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WHAT'S "HOT" IN D.C.: HEALTH CARE REFORM FEDERAL DEVELOPMENTS

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Panelists will discuss health care reform at the federal level.

MR. WILLIAM R. LANE: I would like to introduce Donna Novak of Blue Cross/Blue Shield Association in Chicago. She will talk about health care reform in the legislative bills and some of the issues that are involved.

MS. DONNA C. NOVAK: I will address the characteristics of reform that are found in some combination in many of the federal and state bills. The components that we see are guaranteed issue and/or portability, guaranteed renewability, limitations on preexisting conditions, rating restrictions, and standard benefit packages that a carrier would have to provide and, in some cases, self-insured plans would have to provide.

Guaranteed issue takes a number of different forms. The first form is that a carrier would have to accept all applicants, possibly for a 30-day open enrollment period, possibly 365 days. The second form is that a carrier must accept all current insureds. This is more of a portability issue where once an individual is in the system, he or she has guaranteed access to insurance as long as he or she stays in the system. So current insureds would have a guaranteed issue availability to them. Another alternative to guaranteed issue from a carrier perspective would be state high-risk pools that would accept the uninsured, and, therefore, individuals would have access to insurance either through the insured market-place or through a high-risk pool, if they had a health problem.

When we look at guaranteed renewability, normally what we see is that an individual or group cannot be canceled except for very limited reasons such as nonpayment of premium, fraud or misrepresentation. Additionally, on the group side, there may be participation rules. If a carrier leaves the marketplace, and remains out of the marketplace for five years, then the carrier could nonrenew policies. One bill has a provision that allows for replacing policy forms with similar policy forms and allows for dropping a particular policy form as long as it is dropped for everyone and a replacement policy form is offered to everyone covered in the original policy form. Although one bill allows this replacement, generally replacement is not allowed. Therefore, for a carrier to discontinue a policy form, it would have to exit the marketplace altogether.

All of the bills that exclude the preexisting condition limitation give credit for prior coverage. Provisions differ as to what coverage would be allowed for credit; some are restricted to similar coverage, and some allow any coverage in a high-risk pool, such as Medicaid coverage, group or individual coverage. This is what actually defines portability, for example, group to individual, Medicaid to individual. Most of the bills, if not all of them, do not include maternity as a preexisting condition. An HMO cannot administer preexisting condition limitations. There is typically a waiting period in an HMO situation that serves the same purpose. It prevents individuals from waiting until they're sick to get

coverage, and so preexisting limitations are an antiselection deterrent. Typically, the preexisting condition limitations that we're seeing have a 3/6 or 6/12 provision. That is they have a three-month look-back with a six-month limitation, or a six-month look-back with a 12-month limitation. Occasionally provisions differ between late enrollees and individuals who apply for guaranteed issue coverage at the time they are first qualified to do so.

If rating rules are limited, typically carriers can only rate on benefits, geography, and family status, but not on health status. There may be limits on rate differences within age or within industry.

The benefit packages being offered are typically not being defined in the federal bills. If they're established at all, they're referred to the states or to the NAIC. It is "to be determined later" by the NAIC. There may be a metropolitan statistical area (MSA) and catastrophic combination mandated which may be defined in quite a bit of detail.

Representative Harris W. Fawell (R–IL) has written two bills in combination: 995 and 996. One addresses individual and one addresses group. Representative Fawell is on the House Economic and Education Opportunities Committee. The basis of both bills is basically an expansion of ERISA. Bill 996 encourages small groups to band together in multiple employer welfare associations (MEWAs). The small group guaranteed issue is encouraged through the MEWAs. Individual guaranteed issue is not available if you're eligible for group coverage. All plans would be guaranteed renewable, and preexisting condition limitations would be restricted to 3/6 for group and 6/12 for individual. The rating restrictions are very restrictive as far as limits on the age, base rates, and health status for small group plans.

Representative William M. Thomas (R–CA) wrote a bill, HR 1234, but has not submitted it. It's really his wish list and is a more complete bill than the one he actually submitted. It would include guaranteed issue for small group plans, a 30-day open-enrollment period with a preexisting condition limitations of 6/12. All plans would be guaranteed renewable, and rating is linked to state laws. What Representative Thomas actually submitted is a very watered down version of HR 1610, which provides group-to-group portability. It has received quite a bit of support both from the insurance industry and Capitol Hill. It is a first step in incremental reform and it could get through because of its restricted scope.

Representative Nancy L. Johnson's (R–CT) bill is also a portability bill. She is on the House Ways and Means Committee. Her bill is primarily portability from group to individual plans, with some guaranteed issue of individual coverage. Should a carrier stop writing coverage, an individual would have to be guaranteed issue, or if an individual leaves their service area, the individual would have to be guaranteed issue. There is portability to the individual marketplace from high-risk pools or Medicaid. Medicaid and high-risk pools would be qualified coverage for preexisting condition limitations and would guarantee access to insurance. There are no predefined plans or rating rules in this bill.

Senator Phil Gramm's (R–TX) bill, S121, goes beyond portability. It offers a low-cost COBRA which could be funded from an IRA. A person could use IRA withdrawals, 401(k) withdrawals, to purchase conversion coverage. There would be no guaranteed issue requirements in the individual marketplace, but health status could not be used to

rate. It does not include standard benefit plans. He also includes a couple of other miscellaneous provisions. One is a paper reduction and another is a meaningful medical liability reform.

Senator Alfonse M. D'Amato's (R–NY) bill, S715, includes portability, guaranteed renewability, high-risk pools, MSAs, and, as he says, other purposes. His other purposes include an expansion of COBRA down to groups of two lives and a 36-month availability of COBRA. His bill includes guaranteed issue for individuals that are losing their dependent's coverage including a 6/12 preexisting condition limitations with credit for prior coverage.

MR. LANE: Let's talk about the MSA concept and what the legislation intends to do. In essence, a medical savings account is an individual or a family savings account. The money in the account essentially is meant to be available for medical expenses only. Employer contributions to an MSA are not intended to be taxable, and if you make a withdrawal for nonmedical expenses, or medical expenses that aren't considered as part of the MSA, there's usually a penalty for that. And last but not least, it is typically tied to a high-deductible major medical policy. The MSA does not stand on its own. It's usually in conjunction with some sort of catastrophic major medical plan. Now, some of the original proponents of the MSA concept wanted the inside buildup (any interest on the monies that are in the MSA) to be tax-free as well. None of the proposals have done that. In essence, when they looked at the cost of allowing tax-free buildup for an MSA, much like an IRA, they felt it cost too much, and they couldn't afford to do it. So the MSA proposals we're seeing out of the federal government aren't quite what some of the original proponents wanted, but they do come close to what they wanted.

In essence, an MSA takes your standard medical coverage and splits it into two pieces, and instead of funding just going to the premiums for a comprehensive major medical plan, that funding is going in two, different directions. First of all, it's going catastrophic coverage, some form of high-deductible major medical, and the rest of the money that would have gone comprehensive coverage is going the MSA itself. The key is that if you have a catastrophic claim, both the MSA and the catastrophic coverage are intended to kick in. You may not have enough money in the first year in the MSA to cover all of the deductible—so an individual would be at risk for that. However, if you had the MSA in place for a number of years and have built up the balance, it will probably have more money than the deductible, and the two together should be sufficient. It is a risk that people take if they purchase an MSA as they typically have to put down more out-of-pocket money up front than they would have if they'd had comprehensive coverage. If you have a small claim, it will be below the catastrophic deductible, and that coverage will no longer be paying toward it. It all has to come out of the MSA, but the key feature of the medical savings account is if you have no claims, the money stays in there and grows with interest so that you no longer have to use it or lose it like you do a flexible spending account (FSA).

Well, where does the money come from for these MSA deposits? The concept is that if you have a premium for comprehensive coverage, it's a substantial amount of money. Currently, it's essentially given a tax preference because the employer can deduct it as a natural business expense, but the employee doesn't see it as taxable income. With an MSA, the bulk of that money goes toward the catastrophic coverage. Here again it's

deductible for the employer, and it's not taxable income for the individual. And what's left? The difference between the comprehensive premium and catastrophic premium is intended to be, in general, the contribution to the MSA, and because that money today has tax preference, it could continue to have tax preference, and there's no tax cost. Because the full amount of the comprehensive premium today is not taxable, the government can afford to make the full amount of the catastrophic premium plus the MSA deposit nontaxable. The problem MSA proponents were having, of course, was if they allowed the buildup to be nontaxable, that would have been an added cost because that's not there today, and that's most likely the reason it has been taken out.

Now, MSAs are very similar to a flexible spending account, but there are certain key differences between the two. The big one is that with an FSA, it's use it or lose it. If you put money in during 1995, you have to spend that money or it's gone. You can't roll it over and let it grow over the years like you can with an MSA. With an MSA, when you put money in, it's nonforfeitable. You cannot lose it. You have to keep it. You can't let it go somewhere else. The key there is with an FSA you don't put money in unless you expect to spend it now. You put it in for things that are known, that are budgetable, that are planned. You may know you're going to have some kind of surgery. You will probably know you're going to want to buy some eyeglasses. You know you're going to have certain kinds of expenses. That's what you put in the FSA. You may think you're at risk for a heart attack, but that could be anywhere between now and ten years from now. You don't put money in an FSA for that because if you're trying to save money to help cover the cost of that cardiac care, every year it will go away, whereas with an MSA it would hang around. Because of that, the focus on FSAs is typically on ancillary services, and the intended focus of an MSA is on medical services. Something else we've seen is that MSAs are also focused on long-term-care services or long-term-care premiums. So, there really is a difference between the two.

MSAs have been proposed in a number of pieces of legislation. Many of these are ones that Donna has already gone over. Senator Phil Gramm in S121 said the MSA has to be tied to catastrophic coverage, and the catastrophic deductible has to equal or exceed $3,000. That $3,000 will be indexed for the consumer price index (CPI), and the maximum amount of money an employer can put into the MSA for the employee is also the same $3,000 adjusted for CPI. In the Gramm proposal, the money that is to come out without penalty, can only be one of two things. It can be money used to pay for long-term-care services, or it can be money paid for medical services. But in Gramm's proposal, it's only medical services that are covered by the comprehensive coverage. So, if you're buying a medical policy that doesn't cover eyeglasses, you couldn't take it out of the MSA in Gramm's proposal. So, he's specifically trying to tie it to that catastrophic policy.

Senator D'Amato took the other direction in his proposal where the catastrophic deductible can't exceed $5,000. It tries to prevent somebody from not having any realistic coverage at all. Here, the maximum contribution equals the initial premium difference. Now, the maximum contribution in most of these proposals gets to be a very tricky subject. How do you determine how much people can put in? There are many different ways to do it, most of which are fraught with problems, and this is one of them. The initial premium difference means you have to determine how much the comprehensive coverage costs and how much the catastrophic coverage costs for that individual, and thereafter, that difference is basically frozen and increased with CPI. So, you don't look at the difference in

premium three years from now, for three years from now; it's the difference in premium today. It's basically an unworkable system, but it is what Senator D'Amato was proposing.

One thing Senator D'Amato allowed is not only funding long-term-care services out of an MSA, but funding premiums for long-term-care insurance. In essence, with the D'Amato bill, you could take money, put it into an MSA, and immediately take it out and pay the premiums for a long-term-care policy. As long as the amount of money you're using in the MSA is less than the difference in the premiums for your comprehensive and catastrophic coverage, you've now got a tax-preference and a long-term-care policy.

As Donna mentioned, Representative Thomas sort of put his wish list in HR1234. It was never actually formally submitted, but it does contain much of what Thomas thought were important things. They're not defining what the high deductible plan has to be. They're only saying it has to be between 60% and 80% of the actuarial value of the comprehensive plan that's in place, and the maximum contribution here equals the actual difference in premiums year-by-year. You cannot offer a catastrophic plan unless you're also offering the comprehensive plan, and therefore, a carrier will always have to offer the two in sync which means you'll always have the difference to look at, even if no one has ever purchased the comprehensive. Here, you can also fund long-term-care premiums, but there's a specific limitation on what kind of long-term-care policy. It can't be over a $200-per-day maximum. It can't have a cash value, and so forth and so on. So they're trying to define what kind of long-term-care insurance would be acceptable, but you can fund long-term-care premiums out of the MSA.

Representative Bill Archer's (R–TX) bill came out recently. It also dealt heavily with MSAs. Representative Archer would put the catastrophic deductible at at least $1,800, increased for CPI, and the maximum contribution or deductible at $2,500, whichever is less. If you go with the $1,800 deductible, you can only have an $1,800 contribution. If you go with a higher deductible, you could have up to a $2,500 contribution. And here again you can fund medical services or premiums for the long-term care. Representative Archer would also allow you to put money in the MSA and use that money to pay for the catastrophic health premiums. I'm not sure why he wants to do that, but that is in the bill. There is a variety of different things you can fund out of these MSAs.

One of the big kickers with the MSA is the penalty that applies if you don't use the money for what it was intended. This has a big impact on how popular the MSA will be because if you put a large sum of money into an MSA, and if you can't pull it out if you don't get sick, it will not be a very popular thing. Legislators are trying to find ways to keep the use of the MSA limited to what it was intended for but still have enough flexibility so that people can, in fact, fund it and feel like they'll get their money back. All of the bills are going to have this top provision—if you have a withdrawal, and it's not for long-term-care services or it's not for medical services, as defined by the bill, it'll be subject to income tax, for the withdrawal, but only to the extent that the deposits were tax-free. Now, keep in mind interest is no longer tax-free in an MSA, even though some of the proponents tried to do it that way. Eventually you may have much of a balance of an MSA that was taxable income. You will only be taxed to the extent that the money was tax-free to begin with, which means that all of that interest can be taken out without penalty later on because all proposed bills tie the penalty to whether the money was taxable. In S121 the penalty's

10%, which seems to be pretty common, and it applies only if the withdrawal lowers the amount in the MSA to below the amount of the deductible. What the proposal is trying to do is to get people to fund their MSA at least to the level of their deductible. If they go beyond the amount of the deductible for their catastrophic major medical, there's no penalty for withdrawing it, even if it's for nonmedical type expenses, but if they take it down below the deductible, even if it's for long-term-care services, there will be a penalty applied. This will ensure that people have enough in the MSA itself to at least cover a one-time application of the deductible.

Senator D'Amato's bill, again, only taxes you if the money went in tax-free. Here you have a 10% penalty if the money is taxable, regardless of how much money is in the account, but only if it's before age 59.5. What the D'Amato bill is attempting to do is to make sure that the monies stay in the MSA, and you will be penalized if you take them out. The bill is trying to say at some point in time you can take the money without penalty (I would guess 59.5 is too early, although the bill basically uses the IRA limit). Now, the money is still taxable to the extent it went in tax-free. You still will have to pay tax on it coming out, but there's no additional penalty to it. Of course, you're always better off if you can take money and not pay tax on it up front and pay tax on it later on when you take it out.

Representative Thomas had essentially the same concept. He applied an age-65 limit as opposed to 59.5 which makes much sense, but I think the Thomas bill applied a 100% penalty. The bill will make sure people do not take money out of an MSA unless they have to for medical services. Now, as Donna mentioned, HR1234 was never formally submitted, but this was Thomas's wish list. I doubt 100% penalty could survive the process no matter what, but it does sort of speak to some intent. At least some people within Congress are trying to make sure that if you put money in, it only will be used for the purpose it was intended.

Last but not least is Representative Archer's bill, and, again, you're only taxed if the money went in tax-free. His bill has a 10% penalty, but he has no age limit on that. The advantage of an age limit is if you put the money in, and at age 65 you no longer need it for medical services because now you're covered by Medicare or a Medicare risk contract, you can take that money and use it for things other than just long-term-care services. You can use it for a Medicare supplement premium and things like that, whereas in the Archer bill, you'd have to keep it in there essentially until you die in order to avoid the penalty.

MSAs are one of the few components that have a high likelihood of passing in Congress. Many states have passed some kind of MSA legislation, even if it's very minimal, or have at least had an introduction of MSA legislation. Not much has been passed in some of those states, but the concept is popular. It's coming up everywhere. It's not just the Republicans in Washington, D.C. that are promoting it. It's being promoted in the State Houses around the country, so the concept is likely to be one that will last. I will turn it over to Tom to talk about what they're trying to do to Medicare and Medicaid.

MR. THOMAS F. WILDSMITH: Let's begin by briefly reviewing the programs, although I'm sure we all have some familiarity with them. These programs are among those things in life that we know are there, but tend not to think about very often. The Medicare program consists of two parts. The first is Medicare Part A, which is the hospital insurance

(HI) program. The people it covers include essentially everyone who's over age 65, those who have received Social Security disability benefits for more than 24 months, and those with end-stage renal disease (ESRD) or, in other words, kidney failure. Participation is compulsory for all who are eligible. It's projected to cover about 37.6 million individuals in 1996.

The benefits provided by Medicare Part A are in-patient hospital services, skilled nursing facility services, and home health and hospice care. Now, we need to make an important distinction here. The skilled nursing facility services provided are essentially convalescent care for someone who has been hospitalized and is still recovering. It doesn't include any kind of long-term care or custodial care for the person who's just too old or too feeble to care for themselves. The financing of Medicare Part A is primarily through a payroll tax on both employers and employees. The tax rate is currently 1.45% for both the employer and the employee. There's also a small degree of funding through interest earnings on the trust fund that's set up for this particular program.

The hospital insurance portion of Medicare does, in fact, have a trust fund similar to the ones that we have for Social Security. The other half does not. This is Medicare Part B, or supplementary medical insurance (SMI). Participation in Part B is entirely voluntary. Anyone over age 65 is eligible, as well as anyone who's enrolled in Medicare Part A. Eligibility through enrollment in Part A brings in those who are Social Security disabled for more than two years and those with ESRD. A monthly enrollee premium is required. The Medicare Part B program is projected to cover 36.3 million in 1996. Almost everyone in Medicare Part A does, in fact, elect to participate in Medicare Part B. The benefits provided include: physician services, laboratory services, durable medical equipment, out-patient hospital services, and some other miscellaneous coverages. The financing is through a combination of federal general revenues and the monthly premium paid by the beneficiaries. It's not in the law, but for a number of years, the informal goal has been for general revenues to provide roughly 75% of the funding, while the enrollee premium provide about 25% of the funding. That, I suspect, is why almost everyone who is eligible does, in fact, participate.

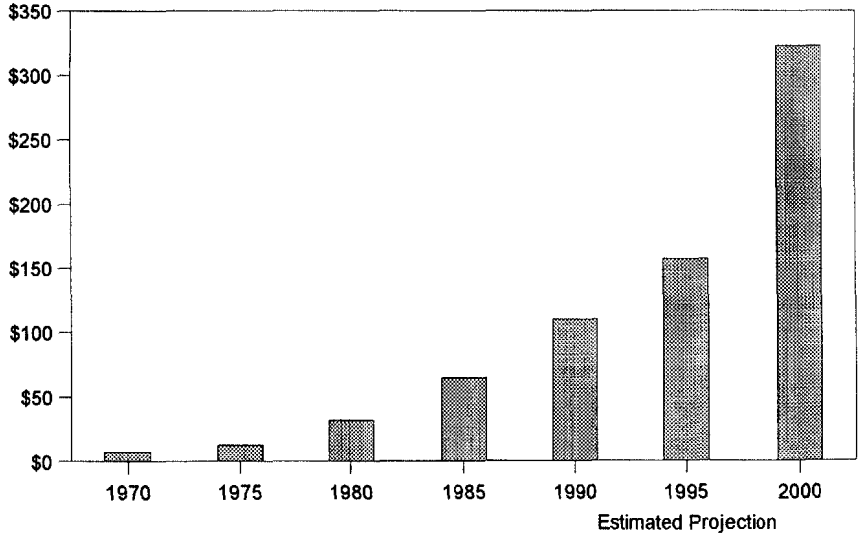
Medicaid is a joint federal-state program, and it's quite unusual among federal programs in that state participation is optional. Currently all 50 states participate and have for a number of years, but this truly is an optional program. For a decade-and-a-half, Arizona chose not to participate.

Who is covered? The primary public served are those individuals who are eligible for some form of cash assistance. "Cash assistance" would include aid to families with dependent children (AFDC), supplemental security income (SSI), and other similar programs. States may also make it available to other low-income persons, generally those considered medically indigent. Each state sets up its own definition of medical indigence, and the states have broad discretion not only over the eligibility but over the types of benefits that are provided. Medicaid covered roughly 33.5 million individuals in 1993. There is a core set of benefits that all states must include to participate. These core benefits include in-patient and out-patient hospital services, certain physician services, x-ray, laboratory services, home health care, and skilled nursing care services. Beyond that, the states have a great deal of freedom.

Medicaid is often thought of as a form of welfare and as a program that only aids those that we traditionally think of as the poor, but in a very real sense it has application and meaning to the middle class. Medicaid currently pays about 45% of the long-term care costs in this country. Much of those costs are being incurred by individuals who we would consider middle income or middle class or who, at one time in their life, were middle class. This happens because Medicaid is essentially filling a funding hole or void that has been left by Medicare and the private sector. The phenomenon involved is referred to as "spending down." For instance, someone at age 70 needs long-term-care services. The individual has been middle income in the past and has certain assets available. But as the person ages in a nursing home those assets are "spent down." The person reaches his state's definition of medical indigence and then becomes eligible for Medicaid.

Why are Medicare and Medicaid an issue at all? It's because of cost. The costs have been increasing quite dramatically over the last 20–25 years in both the Medicare and Medicaid programs. Chart 1 shows Medicare costs from 1970 projected to about the year 2000. In the "good old days" of 1970–75 we were talking about costs at approximately $7 billion annually. By 1980, we were talking about $35 billion. In 1990, it was $110 billion. In 1994, it was $162 billion. It's projected to run close to $323 billion in the year 2000. The recently released *1995 Report to Congress of the Social Security and Medicare Trustees* projects that the hospital insurance trust fund will be exhausted in the year 2002.

CHART 1
MEDICARE COSTS
(IN BILLIONS)



Medicaid has a similar cost profile (as shown in Chart 2). In 1995, we are projected to spend $195 billion on the Medicaid program. In the year 2000, we're projected to spend $348 billion. If you project it out over a longer period of time though, the cost becomes truly horrifying as shown in Chart 3. In the year 2030, the Health Care Financing

Administration (HCFA) is projecting a Medicare expenditure of about $4 trillion. In 2030, it's projecting a Medicaid expenditure of $2.8 trillion.

CHART 2
MEDICAID COSTS (IN BILLIONS)

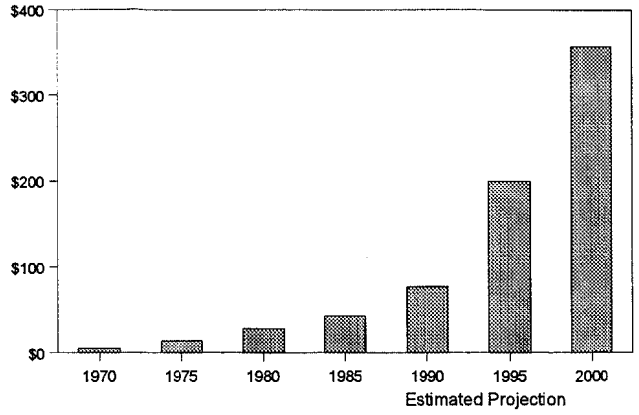
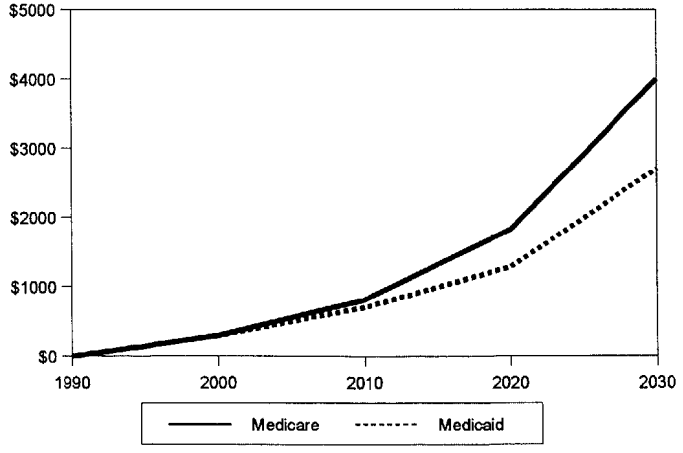


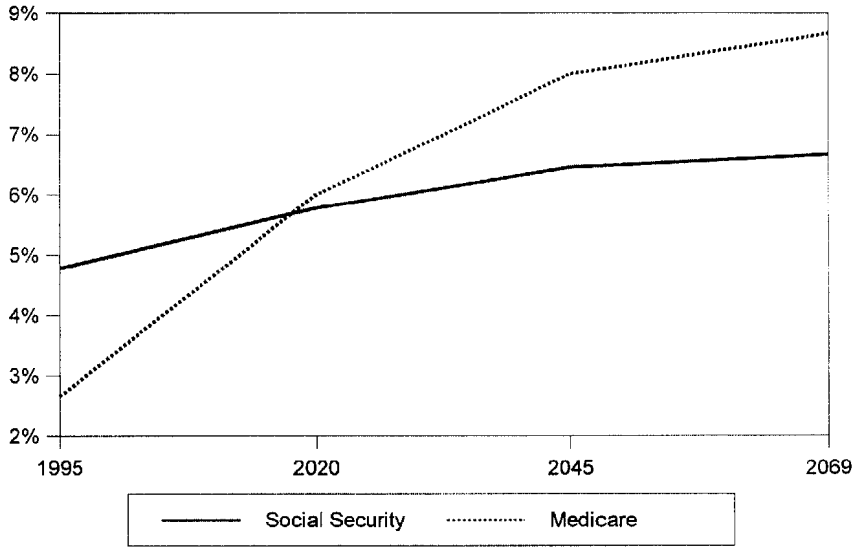
CHART 3
MEDICARE AND MEDICAID—PROJECTED COSTS (IN BILLIONS)



Of course, we all understand that these are nominal dollars, and things have to be discounted for inflation. But when you look at it as a percentage of gross domestic product (GDP), it's still disturbing, as Chart 4 illustrates. You see that Social Security has an increasing cost as our population ages. That's something we're all familiar with. However, Medicare, over the long term, is potentially a much larger funding problem than

Social Security. During the period from 1995 to 2069, the cost of Social Security is projected to rise from about 4.8% of GDP to about 6.8% of GDP, which is a significant increase. On the other hand, Medicare is projected to go from 2.6% to 8.8% of GDP. Of course, that's assuming that there are no significant reforms or other significant changes in the program as it currently exists.

CHART 4
COSTS AS A PERCENTAGE OF GDP



Let's talk for a moment about the political environment. The public tends to view Social Security and Medicare as a package deal, and it's a deal that people like. These are government programs that the beneficiaries absolutely love. Interestingly enough, the beneficiaries of these particular programs tend to have the most potent lobby in the nation's capital, which makes it very difficult to mess with either one of the programs.

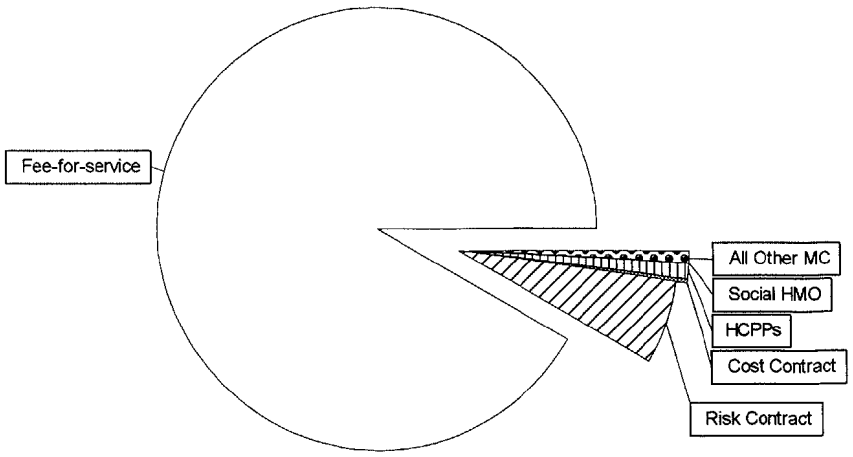
Over the course of this year there's been a very interesting evolution of "sound bites" as they're often termed. The Republicans started by saying, "We must cut Medicare because we have a budget problem. We're running this deficit. We have to balance the budget." The immediate response from the Democrats was, "You're balancing the budget on the backs of the elderly." The Republicans responded by saying, "We're not balancing the budget on the backs of the elderly. We must cut Medicare to save Medicare. It's not in sound fiscal condition. It will go belly-up and the program will self-destruct. So, we need to save it." The Democrats felt Republicans were cutting Medicare to pay for tax cuts, and the response from Republicans was, of course, "No we're not. We would never do that." The Democrats responded saying that Medicare needs to be reformed because medical expenses are totally out of hand, but "any reform has to be part of an overall, broad-based health care reform package. You can't solve Medicare in a vacuum."

The whole nature of the debate has changed recently with the introduction of the Clinton administration budget proposal. What changed is that for the first time the Democratic Clinton administration has said, "Yes, we need to cut Medicare and Medicaid expenses but not as much as you guys are proposing. You're cutting them too deeply, too fast. It's heartless. It's damaging." So, the nature of the debate has changed from whether we should do it or not, to how much and how quickly. One of the key concepts that many people are hanging their hopes on is managed care. The idea is that if we can just manage the care of the elderly, we will be able to provide better benefits at a lower cost, and everyone will be happy.

Currently, there are a number of attempts to bring managed care into the Medicare arena with a number of different types of programs. There are HMO risk contracts and HMO cost contracts. The HCFA is aggressively encouraging a movement from cost-based contracts to risk-based contracts. There are health care prepayment plans (HCPPs). These have been around for a number of years, but there aren't too many of them. An HCPP is similar to a HMO cost contract that only deals with Medicare Part B services. There have also been some small demonstration projects with social HMOs, or SHMOs. A SHMO is a HMO that also incorporates long-term-care-type services. And, finally there's the Medicare Select program which allows Medicare supplement PPO plans.

Managed care has currently made only very modest inroads into the Medicare population. At the end of 1994, one estimate is that only 8.1% of all Medicare enrollees are in one of these forms of managed care contracts as shown in Chart 5. The vast majority of Medicare enrollees are still in the traditional fee-for-service Medicare program that we're all familiar with. As another point of reference, at the end of 1993 only 5% of Medicaid enrollees were in some form of managed care.

CHART 5
MANAGED CARE ENROLLEES



8.1% of all Insureds

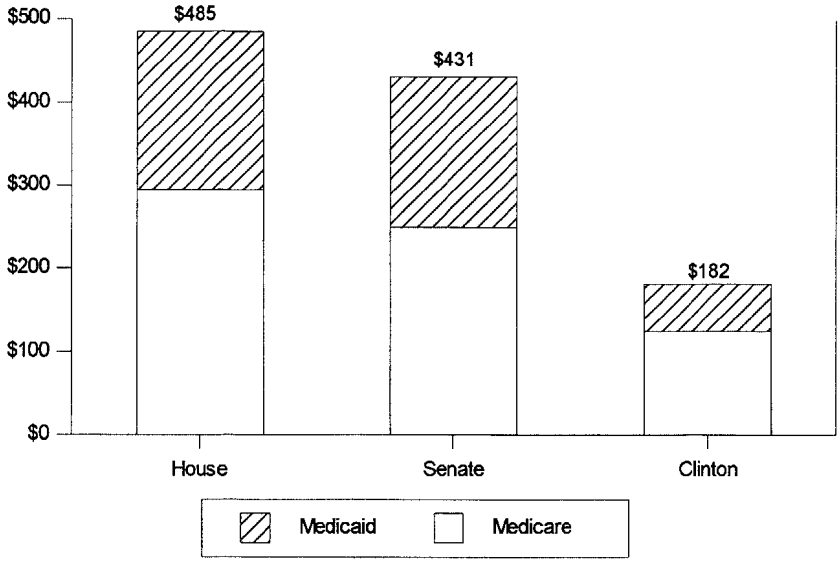
Now, there are a couple of political realities that we need to understand. First, there are some in Washington who simply do not trust and do not like managed care. I think part of that's ideological. They believe in a free market and in free choice and people being able to spend their money anywhere they want to. As a result, the whole HMO control concept just doesn't sit particularly well with them. Also, a number of legislators in Washington are being approached by their elderly constituents with what can only be described as HMO or managed care horror stories. These individuals are saying "I (or my friend) was involved with this HMO and this happened, and it was a horrible situation. You can't force us into HMOs." This is, I believe, one of the things that's driving many people to propose some sort of MSA option for the Medicare eligible population. In addition, there's another cross-current that is also very important. There are many people who believe that HMOs are currently receiving a windfall from the government HMO risk contract program.

What happens now is that for each Medicare enrollee joining an HMO under a risk contract, the HMO is paid 95% of the adjusted average per capita cost (AAPCC) for the Medicare program. This is an average cost that's calculated off the fee-for-service Medicare base. This fee-for-service-based per capita cost is adjusted for age, sex, and geography whether the enrollee is institutionalized or not, and whether or not the enrollee is eligible for Medicaid. It does not make any further adjustment for health status. The HCFA is convinced that the HMOs participating in the Medicare risk contracts are systematically receiving a healthier variety of Medicare enrollee, and as a result, they are getting a savings in excess of the 5% discount (remember, HMOs are being paid 95% of the AAPCC). In other words, HCFA believes that risk-contracting HMOs are actually getting enrollees that are 12–15% healthier on average than the average Medicare enrollee, and as a result, are reaping some windfall profits. This perception of windfall profits will affect how they want managed care integrated into the Medicare program.

There are a number of current budget proposals as illustrated in Chart 6. On Medicare, the House budget committee is suggesting $298 billion in savings over the next seven years. The Senate budget committee is asking for $256 billion over the same period, while the Clinton budget only projects $127 million in savings from the Medicare program. On Medicaid, the House budget committee projects $187 billion in savings. The Senate budget committee projects $175 billion, and the Clinton budget projects roughly $55 billion. Now, there's something subtle going on here that's not immediately evident. Apparently, the Clinton administration is using economic assumptions that are somewhat more optimistic than those used in the congressional projections. Senator Pete Domenici (R–NM), the chair of the Senate Budget Committee, is one person who has been pointing this out publicly.

The Washington Times has reported on a Senate budget analysis that indicates that if the Clinton budget proposals were scored on the same basis as the Senate budget committee proposals, then the savings would turn out to be $192 billion for Medicare and $122 billion for Medicaid, which is significantly higher than what the administration is projecting. It was also reported recently that the House and Senate budget negotiators had come to a tentative agreement of $270 billion on Medicare and $175 billion in Medicaid. This roughly split the difference between the House and the Senate on the Medicare program and goes with the Senate number on the Medicaid program.

CHART 6
PROJECTED SAVINGS FROM HEALTH CARE REFORM
OVER SEVEN YEARS (IN BILLIONS)



The House budget committee has also made some specific recommendations as to how these savings might be developed in the Medicare program. In talking about this, it is important to understand that the budget committee doesn't actually make appropriations. It only sets the budget, and then different committees have to make the detailed appropriations to the programs. These appropriation committees actually determine how the money's spent, but the House budget committee is suggesting to its sister committees certain changes that could be made to produce the budgeted savings. Specifically, it's suggesting $160.7 billion in savings through different changes to provider payments (essentially reducing provider payments). This breaks down into about $135 billion from hospital payments, $18 billion from physician payments, and $6.7 billion from other provider payments. As you can imagine, the hospital industry is not particularly enamored with this. Essentially all of the savings that the Clinton budget proposal makes come from one form or another of provider cuts. In effect what the administration is doing is saying, "Yes, we need to make these savings. We will get the savings by cutting provider reimbursement, but we're not going to cut back on benefits or increase premiums for enrollees."

The House budget committee is also suggesting roughly $54 billion in increased premiums from enrollees. Increases in co-payments and deductibles would gain $41 billion. Some changes in the way that risk contracts are established would be made to gain about $14 billion. The committee is also recommending saving $32 billion or so through various other changes to the program. Finally, it is suggesting that we might want to consider changing Medicare over to a defined-contribution basis. What this would mean is that the government would make a standard contribution (for political reasons it's not a *voucher* but a *contribution*) on behalf of each Medicare enrollee. It would be adjusted for age, sex,

geography, we're not entirely sure what, and the enrollee could take that contribution and go to any of a number of health plans operating in the enrollee's area, sign up and get whatever kind of coverage the enrollee wants. The committee seems to be envisioning a program administered similarly to the current federal employees' health benefits program (FEHBP). The goal is, of course, that by encouraging enrollees to make prudent choices (that is, choose managed care), a great deal of money will be saved. A clear vision for how all this can be accomplished has not yet coalesced.

The suggestion that we consider converting the Medicare program to a defined-contribution basis probably illustrates where the focus of the current debate lies. It seems clear that HMOs will be part of the system if some sort of multiple choice, private option approach is taken. Probably PPOs and point-of-service (POS) plans will also be allowed to participate. There's also a strong lobby for some sort of MSA option to be available. And, of course, this sort of private market reform might be done and might not work. The final suggestion that the house budget committee made was to consider combining a defined-contribution plan with some sort of look-back provision that would essentially say, "OK, we've done this. Did we save the money we expected to?" If not, then something happens to force the necessary savings out of the system. The kind of things that would happen would be reduced payments to providers, increases in co-payments and deductibles, and other similar changes to the program.

Let's look at Medicaid briefly. We seem to be heading towards a block grant to the states. Medicaid does not have the kind of lobby that Medicare and Social Security do. So politically it's a little easier to be totally radical here than it is on Medicare. Currently there's a great deal of disagreement about the constraints that should be placed on the program. The state governors essentially want no constraints, or at least as few constraints as possible. Their feeling is if they are going to get this block grant, and then they are going to be on the hook to produce the savings or else, and they need the flexibility to do what needs to be done. There are some other constituencies here also, though. There are some that want some social constraints on it, for instance, no funding for abortion, no funding for unwed teenage mothers, no funding for unwed teenage mothers who are living alone, or no funding for illegal aliens. On the other side, there are some people who want to put very different constraints on the program, such as you must cover everyone on cash assistance, you must cover disabled children, or you must cover individuals who are under a specified percentage of the poverty level.

MR. DANIEL D. SKWIRE: Do any of the panelists have any comments on developments in federal regulations that might be impacting the disability income products. I'm thinking, in particular, of some of the guidelines around guaranteed issue, restrictions on underwriting, and that sort of thing, that might apply to disability either intentionally or unintentionally in the broader picture of health care reform.

MS. NOVAK: I can address the unintentional. I don't see anything intentional. Where I see restrictions on the definition of health care, the wording is pretty careful to define it as traditional health care, not disability income or a specialized product.

MR. EDWARD MCKAY MOORE: You mentioned that some states have MSA legislation. Could you give a little more information on Texas?

MR. LANE: I could certainly get you more information. In Texas, MSA legislation has only been introduced. It has not been passed.

MR. JERRY WAYNE FICKES, JR.: When you said that the interest on the MSA account was not taxable if you took it out, is that because you are not allowed a deduction as it is earned?

MR. LANE: Correct. That's because now it will be taxable as you incur the interest. The original proponents of MSAs had wanted it to be like an IRA. They had wanted the inside buildup to be tax-free. Only when you took the money out would there be a tax. But the cost of that has been too much, and all of the federal proposals to date have made the inside buildup taxable. So, if you take that interest out later on because it's already been taxed, it is not taxed at that point in time.

FROM THE FLOOR: Bill, isn't this going to cause a great deal of confusion with the various state programs that are coming out?

MR. LANE: Absolutely.

FROM THE FLOOR: It must be that way because everyone has a different deductible. I know ours is completely different, even what you can withdraw. If I can also ask Mr. Wildsmith a question, I noticed we kept throwing around the term *health care reform*. Maybe his topic is, but the rest of this is more health *insurance* reform. But on your Medicaid and Medicare basically what we're saying is we're going to cut the amount that is paid to the provider. Isn't that just going to cause more cost transference which will cause more problems on the federal level and give Donna more bills to report on? When times are good, we don't hear much about health care reform, but every time that cost starts going up, believe me, we hear about it.

MR. WILDSMITH: That's certainly a concern, and clearly with the Clinton administration budget, essentially all of the savings are projected as coming from the cuts to provider payments. However, many people in Washington have high hopes for a structural reform of the program. That's what they envision moving to a defined-contribution approach would be. Under that kind of approach, you would essentially be given a pot of money and told to go to this free market and purchase your Medicare coverage. The hope is that if we could change the numbers so that instead of having 8% of the Medicare enrollees in some form of managed care and 92% not, we would have the 92% in managed care, and we could generate some real savings that would not just be cosmetic savings from cost shifting in the provider community. I don't know whether it'll work or not, but there seems to be agreement that something needs to be done.

MR. LANE: To use Tom's number, what legislators are looking for is to cut Medicare and Medicaid by about $400 billion over five years. These numbers become sort of magical over time. Over seven years that's about $60 billion a year. Right now the health care in this country is about $1 trillion, but that includes long-term care, dental, and many things that really aren't covered with this. If, in fact, you look at pure medical costs, they're more like $600 billion. Legislators are talking about something that, over time, is intended to reduce the payments to providers by roughly 10% of the total, and that's not an easy thing

to manage out. Theoretically it's at least possible, but if it doesn't happen, we're all at risk in some way.

MR. THOMAS J. STOIBER: In regards to the Medicare revamping, if you will, over the course of the last several months I've been getting telephone calls from companies that are in the Medicare supplement business that are very worried about reform and what's going to happen. Many of these Medicare supplement plans are unfunded, nonreserved, level premium plans, and these people have much to lose if they have a high lapsation rate. Being with Health Insurance Association of America (HIAA), I'm wondering if you've heard any reaction or precaution from Capitol Hill. Is it too premature to speculate on what might happen to these companies that have so many big blocks of business that might have 50% lapse rates one year?

MR. WILDSMITH: We, as an association, are very concerned about that. It's a little premature to predict what's going to happen, but frankly, the people in Congress seem to be looking for basic, structural, radical reform. I don't think they care if the Medicare supplement industry bleeds on the path to that reform. I think one reason that legislators are willing to look for basic Medicare reform is that this is fundamentally different from what Clinton tried to do last year with health care reform. Essentially, he was taking a private market and going in and reforming it in a little more government-controlled fashion. This is already a government program. So, they're a little happier to monkey with it.

FROM THE FLOOR: Let me be very specific. There are companies that are sitting on actual lifetime loss ratios, experienced data, like 45–50% because all their business was written in the last three years. There are state laws mandated by Bockus et al. that say they have to return 60%. If they all of the sudden lose all their business, they're going to have to give huge refunds, and there's no money to refund it. I'm flabbergasted that no one is talking about this. If no one takes the Medicare reform on the Hill very seriously, could this result in many lapsations, or will there be a transition type thing?

MR. WILDSMITH: I don't know if there will be a transition or not. The HIAA clearly is very concerned because a number of our members are in that line of business. Unfortunately, it's a moving target right now, and we really don't have hard legislation on what's going to happen. Candidly, the HIAA itself is still trying to figure out all of the issues, and we aren't sure how we think it should go yet.

MR. LANE: The American Association of Retired Persons (AARP) is a very powerful lobby, and the likelihood of forcing all of the elderly into HMOs is very small. However, a number of the congressional projections show over half of the elderly going into some form of Medicare risk contract, which means they would no longer have a Medicare supplement as is traditional today within five or six years. So, Congress is planning on trying to make the market happen so that people choose Medicare risk, which means they're getting their entire medical coverage through the HMO, which really reduces any need for Medicare supplement. So, there is some intention to move a large number of people; yes.

MR. JOHN DANTE: That's related to my question. Tom, could you comment on two things that I've been noticing in the press lately. One, it seems like there's more of an attack on the AARP and I get a feeling that it may be an obstacle to us moving forward with Medicare reform. Second, I just read that the HMOs with these risk contracts that

we're trying to enroll people in is just not working out very well. There's a lot of opposition going on and I hear that the elderly are not being treated properly. I guess it's similar to the whole telephone industry, and converting people over.

MR. WILDSMITH: The AARP is certainly a very formidable lobby, and it's interesting that it's under scrutiny right now. Of course, the normal retirement age at one time was considered impossible to buck, and we now know that's not true. So it may well be that the AARP won't win in the end. Interestingly enough, I've also read that there have been a number of people who lapsed their membership with the AARP due entirely to the organization's stand last year on the Clinton health care proposal They did not feel that they were being represented.

I don't think anyone knows why HMO enrollment is as low as it is in Medicare. There are a number of possible reasons for this. For example, the HMO enrollment tends to be much, much higher where there are many HMOs. So if you go to California or Arizona, you're going to see 20–30% enrollments. If you go to Louisiana, it's going to be even less than 1%. There's also some feeling that it may be related to capital. HMOs seem to be making a great deal of money in that particular line of business, but some analysts feel that in the late 1980s and into the early 1990s they simply didn't have the capital they needed to expand their networks and more aggressively pursue the Medicare eligible. There have been some studies done by the HMO industry on enrollee satisfaction with HMOs. It appears that people who have selected to go into an HMO tend to be happy with it, at least as much as people who are in the traditional Medicare program. I don't know if they are self-selected by the fact that they are still in the HMO or not. And then, finally, I do think there is some fear, and there is some lack of familiarity. I think of my grandmother who is about to turn 90. I think simple utilization review would totally blow her mind. There's no way in the world she will go into an HMO. Luckily, I don't think there's anyone who's talking about trying to make her do so.

MR. LANE: To add to that, historically with your Medicare risk contracts, you still had a premium to pay if you wanted to join the HMO. More and more we're seeing in the marketplace that the Medicare risk contract, which is in essence a combination of Medicare coverage and Medicare supplement coverage, is zero premium. Some sales representatives are finding it relatively easy to sell zero premium, especially when it includes drug coverage, and that is starting to fuel the transfer of the population even though there may be no government push for it. Just the marketplace is making it happen.

MR. EARL L. HOFFMAN: Just a comment about the MSA proposals. If you look at a comprehensive plan with a $250 deductible versus a catastrophic plan with a $3,000 deductible, the actuarial difference in the value between those two plans was much less than $2,750. So, if the employer wants to kick in even the full premium difference between the two into an MSA, they still will have a large gap between the deductible and what's in the MSA, at least initially. Given the fact that many employers are very risk averse, is this MSA concept even going to be used all that much?

MR. LANE: Well, I think you can answer that by looking at flexible benefits programs where people are offered the choice between a $250, $500, and a $1,000 deductible. Not everyone will select the $1,000 deductible, but a significant number of people will. Part of it will be dependent upon how the catastrophic coverage is priced and whether it includes

the aspect of healthier people being more willing to take that kind of risk than unhealthy people. It could be a very attractive option for healthy people. You're correct that you cannot fund the full deductible. The difference in premium will never equal the deductible itself.