doesn't have all of its computer problems solved yet, there has to be a broad universal treatment. There is, for example, a lot of concern in Congress. Probably the reason the freeze will not occur is that some people want to say that we want to give the COLA to people with low income, and

not to the people with high income. To find an administratively feasible way to do it is really virtually impossible.

MR. W. WESLEY WELLER: With respect to setting the fee for service equivalent costs in medicare, and ignoring the prospect of selection by the HMO, the 95 percent of the fee for service equivalent costs could conceivably still not be cost effective for medicare, depending on how the administrative costs are handled. The marginal administrative costs for medicare are extremely low. Administrative costs for the HMO would be much higher. So if the fee for service cost is defined on a per capita basis where all medicare administrative costs are spread over all of the medicare recipients, the rate would be much higher and 95 percent of that rate could still be higher than the marginal medicare fee for service costs. I'd like to know if 95 percent of that fee for service equivalency is based on the marginal administrative costs or the per capita administrative costs?

Actuaries generally don't argue the fact that when price controls are instituted a cost shift occurs between government and private sector and there could be a fee for service cost of medicare that poses a surcharge. Will that be recognized in fee for service equivalent costs for HMOs?

MR. SORBO: My understanding is that the AAPCC which is the basis for the payments that Medicare makes to the CMP or the HMO, includes the percentage of medicare cost for administering the medicare program. In my exhibit, there was a provision in the workup of the HMOs cost for its own administrative expenses, surplus or profit. HMOs are developing their own budgets by looking at their administrative costs in the commercial program, be it 10, 12 or 15 percent of premium and making that same provision on the medicare side.

MR. WELLER: If one person moves from medicare to an HMO, that might result in virtually no reduction in costs for medicare for administrative purposes. For the HMO to be cost effective for medicare, there would be no administrative component to that 95 percent of the fee-for-service cost. It would just be 95 percent of the service cost.

If medicare arbitrarily holds reimbursements to hospitals down below their costs, hospitals just shift the costs to the commercial side, and it comes up as an increase in the insurance premium. That's a fee-for-service cost to the medicare program. It wouldn't be there if it wasn't for the medicare program. Shouldn't that be added to the fee that medicare is willing to pay an HMO in certain instances.

MR. SORBO: No, medicare is only going to pay what they are projecting their costs to be for that person based on the DRG system. So it's a tax cost; it's not the social cost of the medicare program.

There is going to be some cost shifting. It's not clear that under the current DRG payment system, there is that much because a lot of what we've seen is that many hospitals are making out a lot better under the DRGs than under the old system. There's no reflection of any of that

cost shifting in what the HMO gets from medicare, and the HMOs and CMPs cut their own deals with the hospitals that cause some cost shifting inevitably.

MR. THOMAS J. KELLY: In trying to keep costs of maintaining people on some kind of a medicare medical supervised service, what study was done to increase the coverage for skilled nursing home or custodial care facilities, either as a credit against hospital confinement, which is a higher cost, or as an additional benefit to try and encourage more of this downgrading, as medically qualified, of the type of care in hospital and nursing home care?

MR. MYERS: A type of proposal like that was considered at the very beginning of medicare to try to get people out of expensive hospitals into intermediate care facilities, but it never was adopted. I don't know now with the new DRGs, how this would operate. It's theoretically good, but perhaps with the hospitals desiring to shorten the stay, they may be able to figure out some way to get skilled nursing facility care available. Government regulations are so slow in being modified. If a person needs hospitalization after surgery at an ambulatory center, HCFA refuses it, though for some procedures, the vast majority could be done in the ambulatory surgical center at a considerable savings. We need greater flexibility and speed on the part of HCFA.

There is concern with DRGs where a doctor might put a person into a nursing home for a period of time. Even if that were part of a scheduled medical treatment, that would be an improvement in the total costs to control. The basic bottom line is where the doctors have a sharing of the risk. The doctor's cooperation determines the success or failure of the program.

MS. ANDREA FESHBACH: Mr. Trapnell, you were saying that putting up the entire medicare eligible for capitation bids might be attractive to some organizations. Could you elaborate on that?

MR. TRAPNELL: I can obviously point out the attractiveness of that to the government compared to the present system of contracting with CMPs and HMOs. The ones that can find ways to get favorable enrollments will continue; the ones that don't get favorable enrollments won't succeed, so they go back into the pool. This process alone is enough to assure that the government is going to lose money on the CMP initiative. The monies that are going to the CMPs are financing additional administrative costs, more deductibles and other cost sharing, and additional benefits in some cases so that the medicare program does not save. In other words, when it gives 95 percent of the AACPP to an organization that is taking people that hadn't cost medicare more than 80 percent, it's actually losing 15 percent on each one and the extra money is going to pay for more cost sharing and administrative costs of the CMP, perhaps higher payments to some physicians or hospitals, and some additional benefits or other uses. This proposition is not attractive to the government.

The visionaries who have supported this approach have extrapolated to

a world in which everyone has joined a competitive medical plan and no one is left in medicare, or that the proportion of people left in medicare is so small as to determine the cost of the program. But the evidence is that even if they were compensated properly, the HMOs and CMPs are taking the younger and more mobile beneficiaries. The very aged, especially the institutionalized, are not leaving and joining these other plans. For these reasons, the government could conceivably want to protect itself (this has actually been discussed at some conferences where some of the academic policy research groups have brought in papers in which they explain how a capitated system like this might work in government) against antiselection and also provide an incentive to the underwriter to control the costs of the most expensive people first because that's where the potential would be greatest for savings. They could provide optional coverage plans like an employer does. If he has a high and a low option, the employer really doesn't have to worry if he is making money on the low option and losing money on the high option. He can rate them by their actuarial value instead of experience rating if he wishes because he is paying the bill for both. An area carrier would be in the same position.

MR. DAVID B. TRINDLE: The Minneapolis demonstration project had achieved a 25 percent market share of the senior citizens. I suspect that, in Minneapolis, HMOs have a larger market share than in some other cities. Is there anything available, summary or writeup, of the demonstration projects that might show, for example, what an HMO that has a 10 percent market share in the under age sixty-five market has achieved in a similar market share over sixty-five in the demonstration projects or any other kind of summary which would give us some kind of indication of what kind of penetration we could expect?

MR. SORBO: Each of the demonstration programs has a condition that the demonstrationist is supposed to submit a final report regarding the experience of the demonstration program which covers the marketing results and financial results, but it could be at least a couple of years before all these are forthcoming. Some have been published. I think it's possible to obtain them from the HCFA. Those types of reports should give you some of the information you are interested in.

MR. TRINDLE: Is that available from HCFA?

MR. MUSSEY: Some of the previous studies were published in the Health Care Financing Review. I don't know if any more recent studies are included. You will have to check with the HCFA.

MR. TRINDLE: You also mentioned that the demonstration project in Florida and other demonstration projects had experienced high turnover. Of the few things that I've read, they seem to quote some very low turnover rates, .5 to 1 percent or 2 percent a year.

Are there some published statistics or is there some firm data that we can verify that?

MR. SORBO: I haven't seen reference to the Florida experiences. I've heard comments from clients and other people in the industry, and I'm

sure the turnover in some areas has been quite low. I don't think its been all that high in the twin cities. I know there have been some delivery problems in certain areas in Florida that have precipitated very high turnover, and I have heard numbers in the range of 20 to 30 percent.

MR. TRINDLE: When reasonable charges are cut back from the medicare program, there has been an experience where the doctor will just treat a person more than once instead of treating a person once and charging them a higher fee. There has been a freeze in effect for a while now. Is there any data to support that statement?

MR. TRAPNELL: Yes, but I don't want to imply that it is by increasing visits. There are many ways in which a physician can increase his income within a fixed fee structure. The mix of services can change. You can have fractionalization of services. He can charge separately for some things that he used to charge as a bundle. There could be a higher proportion of consultations and a lower proportion of brief visits. The data, such as it is, is just looking at the trend of per capita costs and then factoring out of that the allowance for fee screen increases. This is where you find that the theoretical price increase has been reduced by such actions like it was during the 1972-73 nationwide fee controls. The per capita costs to the program continue to increase just as if that had never happened. You can look at some instances like this, but you can never get data that would pinpoint exactly how it occurred. If they did, the regulators would use that to prevent it from happening.

MR. TRINDLE: Is the difficulty the IPAs are having in making money under the demonstration projects, and is there any explanation for why they are having more difficulty than the others?

MR. SORBO: The ultimate trend hasn't emerged yet, but because most of the IPAs involved in various demonstration projects have only one year's experience or less, that first year, in some cases, has been horrendous. It may be due to some initial selection. It seems that these HMOs sign up many people who seem to go in for a cataract operation or something so they experience some of that which may wash out over time. The IPAs, strictly those that have 60, 70, or 80 percent of the physicians participating from within the medical community, are going to be exposed to natural adverse selection because, as long as these medicare people can keep their own doctor at the broader services at a much lower cost, they will join the HMO. Its just a natural selection to work against the IPAs.

MR. CHARLES L. TROWBRIDGE: This question has to do with the operation of the provision in the 1983 amendments, which put in effect general revenue financing into the OASDI system by transferring tax money from taxes on social security benefits. How does that work and how does it affect the Trustee's Reports that are just out?

MR. FOSTER: The way it works in practice is that there is a group in the Department of Treasury that estimates the liability on the taxes on social security benefits for the calendar year. The law specifies that

this revenue be transferred in advance on an estimated basis to the trust funds at the beginning of each quarter so the group in Treasury basically estimates the total amount for the year. They more or less divide it by four, and they transfer each of those amounts at the beginning of each quarter. This happened for the first time in calendar year 1984, so we began receiving such revenue as of the first day of 1984. In real life, of course, most of the money is actually showing up right now in the last month or two. Does that answer your question sufficiently?

MR. TROWBRIDGE: Yes, except how about the allocation of it? You can say that the tax is on the marginal rate which is higher, or you could say it's on an average rate. You must have some theory.

MR. FOSTER: The money is allocated by trust fund on the basis of the benefits which generated the taxes. In order to do that allocation properly, it is going to take an enormous study. They have only begun to try to figure out how to prepare the study and how to go about it. I don't see the adjustments based on actual experience to these estimated transfers for easily two years or more.

MR. MYERS: It's based on the marginal rate: in other words, looking at that as being the last source of income that's taxed. It was done very unfairly. The money is transferred at the beginning of the quarter, so there is a government subsidy on that of giving them the interest. On the advance monthly transfers of payroll taxes, there is an equitable treatment between the trust funds and the general fund in that the trust funds that get the money at the beginning of the month before the taxes are collected have to pay interest on that money. So it's like temporary one month loans not like your friendly bank giving you credit for your paycheck at the end of the month on the first day of the month without charging interest. On the other hand, interest is not charged to the trust funds for the advance transfers of income tax accruals. This is an inequitable way of doing it, since the transfers are made on the first day of the quarter rather than in the middle of the quarter. It was a slip-up in the 1983 legislation which was never corrected.

MS. MARIA TRASKA*: A number of actuaries think that hospitals are doing okay under DRGs. It might be useful to take a look at which hospitals are not doing so well. Small rural hospitals seem to be doing poorly, and they have a particular problem with the area wage index. Rural hospitals have to pay more, both for supplies and for personnel. Public hospitals are having a lot of difficulty with transfers due to DRGs, and in many cases, they have to be creative in doing so to screen out which transfers they are not going to accept. There have been well documented cases of people in comas being transferred. They have no business transferring people like that.

*Ms. Traska, not a member of the Society, is with Hospitals Magazine.

The other problem that hospitals are seeing is that a significant proportion of them are getting killed on DRG outliers. If you wanted to get numbers on that or names of hospitals, either the American Hospital Association or any number of the state hospitals would be happy to provide them because they have been tracking this. As evidence of DRG outliers being a problem, I would point out that Lloyds of London has backed two policies that have become available so far this year to cover DRG outliers because medicare will only pay a portion of the approved outliers. Then, of course, there are the problems with peer review organizations (PROs).

In all the projections regarding medicare, I've heard nothing about the possible influence of cuts in veteran's benefits in the medical area. Last July, the Veterans Administration came out with a report whereby they projected their needs along with the aging of the general population. When the Reagan administration delivered its budget, the aging veteran's population did not get an approval for a projection based on maintaining a steady level of veterans using medical benefits but, in fact, suggestions of serious retrenchment. Now they are talking about a means test. If the numbers they have been throwing around lately about the means test are correct, they are talking about a 15,000 dollar cutoff for annual income. That is significantly above the level that most medicaid payments in most states contribute. The commercial insurer and Medicare are going to get loaded with all these veterans.

Chart 1
Past and Projected OASDHI Income, Expenditures, and Assets, 1937-1989

[In billions]

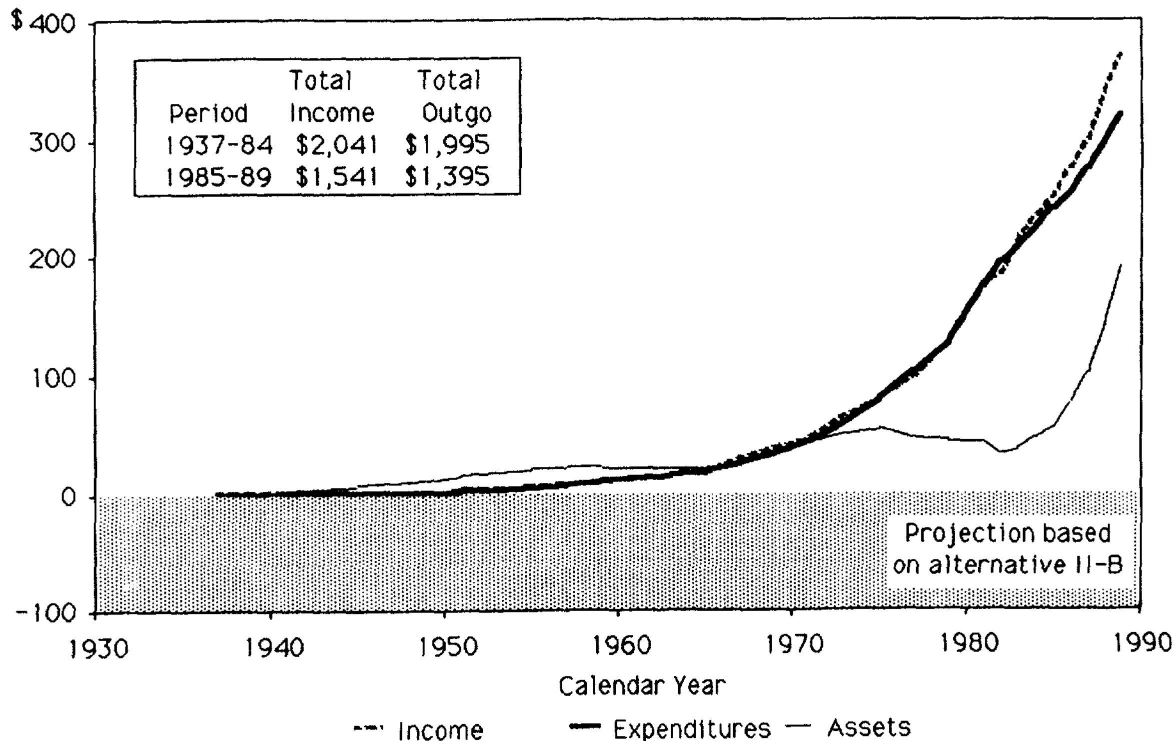


Chart 2
OASI Assets and Benefits,
January 1982 through August 1984
[In billions]

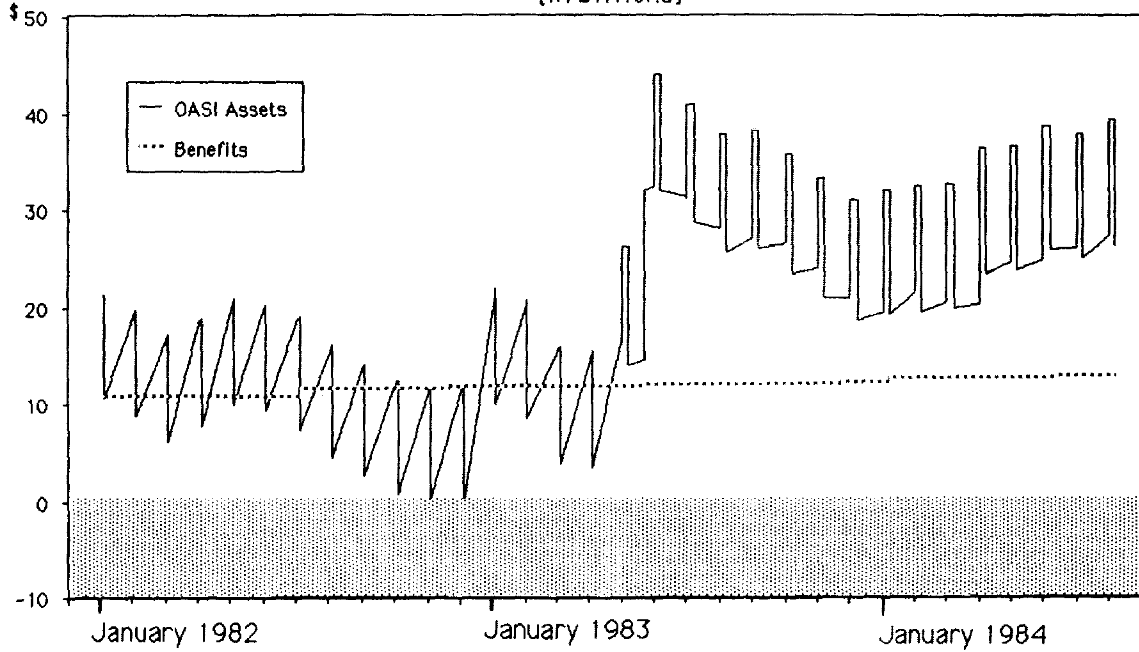
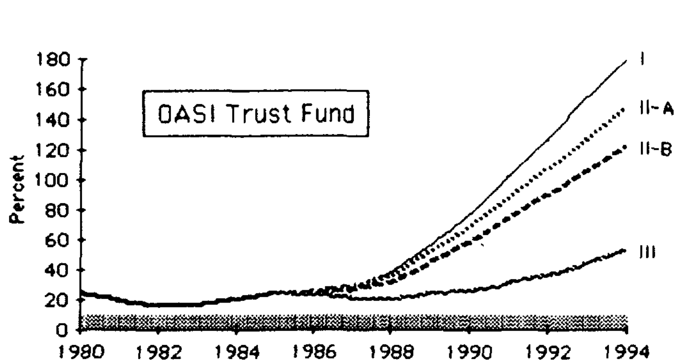
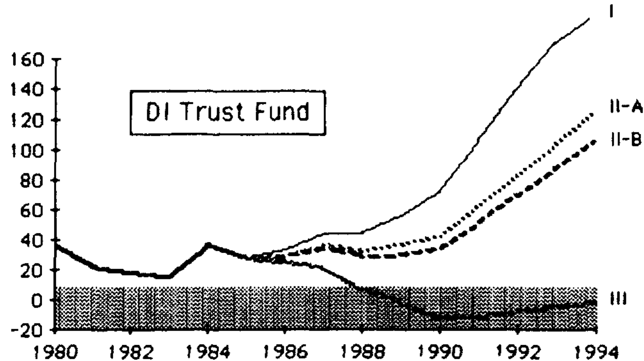
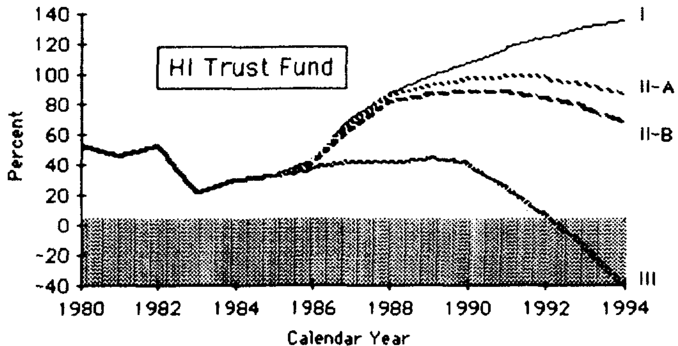


Chart 3
OASI, DI, HI, and SMI Assets as a Percentage of Annual Expenditures, 1980-94







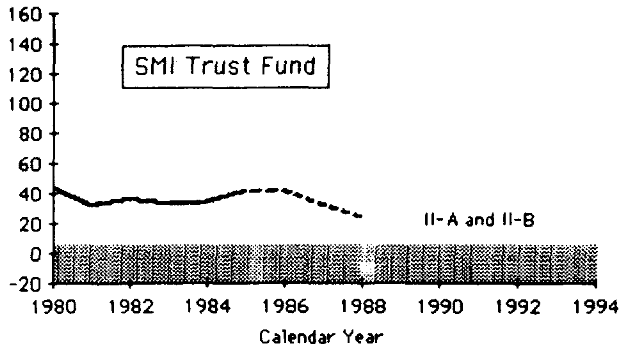


Chart 4
Past and Projected OASDI and HI Cost Rates and Income Rates, 1937-2059

[Percent of taxable payroll]

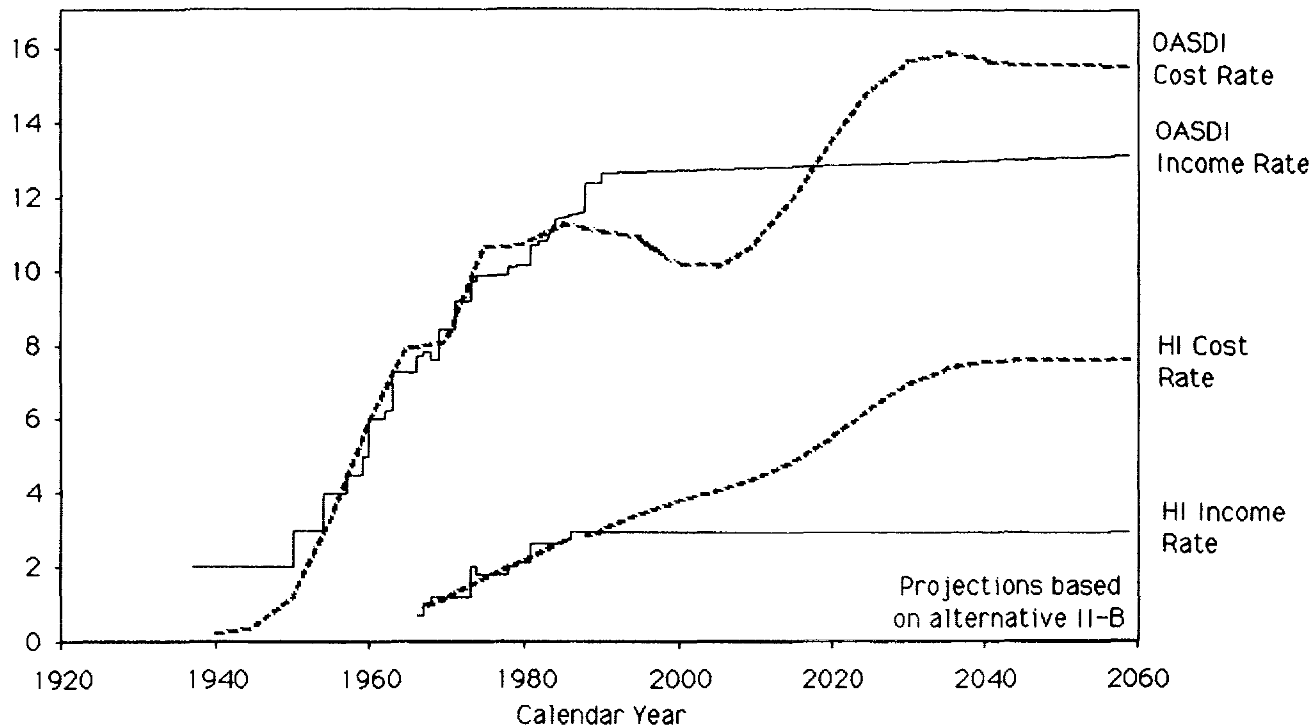


Chart 5
Past and Projected Beneficiaries per 100 Covered Workers, Based On Alternative Fertility and Mortality Assumptions, 1945-2059