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Back to the Future with Medicare: What Lies Ahead?

Track: Health

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Panelists: JOSEPH ANTOST†
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RICHARD S. FOSTER
ROBERT G. LYNCH

Recorder: ROLAND E. KING

Summary: Experts debate legislative changes to the Medicare program. Included will be an overview of the changes in the 1995 legislation, expected savings in the Federal budget, a debate as to the realism of these expected savings, reaction of enrollees, and discussion of anticipated effects on the private sector of the healthcare system.

Mr. Roland E. King: There is a certain amount of familiarity with the Medicare reform that has been discussed at this meeting. In particular we are keying off the Medicare Preservation Act, which was enacted by the Congress and then vetoed by the president in 1995, because that seems to be a basis for what we can expect for future Medicare reform.

Some of the controversial issues that we are going to be dealing with are as follows: Did the Republican plan reduce Medicare spending too much, or did Clinton's plan reduce Medicare spending too little? What is the right number? Does the Medicare Plus program (which is the expansion of the risk program) by itself result in reduced Medicare spending? Should provider-sponsored organizations be included in Medicare reform? What role should they play? What should their capital requirements be?

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Another issue is the role of medical savings accounts (MSAs) in Medicare reform. Another controversial issue is: do health maintenance organizations (HMOs) currently contribute to reduced Medicare spending? Is the geographic reconfiguration of the adjusted average per capita cost (AAPCC) a wise thing to do. In other words, is it going to save money or is it going to cost money for the Medicare program?

We have a very knowledgeable and distinguished panel. Joe Antos is currently the assistant director of health and human resources at the Congressional Budget Office. He has also been the associate administrator for management at the Health Care Financing Administration (HCFA). He has been the director of the office of research and demonstrations at HCFA, and he has also had positions at the Department of Health and Human Services (HHS), the Office of Management and Budget, and the Labor Department.

Ron Bachman is a partner and a consulting actuary with Coopers & Lybrand. He was a member of the Medicare work group, and he chairs Newt Gingrich's advisory group on Medicare reform. He also played an instrumental role in helping us, when I was at HCFA, to make more accurate mental health coverage cost estimates for the 1994 Health Security Act.

Rick Foster is currently the chief actuary of HCFA. He is a former deputy chief actuary at the Social Security Administration. Rick stood out at the Social Security Administration as a proponent of realistic cost projections for social insurance programs.

Robert Lynch is an actuary with WPS in Wisconsin and he is also a member of the Medicare work group.

Rick will set the stage for us and base his comments on the 1996 Trustees Report that just came out this month. Then the other speakers will present in alphabetical order.

Mr. Richard S. Foster: I will say a few words about the financial status of Medicare. I will focus primarily on the hospital insurance (HI) program because that is the one that gets all the attention and has caused all the uproar. I will also say a few words about the supplemental medical insurance (SMI) program.

Table 1 shows a few of the Medicare basics. I will remind everybody that Medicare has two parts: Part A and Part B. Part A is otherwise known as HI. Part B is known as SMI. The two programs have very different methods of financing. It is worth noting that the benefits are fairly well understood for each part. One covers

primarily hospital and related services, and the other covers primarily physician and outpatient hospital services. It is worth noting that HI is more of an old-fashioned insurance plan in a sense that you are covered against the risk of a fairly expensive event, and not that many people encounter such events in a given year. For HI, in the course of a year, maybe 22% of beneficiaries use these services. For SMI, on the other hand, the deductible is only \$100. It is fairly easy to meet that. In the course of a year something like 84% of our beneficiaries end up with at least some services covered by SMI or Part B.

TABLE 1
MEDICARE ENROLLMENT, BENEFITS, AND FINANCING

	Hospital Insurance (HI)	Supplemental Medical Insurance (SMI)
Enrollment in CY 1995: Total Proportion with services	37.1 million 22%	35.6 million 84%
Benefits	Inpatient hospital care Skilled nursing care Home healthcare Hospice care Subject to deductible and coinsurance	Physician services Outpatient hospital services Other services, e.g. ● Diagnostic tests ● Medical equipment ● Ambulance Subject to deductible and coinsurance
Financing	HI tax on covered earnings: ● 1.45% payable by employees and employers each ● 2.90% payable by self-employed ● Following elimination of HI contribution base (effective 1994), HI tax applies to <i>all</i> earnings in covered employment Revenue from taxation of OASDI benefits (portion between 50% and 85%)	Premiums paid by enrollees: ● \$42.50 per month in 1996 ● Currently covers 25% of costs General revenue transfers: ● \$127.30 per month for aged persons ● \$167.70 per month for disabled ● Covers remaining 75% of costs

Let's focus on how these two parts are financed because that's critical. In particular, the HI program is financed primarily by a portion of the Federal Insurance Contributions Act (FICA) and the State Insurance Contributions Act (SICA). These are payroll taxes that you pay. It is 1.45% of earnings paid by employees and employers each, and self-employed pay a total rate of 2.9%. I suspect many of you are aware that the maximum tax limit or wage limit on which you pay HI taxes was removed effective 1994. So you now pay HI taxes on your total wages and salaries regardless of how high they are.

There are other minor sources of income for the HI program, such as interest income, some revenue from the taxation, and the income taxation of social security benefits, but they are small by comparison.

Now, contrast that to the financing for SMI, which is a voluntary program. It is financed in part by monthly premiums paid by the enrollees and they currently cover 25% of the total cost of the program. The other 75% is picked up from general government revenues.

Each program has its own trust fund. There is financial oversight provided by a board of trustees and the discussion that I will make is based on the 1996 Trustees Reports. Projections are made in the Trustees Reports for a short-range period (the next ten years), and a long-range period, the next 75 years. The purpose of these projections is to illustrate how these programs would operate under specified conditions that could reasonably be expected to occur. That is useful for policymakers.

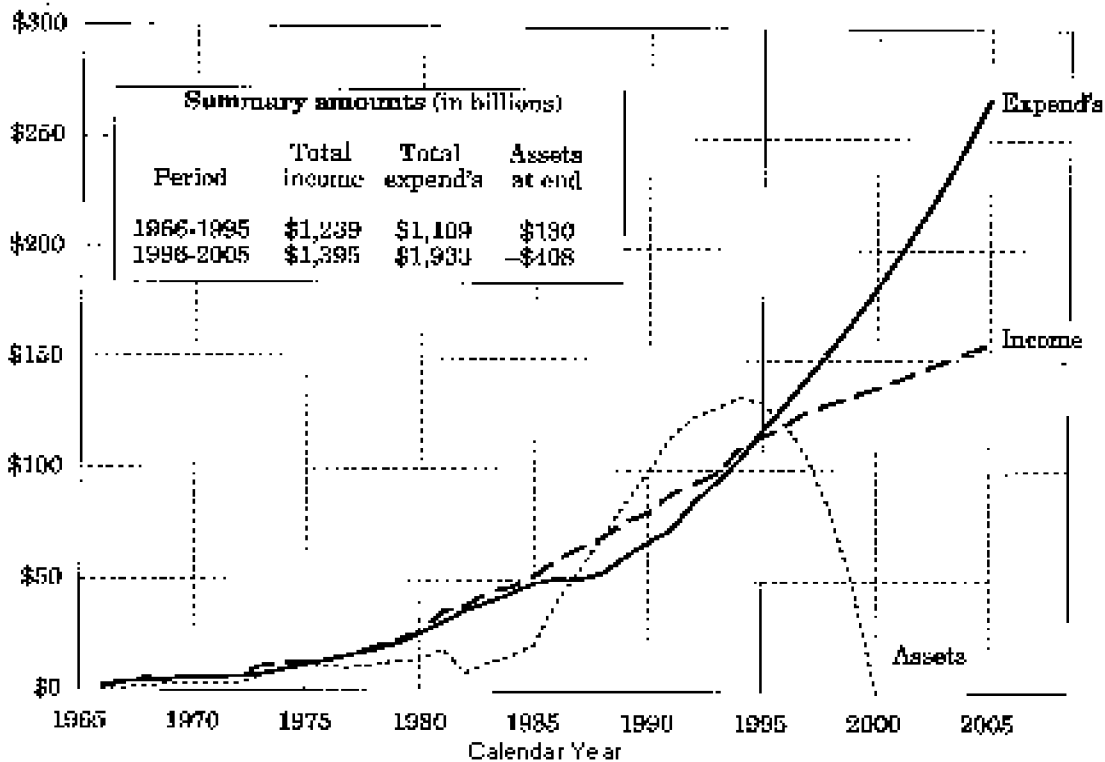
The only thing we can really count on is that any single projection will be wrong, and probably very wrong. For that reason, we show three sets of assumptions or projections under three sets of assumptions to illustrate the uncertainty and the possible range of outcomes. Of course, it is also entirely possible we could fall outside of that range, as we have from time to time in the past.

Let's take a look at the short-range outlook for the HI trust fund. In Chart 1, the solid black curve is the past and projected future expenditures of the HI trust fund. The heavy dashed curve is the past and future income to the program.

You can see that throughout most of the past, those two curves have been fairly close together, which illustrates the fact that the programs have been financed on a pay-as-you-go basis throughout HI's history. You can also see the basis for the problem we have for HI.

Starting in 1990, the expenditures of the program were increasing considerably faster than the incomes. We project that will continue to happen. In particular, we have expenditures increasing at 8% or 9% a year, whereas the income is increasing at only 5% or 6% a year.

CHART 1
 HI INCOME, EXPENDITURES, AND TRUST FUND ASSETS
 (IN BILLIONS)



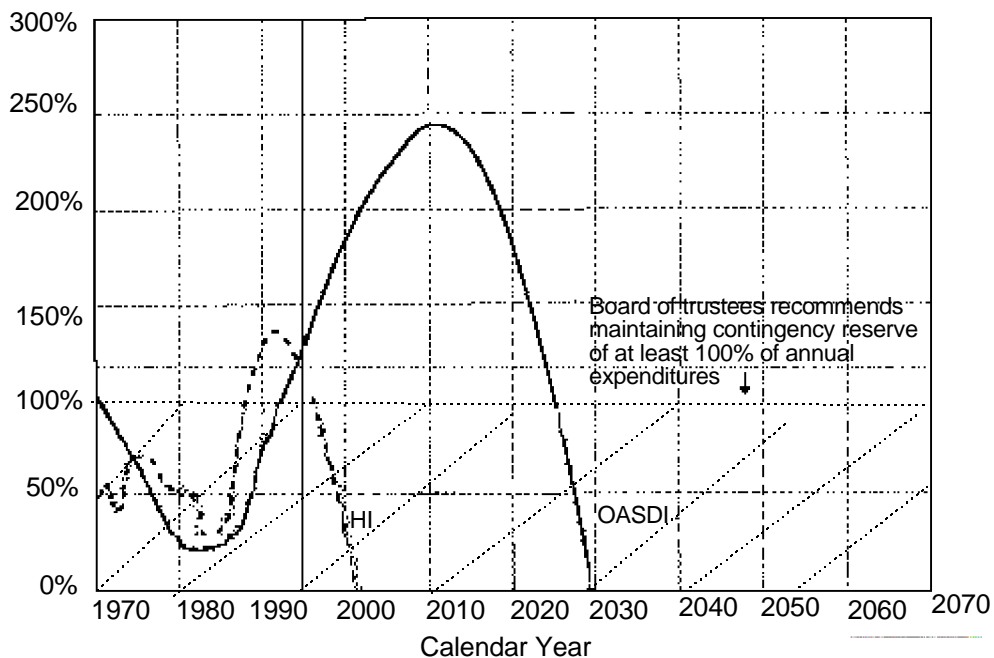
Note: Projections are based on the intermediate assumptions from the 1996 Trustees Report.

In 1995, we ran a deficit. In other words, our income was not sufficient to cover the expenditures. That was only the second time it ever happened for the program. It caused quite a stir. A deficit is not the end of the world. We have assets that are invested in government securities. We can redeem those assets to cover any shortfalls, but as you can see from the thin assets curve, they will not last forever. In particular, we used up \$2.6 billion of the assets last year, and we will use up probably \$8 or \$9 billion this year, and we are going to use it all up by the time we get to early in 2001.

One other thing you can notice is right now the income and the cost curves are fairly close together, so if we tried to fix the problem today, we would have to change the trends, get that cost trend down, and get the income trend up. Suppose we wait a year or two, or three, such that these curves have continued to grow apart. The longer we wait, the harder it is going to be to bring the system back into balance.

Let's look at Chart 2. This is another way of looking at the trust fund assets for HI. Here we express the assets as a percentage of annual expenditures, so we get a relative measure. For the fun of it, we have put the social security or OASDI program on here for comparison. You probably have seen in the newspapers that the OASDI trust fund is expected to peak at about 2011 and then be depleted rapidly once the baby boomers retire. Notice for HI that we already have peaked and, moreover, we will go broke long before the baby boomers even start to retire. That is all without corrective legislation, of course.

CHART 2
TRUST FUND ASSETS
(AS A PERCENT OF ANNUAL EXPENDITURES)

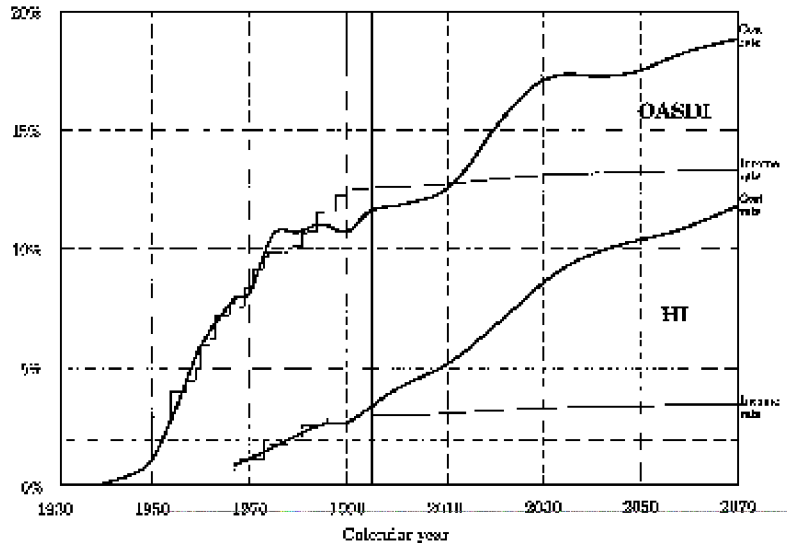


Note: Projections are based on the intermediate assumptions from the 1996 Trustees Report.

Let's take a look at the long-range income and cost rates for HI. In Chart 3 we have taken the same source of income and expenditures and expressed them as a percentage of taxable payroll. In other words, all the wages and salaries and self-employment income is subject to the HI payroll tax. That is maybe \$3.6 trillion these days. Notice in the past the income rate curve and the cost rate curve are very close together. Notice also that the cost has generally gone up very quickly even expressed as a percentage of payroll, but the income has kept up with it. From now to 2070, the income rate does not change very much. That 1.45% tax rate paid by both employees and employers is written into the law. It is fixed. It will not change until Congress decides to change it and the President decides to accept

it. The income does go up a little bit, because the revenue from the taxation of Social Security benefits increases over time. That is really the only increase we see.

CHART 3
LONG-RANGE INCOME RATES AND COST RATES
(AS A PERCENT OF TAXABLE PAYROLL)

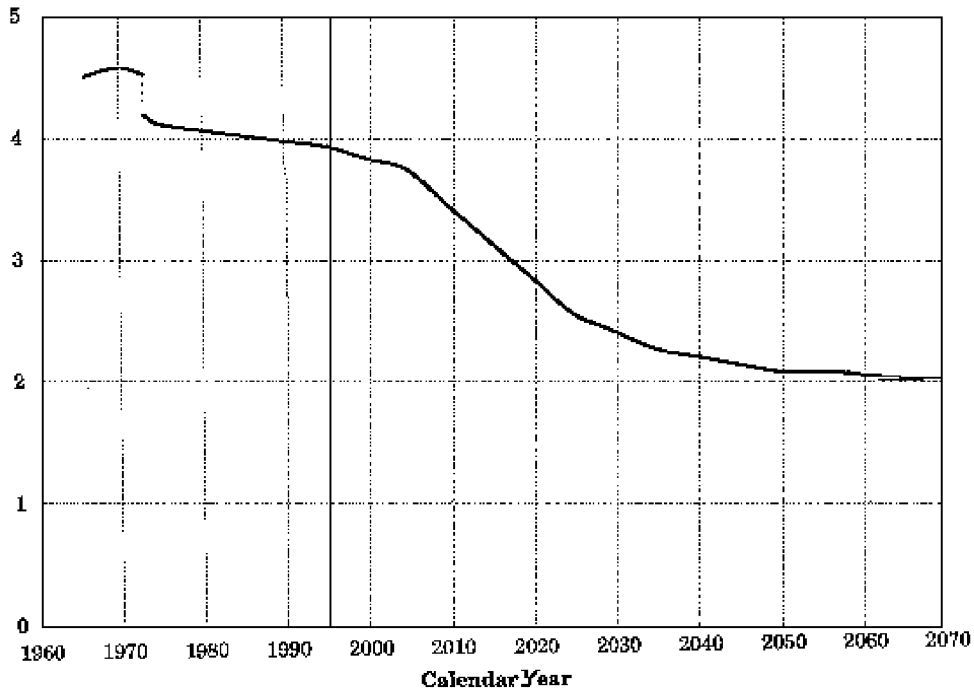


In contrast, of course, we project the expenditures to continue to grow fairly quickly. You can see that we already have a small deficit, and it will continue to grow indefinitely particularly when the baby boom begins to retire. If we wanted to bring income and expenditures back into balance over just the next 25 years, we would either have to reduce the benefits immediately over that period by 39%, or we would have to raise the income to the program by 63%, and that is just for the next 25 years.

If we wanted to do the same kind of calculation for the entire 75-year projection period, you can see that immediately we would have to either cut the cost by more than half, or more than double the income to the program. So major changes would need to be made in the long range.

Everybody is fairly familiar with the demographics, but in Chart 4 we can look at the ratio of how many workers there are supporting each HI beneficiary. It is currently 3.9 workers for each beneficiary, but once the baby boom generation starts to retire in about 2010, that will rapidly change and we will eventually end up with about two workers to one beneficiary.

CHART 4
NUMBER OF COVERED WORKERS PER HI BENEFICIARY



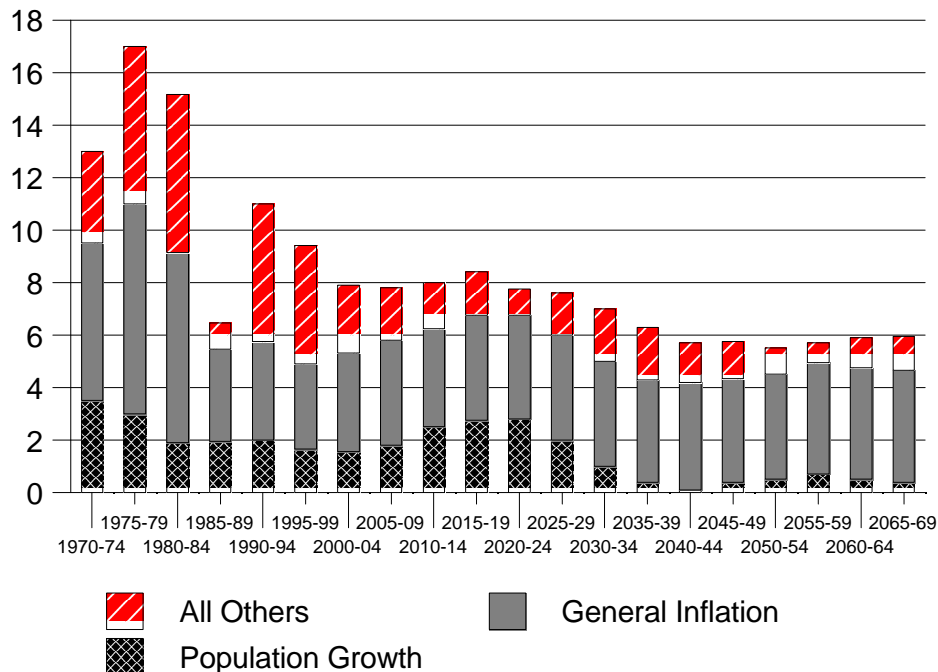
Note: Projections are based on the intermediate assumptions from the 1996 Trustees Reports.

Let's take another look at some of the factors underlying the projected growth in HI. Chart 5 shows for a five-year period the average percentage change in three categories of factors that drive HI program costs. Particularly, we have growth in the number of beneficiaries. That is the solid black set of bars at the bottom. Then the gray section of each bar is general inflation as measured by the consumer price index. This is general economy-wide inflation. The white bar on top is everything else. Notice that in 1995 and in the next few years, the growth in the number of beneficiaries is actually low compared with the past or the future, and we know why that is. The people turning 65 these days were born in 1930 or 1931 which was during the depression years when birth rates were very low. Right now we have a slower-than-average growth in the number of beneficiaries. However, once the baby boom generation begins to retire, you can see the bars expand there and that will cause program costs (other things being equal) to grow fairly substantially for a number of years. After the baby boom generation is fully retired, it slows down considerably when the baby bust generation will finally retire.

For the general inflation we assumed 4% a year as a long-term average. That is shown by the constant gray bars. The interesting point is everything else, whatever is left over, and that includes changes in utilization, differential wage, and price increases in the health care sector above and beyond general inflation, and intensity

in services. You can see there that in the past it has jumped around a little bit, but it has generally been quite high. What we assume for the future is that over the next 25 years we make some progress, that residual cost factors in fact will start to narrow down after a while and return to what would be considered a more reasonable level. This might be considered something of an optimistic projection. On the other hand, it cannot go on forever. It has the worst of the historical levels, because eventually we would all be doctors or patients or both.

CHART 5
HI EXPENDITURE GROWTH FACTORS

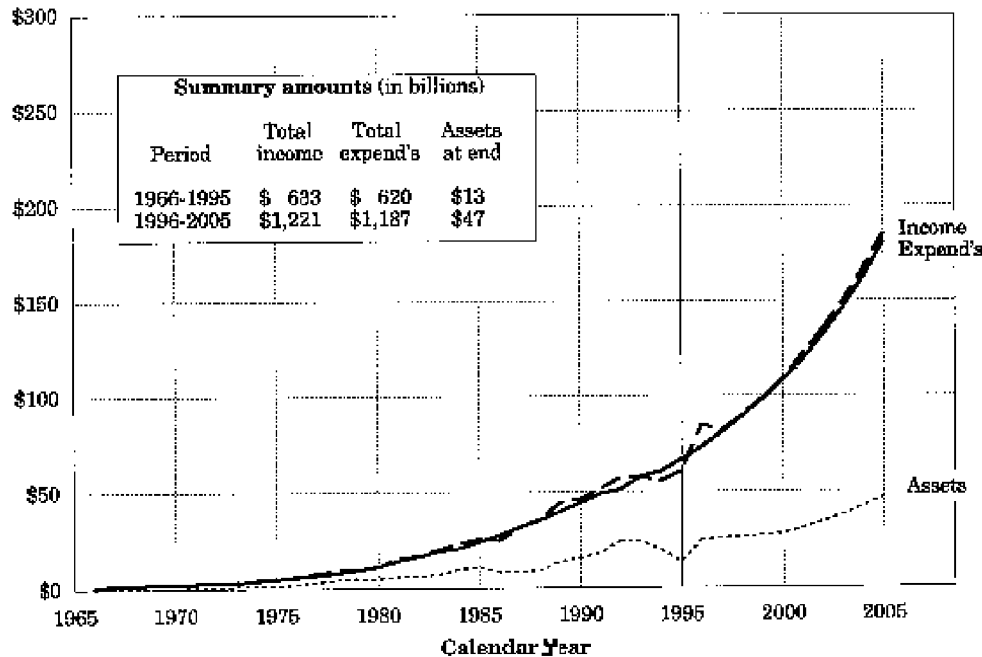


It is interesting to note also that as the baby boom generation starts to show up, the white bars and everything else narrow down a little bit. You can imagine if you have a bunch of 65-year-olds coming into the Medicare program, their utilization is lower than average for everybody else. That actually ends up in a slower-than-average per person rate of growth. Once the baby boom generation starts to age and moves into the higher utilization years, it grows again and the costs are higher in that factor.

Let's take a look at the SMI program in Chart 6. This is just like the earlier chart we saw for HI, with one or two notable differences. Notice how, in the future, even though we have a projected rapid rate of increase in expenditures for SMI, the income keeps pace with it. That is because the premiums and the general revenue financing for SMI are reset every year. Each year we reset those to match our

estimate of the costs for the next year. So it is automatically self-financing. It is automatically in balance. We are still a bit worried, of course, because the rate of increase is so fast, but you do not hear about the SMI program going broke the way you hear about the HI program going broke. For HI, the tax rates are in the law. They will not change until Congress acts. The SMI financing is reset every year.

CHART 6
SMI INCOME, EXPENDITURES, AND TRUST FUND ASSETS
(IN BILLIONS)



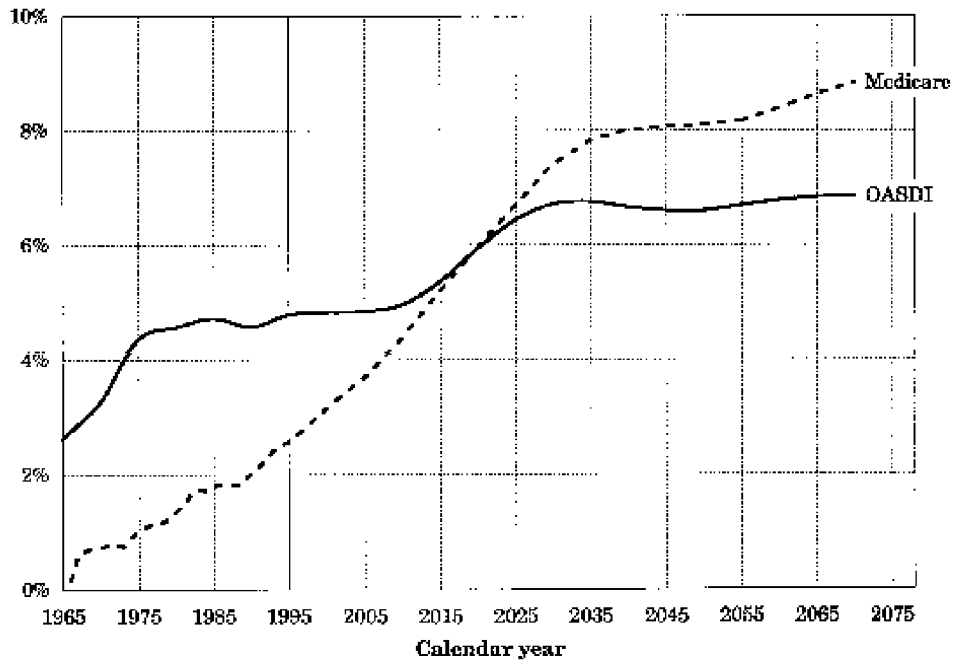
Note: Projections are based on the intermediate assumptions from the 1996 Trustees Reports.

In terms of the gross rates, SMI has grown approximately 53% over just the last five years, and that is about 22% faster than the gross domestic product (GDP). The trustees of the program have expressed serious concern over this rate of growth and have recommended that Congress do something about it. One other concern that has been raised has to do with the percentage of total program costs that is met by the SMI premiums. It has been about 25% for a number of years, but after 1998 it will start to decline and if nothing is done to correct it, eventually it will get as low as only 6% or 7%. So that is a source of concern.

Let's add together the costs for HI and SMI and express them as a percentage of the GDP as shown in Chart 7. Then, for the fun of it, let's compare that to the same kind of cost for the Social Security or OASDI program. Notice the solid curve for Social Security. The cost has been relatively level for a number of years and will stay level until the baby boom generation shows up. What has been happening

with Medicare? The cost increases have been so great that, in fact, we are rapidly catching up and these curves will cross, under present law, inside the year 2020 or so.

CHART 7
EXPENDITURES AS A PERCENTAGE OF GROSS DOMESTIC PRODUCT (GDP)



Note: Projections are based on the intermediate assumptions from the 1996 Trustees Reports.

Just to sum up, obviously the HI program faces severe financial problems, both in the short range and the long range. It is important to point out that all the proposals that have been made to date to address Medicare have been made in the context of the budget process. They have not been made in the context of determining how to finance Medicare for the long term, so none of them really is adequate to cover the long-range cost of the programs or to bring the cost down to the level of the income.

Moreover, they are not really adequate to cover the short range at a level sufficient to maintain an adequate contingency. We see that SMI is automatically in financial balance, so that is nice, but it is still growing by leaps and bounds. I would just say that these problems seem fairly overwhelming, but solutions are possible. We are not going to get the solutions until we get a much better degree of cooperation between the administration and Congress. The solutions are out there, but we need much better leadership than we have had.

Mr. Joseph Antos: Rick did a nice job in explaining the real problem, which is the growth in outlays rather than the relationship between outlays and revenue. Before I start, I have to give the standard disclaimer. I will mention a few Congressional Budget Office (CBO) estimates, but I will give you my own opinions, not necessarily anybody else's.

I will make four points. I think these are four important points about the budget proposals that were floating around last year and the kinds of thoughts that continue this year even though there will be no action.

First, do fee-for-service reductions and in the case of the balanced-budget amendment, the fail-safe mechanisms, actually save money? The answer is yes, but only because of tightening price controls. Ultimately, that will backfire on us. This is not a long-run approach to solving the Medicare problem.

Second, does Medicare Plus actually save money? The answer is yes, but not because of anything having to do with managed care.

Third, how about the higher premiums that were proposed somewhat weakly in the administration's plan and more aggressively by Congress. Do these things help? I say yes. I wanted to observe briefly that the balanced-budget amendment idea of establishing an income-related premium sets up an entirely new and revolutionary principle for Medicare. I am astonished that the American Association of Retired Persons did not voice a complaint in that sector. I did not hear them say that you cannot have income-related premiums because Medicare is not a welfare program, whereas we have heard that many years prior to last year. I think that is a remarkable sign of perhaps greater realism or greater concern on the part of the public.

Fourth, did the entire balanced-budget amendment solve Medicare's problem? I think Rick convincingly pointed out the answer to that is no. I think, however, there are components of the balanced-budget amendment that suggest very plausible policy directions. Neither the administration nor Congress, however, went anywhere near far enough last year and are not going anywhere this year.

The title of this session is "Back to the Future with Medicare: What Lies Ahead?" I think actually that the process in the last year-and-a-half or so reminds me of a different movie, namely *Groundhog Day*.

What have we been repeating over the past year? A few budget statistics will complement the dismal picture Rick gave us from the trust fund perspective. As shown in Table 2, last year we had a seven-year budget window, and over that

seven years Medicare would have spent \$1.7 trillion. When you look at the difference in savings between the administration’s plan and the balanced-budget amendment, compared to \$1.7 trillion, it does not look like such a big deal and maybe it is not. In any event it is clear that this aggressive congressional plan was barely chipping away at something that was growing very rapidly and in the period when beneficiary growth was at its lowest.

TABLE 2
LEGISLATIVE PROPOSALS: MEDICARE
(IN BILLIONS)

	Last Year: 1996–2002	This Year: 1997–2002
Current Law	\$1,700	\$1,500
Administration Savings	97	116
Balanced Budget Act Savings	226	158

Note: Figures for 1996–2002 based on December 1995 baseline and 1997–2002 based on April 1996 baseline.

The modesty of these goals is even more evident when you consider that these savings build up over time. In fact half of the savings from each of the proposals would have been taken in the final two years—in the years 2001 and 2002. If that would happen that would be all right except, politically and practically speaking, the last years never come. There is always intervening legislation. In reality, what were people proposing to do? They were talking about a reduction somewhere on the order of \$7–\$15 billion in the first year, maybe a little bit less. It’s kind of significant, but not earthshaking. It will not destroy the health sector as we know it, and it will not solve the deficit problems. The picture is unchanged this year as shown in Table 2. We now have a six-year budget window, and I confidently predict that we will have a five-year budget window next year. We have had a change in base line assumption. Now we think that over the six years, we will spend \$1.5 trillion in the Medicare program. That is roughly consistent with expenditures in one year. So that seems like about the right number.

The administration’s proposal this year went up a little bit according to our scoring—it’s at \$116 billion. The conference agreement calls for \$158 billion over six years.

I am going to talk mainly about last year’s proposal. There is not a specific congressional proposal to talk about this year, but I think what I have to say is generally true about the thinking in Congress, in spite of the fact that there is no concrete proposal.

Going back to the debate of last year, a lot of noise was heard about whether the balanced-budget amendment was going to take too much out of the system and the administration wanted to go about this in a gentler fashion. Many have the impression that there were two kinds of people. Some people thought the difference in dollar amounts was significant, but the vast majority of commentators felt that the money really was not what mattered, it was the policy differences.

What were the real policy disagreements last year? What I think is maybe the most important indicator of policy differences is both sides obviously agreed. Neither side wanted to make large cuts in the program. I consider that a policy issue. That is not just a numbers game. It indicates an intention about how aggressive both sides wanted to be, and I think the numbers suggested neither side wanted to be very aggressive. Second, both sides agreed that they hold dear the basic structure of Medicare, with a dominant fee-for-service sector and the small, but growing risk-based sector remaining intact.

Third, as you can see from the top line in Table 3 both sides depend primarily on a reduction in the fee-for-service sector for most of the savings. Of course, in reality, those reductions are primarily just a tightening of price controls rather than the development of new or better payment methods. There is no prospective payment system lurking in those numbers; it is all payment reduction. They agreed on that. The fail-safe mechanism that the balanced-budget amendment had was just a way of packaging those fee-for-service reductions.

TABLE 3
MEDICARE SAVINGS IN LAST YEAR'S PROPOSALS
SAVINGS FOR 1996–2002
(IN BILLIONS)

	Administration	Balanced-Budget Amendment
Fee-for-Service Reductions	\$69.2	\$153.9
Risk-Based Plan Savings	17.7	18.6
SMI Premium Increases	10.6	54.2
Total Savings	\$97.5	\$226.7

Source: Congressional Budget Office

In the end, however, there was going to be \$154 billion worth of fee-for-service reductions through the avenue of updated limitations, rather than through the avenue of new payment proposals. Fourth, both sides, of course, would open up the risk-based sector to more kinds of health plans, but both sides provided only modest incentives to beneficiaries to actually move into those plans. There is a great deal of agreement about that. I think that, by and large, there were many

agreements between Congress and the President, which makes the fact of no legislation all the more disappointing to me.

There were some arguments on a number of other issues but, again, I think that the arguments were more apparent than real. For example, there are MSAs. A real bone of contention still is President Clinton's endorsing of them several years ago and not endorsing them now. I am not sure that he holds that strongly to the view. The question of a fail-safe mechanism was a bone of contention for a while. One of the administration's proposals, however, had a kind of fail-safe mechanism—an automatic reduction mechanism—except that the difference between the Republican fail-safe mechanism and the Democratic fail-safe mechanism was that the Republican fail-safe mechanism was going to be somehow automatic, the Republicans were going to write in growth rates for each detailed part of the Medicare program in the law, and then there would be payment adjustments to make sure those growth rates were met or at least helped. One of the administration's plans was instead to give the secretary of HHS full discretion to make adjustments where needed. We did not give a high score to that particular idea.

Finally, the one area where there is disagreement (and you can see it in the numbers) is in premium increases. Most of the significant difference is in the income-related premiums. There was a real policy difference there. When you get right down to it, however, I think that any good politician, without regard to party, would agree that if you could get away without touching the beneficiaries, that would be much better because the beneficiaries vote. I do not see much disagreement between the two sides.

Let me move to a quick discussion of Medicare Plus. Medicare Plus would do a number of important things, but I am going to focus on two items. First, it would broaden the array of plans that could be paid on a capitated basis. Second, it would also break the link between capitated payment and fee-for-service costs. However, where did the federal savings from these ideas, from this program, come from? They did not come from managed care efficiencies. First of all, the efficiencies would not accrue as quickly as the savings do and, in any event, the payment is still a somewhat artificial regulatory-style payment. It is not related in the actual performance of a managed care plan.

Second, it does not come from increased competition, because the federal payment is administered. It is not tied to market prices in the locality or tied in any other way to what is going on in the market. The competition in Medicare would still be in terms of increasing availability of services, quality considerations, and risk selection, and not from price competition. The savings also do not come from the

prudent purchasing of beneficiaries who take the high-deductible option insurance with the MSA option because, again, the federal payment to the whole sector is not tied to actual performance. That is where it does not come from, although everybody who has pushed this seems to have mentioned these ideas.

The savings actually come from the restriction and payment update, pure and simple. Instead of having the payments increase with the fee-for-service costs, they would increase with the rate of GDP. In other words, this policy has much more in common with traditional price-fixing policies than many people realize.

Medicare Plus is obviously not the ultimate policy solution, but it would establish some important principles that I think would provide a basis for longer-term policy making. The Achilles' heel in all this is that we will keep this current structure of Medicare. We are going to retain the traditional sector and the beneficiaries would be able to participate voluntarily either in traditional fee-for-service Medicare or in capitated plans. This is a relatively small part of the overall problem. Ultimately, Medicare will have to change in a fundamental way.

One approach to this is to go to a defined-contribution plan for everybody, which is not what we have been talking about. There would be no choice in that, but all kinds of choices in health plans. That is a way to at least control federal expenditures. I think it could also lead to control of overall acute care costs for the elderly, if only because the illusion that financing is unlimited would forever be shattered. In any event, I have to concur with Rick wholeheartedly that we have lost a valuable two years, maybe three, or four years, and when you look back at the social programs and how we got to modify those programs, the only example I can come up with is the reform of social security in 1982–83. That came about because there was really a threat that a check might not go out. So far we have had the sense that there might be a threat in the HI program, but maybe we have to wait until January 2001 before we get serious. I hope not, because it will be, as Rick said, that much harder.

Mr. Ronald E. Bachman: I want to mention the general market, because I think one of the differences from what you have just heard from the previous two speakers is they are coming at it from a governmental and policy viewpoint. I see it every day in the market. My clients are putting together these programs. My clients are interested in getting into the Medicare risk programs, taking on the challenge of lowering costs and lowering utilization. The critical item is we have a trillion dollar health economy. One of the important aspects to keep in mind is that historically you have two separate major industries. One industry is the insurance industry, the HMOs, and the carriers that have been the financiers of health care in the commercial market area in particular. The second industry is the providers of care who have delivered care.

The industries are merging. You have a trillion dollar health economy with two enormous industries merging. That is causing enormous change in the marketplace that many of you are dealing with and for which you are generating new products and systems. I am not so sure that a few years from now an employee who goes to choose health care coverage will know whether the genesis of that coverage is an insurance carrier that bought hospitals and physician practices, and is not only selling products but delivering care, or whether it is a health care system that has its own HMO license and is taking on risk directly. That kind of a change of enormous dollars in our economy is driving many of us, and the whole idea of managed care and the various aspects are what we are seeing in play.

The commercial marketplace has done this fairly successfully over the last few years and it is not at the end of the game yet. What we are seeing now in the Medicare area that we are talking about in the Medicaid area is how do the governmental programs move into the real world of managed care and generate those same types of savings that we are seeing in the commercial area?

In the Medicare program, in particular, it is very easy to become both cynical and very upset as you get involved in this. I feel very strongly that the senior citizens deserve more from the program that is so critical to their health and well-being. From the chart that Richard showed, where in fact it looked like the Medicare dollars are going to wind up being in excess of the social security payments by the year 2020, we are talking about enormous amounts of dollars that people are depending on, and we are involved in a program that is totally out of control. It is completely mismanaged, in my opinion; it is not serving the seniors well. The unfortunate part is, because they have nothing to compare it to, when you ask the seniors, they love it. They think it is the greatest thing going, they don't want it touched, they are afraid of what is going to happen, but they do not understand what a bad deal they are getting.

Why, when you turn age 65, does the government require you to drop your coverage (which is probably a comprehensive coverage with front-end deductible and a limited out-of-pocket, million dollar high or maximum) and take a governmental program that has a Part A and Part B? Why do we have a Part A and Part B? When was the Medicare program implemented? In 1965. What was the dominant program that was in place in 1965? Blue Cross/Blue Shield. Where did Blue Cross get started? Hospitals. Part A, hospitals. Part B, physicians.

What we have is a Blue Cross/Blue Shield plan from 1965 still in place 30 years later when all the rest of us have moved on from that type of limited coverage. I started in this business in 1969, and we had that kind of limited coverage. The employers went well beyond that with the increase in costs and the catastrophic

delivery of care, and we now have comprehensive health care. The elderly do not have that. You do not have prescription drugs in the program today. Why not? In 1965, prescription drugs were not a major part of health care delivery. Today they are. The seniors have a bad deal.

I am still chairperson of Newt Gingrich's Medicare task force. He happens to represent my area. He has a saying that legislation tends to crowd out the future, and that is exactly what I believe has happened here. We have legislation implemented in 1965 that prevented the future from happening to this part of the population. It makes no sense to me whatsoever that we have a Part A and Part B. We get into the issue of how these things are funded. Is it in a hospital trust fund? That is a big problem because it is limited and structured—we can see that fund going down. We do not have the same complaints about Part B, only because it is coming out of general Treasury and that is a bottomless pit. We have the major problems in Part B that are just as important. In the politics of understanding this, where those dollars are coming from and how it is eating up the potential of what we should have in Medicare, gets lost.

Let's look at some of the differences in what has happened with this plan that we have in place. In 1965, we had Part A, Part B Medicare for the citizens over age 65. Employers have comprehensive plans. There is an enormous benefit gap between what is available today in the marketplace versus what was available under the traditional Medicare.

There are the Medicare Plus and the Choice programs. The Medicare risks that we have been talking about throughout this session and other sessions as well, really are moving towards this type of a more comprehensive plan design that would be available in the private marketplace.

In Table 4, let's take a look at the financing and see how outdated that is. In 1965 when the financing was created, it was a fee-for-service marketplace as was the commercial marketplace.

What has happened since then? Well, there have been some attempts to reform the payment process. They added a diagnostic related group (DRG) basis in 1983 to try to restructure how hospitals get paid and transferred some risks to them.

If you take a look at some of the charts, you will see some leveling of costs during that period of time. It took them about two years to figure out how to gain the system, and then you will see it start to go back up again.

TABLE 4
FINANCING

1965 Medicare Created Medicare (after age 65)	1995 Multiple Options Employers (pre-age 65)																		
Fee-for-Service (1965) DRG (1983) RBRVS (1992)	<table border="0"> <tr> <td>Capitation</td> <td>IPA</td> </tr> <tr> <td>Risk Sharing</td> <td>PCN</td> </tr> <tr> <td>Open Panels</td> <td>DRG</td> </tr> <tr> <td>Closed Panels</td> <td>RBRVS</td> </tr> <tr> <td>Managed Competition</td> <td>FFS</td> </tr> <tr> <td>Equity Models</td> <td>HMO</td> </tr> <tr> <td>Specialty Networks</td> <td>PPO</td> </tr> <tr> <td>Centers of Excellence</td> <td>POS</td> </tr> <tr> <td>Case Management</td> <td>EPO</td> </tr> </table>	Capitation	IPA	Risk Sharing	PCN	Open Panels	DRG	Closed Panels	RBRVS	Managed Competition	FFS	Equity Models	HMO	Specialty Networks	PPO	Centers of Excellence	POS	Case Management	EPO
Capitation	IPA																		
Risk Sharing	PCN																		
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Managed Competition	FFS																		
Equity Models	HMO																		
Specialty Networks	PPO																		
Centers of Excellence	POS																		
Case Management	EPO																		

Resource-based relative value system (RBRVS) is a way of replacing how you pay physicians for services. It started in 1992 and was phased in over a period of years. I think we are near the end of that phase-in period. Again, it is just a matter of lowering the costs in terms of the payments for each service. RBRVS did not have anything to do with utilization control. In fact, in many markets, RBRVS rather than being a low payment is becoming the gold standard for many of my clients. They would love to get RBRVS because the commercial marketplace in competing has been able to use competition to drive reimbursements below the RBRVS.

What has happened in the regular market? We have a whole range of options that the commercial market is using today to finance care from equity models to open and closed panels. We have very little to any of that available except in the Medicare risk, which is less than 10% of the population. The debate, I believe, is how do we open that up. Would Medicare Plus solve the problem? No. The key is it sets the stage for the next phases of market competition and privatizing. In a report that the AAA worked on, one of the biggest criticisms was they were not aggressive enough in some of those areas.

Let's take a look at how easily this works. The numbers are very simple as to how you can cut the costs, and then the ultimate question is, "How much of that can the government wind up saving?" As shown in Table 5, in the fee-for-service market the key here is days per thousand. Out of a population of 1,000, how many hospital days are generated? (It is a good measure of overall costs, but not the only measure. You have outpatient costs that tend to go up at times when you lower your inpatient costs.) About 2,700 days per thousand. That is what the HMOs going into the risk market get paid on the basis of. How much can they deliver care for? On average, it's about 1,300 days per thousand, and in California it is 1,000 days and less.

TABLE 5
ACTUAL EXPERIENCE PER 1,000 ENROLLEES

	FFS	HMO Risk
Hospital Admittance	315	194
ALOS	8.4	6.1
Total days	2,669	1,352

Maybe it is not a 75% reduction that is available every place, maybe it is only a 40% or 50% reduction. We are talking about hundreds of billions of dollars out there that can be put to much more efficient use. The sad part is that savings can be used to provide benefits to the elderly as well as to the federal government. How do you do this? One of the keys is shifting the responsibility, getting it out of Washington, getting it out of the politicians' hands and into the marketplace, and getting it into individuals' hands. We have to have some demand control, and I think that is what MSAs are.

The biggest criticism I have of MSAs is they are viewed under the legislation as a product, a \$3,000–\$10,000 deductible as opposed to a financing vehicle. There are many uncovered expenses in any kind of Medicare program. MSAs ought to be allowed and available for any program even if it is not a high deductible program. Unfortunately, you get into the loss of tax revenues and that causes concerns.

Freedom of choice between Medicare Plus and others, I think, will allow some competition in the marketplace. Shifting of risk to the providers is clearly what is going on in the commercial marketplace and is critical for the providers of care to take on capitation and the risk and to be assured of the quality. If there is any issue that the government does have some continuing role in, it is in the area of quality and access-type issues. But I prefer to think of it in terms of a Security Exchange Commission or a Federal Reserve Board type of role to set the boundaries within which the marketplace can be developed and thrive.

We have clear examples of what is done. Medicare risk, privatizing of these programs have allowed the elderly to get additional benefits. They do not have to have the deductibles or the copays, because what has happened in the marketplace with this 1965 legislation locked in place is that a whole new industry developed called the Medigap industry. The industry sold products that covered these areas, and it cost \$100–150 a month or so for a Medigap policy. In my opinion, that whole marketplace was unnecessary if the government was doing the right job in putting together the programs and being sure that the programs were properly priced in the marketplace.

In fact, most of the items shown in below are added with no cost. About half the plans have no additional premiums for adding many or most of these benefits. What did Medicare Plus do? It took a first step at trying to do some of this. It introduced HMOs, preferred provider organizations, and point-of-service options.

Medicare Risk

- Additional Benefits

—Payment of Deductible	Physicals
—Payment of Coinsurance	Immunizations
—Payment of Copayments	Eye Exams

- Additional Premiums

No Charge	49%
Less than \$20	8%
\$20–\$40	20%
More than \$40	23%

One of the critical areas is provider service networks. I think that is an area in which we are going to see a tremendous amount of growth. In fact, the administration does agree even with provider-sponsored organizations or provider service networks. The administration recently announced 25 demonstration programs across the U.S., and many of those are directly with integrated delivery systems or hospital systems. They are hospitals that are not HMOs, but they are going to be taking on risks directly from those payments. I think that is a good thing. It creates a whole new market of competition out there, and we will need to get into the legislation and regulation on solvency and insolvency requirements.

The administration does believe in it because it is doing demonstration programs. The only difference I see with what was proposed and what is being done today behind the scenes through demonstration is Republicans wanted to open the doors and let everybody come in and create a marketplace, and the administration seems to be doing it in a more structured demonstration mode. I am not sure whether that is not the best way to do it, but it is not an open discussion as to where this might lead and what we are trying to do.

I would only say that as you watch the health care debate, as someone who may not have all the details or be following it on a day-to-day basis, keep your eye on MSAs. To me that is the issue in the debate that is out there. Whether it is the current debate on something called the Kennedy-Kassebaum bill, which reforms the commercial marketplace, or whether it is the Medicare legislation, MSAs are the item that seem to be a bright line between those who are for or against some of these reforms.

They both have somewhat legitimate arguments. The president has said he is against MSAs because they are only for the healthy and the wealthy, and they will destroy the rest of the system. The Republicans say we need MSAs to bring some demand control and some cost control into the situation of transferring responsibility back to individuals. Where is the answer? It is probably in between.

My understanding is the Academy published a report which Ed Husted authored, and it did raise issues of antiselection that could occur in the remaining fee-for-service Medicare if MSAs were allowed. Any choice, however, will create changes and options and some antiselection. I think the ultimate conclusion of the report was that while it may create some antiselection, it was not an insurmountable antiselection that might occur and it would ultimately benefit the system.

In Medicare's future, I think that Parts A and B do not make sense. They should come together at some point in a comprehensive plan with maybe a single deductible— similar to what we have today in the commercial marketplace until we retire. The whole idea of hospital benefits being limited does not make any sense. That's why Medicare supplement policies are sold—there's a fear factor of having to stay in the hospital 270 days or so.

There is no reason why the current fee for service should not have unlimited hospital days. The cost of that, I suspect, is pennies and makes no sense whatsoever. I am surprised politicians do not jump on that and try to make that a play for expanding the current program as they give options to others.

I think a number of the other benefits will be included. There will be more prescription drugs, although not in the fee-for-service market. I do not see many of these things. These will be in the choice programs. There will be improved mental health benefits, wellness, vision, hearing, etc. Adding a lifetime dollar cap, goes against the grain of everybody in the political arena in Washington. They do not like lifetime limits.

If you look at Medicare, it has limitations that are probably worse than any million dollar lifetime limit. I believe that privatizing through competitive market bids is ultimately the way this strategy ought to be priced. The AAPCC does not make sense to me as a long-term strategy. It is price fixing by the government, and as good as they try to be, I do not think it necessarily reflects the market forces. Instead of arbitrarily increasing the rural area costs to encourage the market to get in there and not increase the urban areas maybe as much as the market should, let the marketplace determine what it ought to be rather than the politicians. I think we will ultimately have more choices. Provider-sponsored networks and medical savings accounts will be significant keys to the future.

Mr. Robert G. Lynch: My approach to the Medicare reform has been more of a nuts and bolts approach. I looked at and analyzed the 1995 Congressional Bill a great deal. Mostly I looked at how much money is put in and how much health care it is going to be buying for the elderly.

In the absence of an artificial limit in the form of the fail-safe cap, the Medicare Plus program would cost Medicare quite a bit in the form that it was proposed; that's not to say that there are not some good things in there. I think it is a start in the right direction, but I think it missed the boat especially because it did not try to put in competitive bidding. There is a great need to introduce some sort of competitive bidding to feed savings back to Medicare.

The main areas where I feel that it would be costing money—I seem to be disagreeing with other people up here—are MSAs. They are costly primarily because of adverse selection. The other place where Medicare Plus would be costing money is in the Medicare risk contracting. In my opinion, that is already costing Medicare billions of dollars a year, primarily through its own adverse selection, and there is selection going on in that program. Expanding that program will just expand the adverse selection effects and cost more.

As far as the selection effects on MSAs, the main thing that I keep hearing is that it would benefit the healthy and wealthy. I think that is a misconception because it is projecting from our experience with the working population insurance, and projecting that to the Medicare population is not really valid because the economic situation for the elderly is quite different. Under the proposed plan, Medicare beneficiaries who took the MSA option would be able to essentially buy out of Medicare and take their entire AAPCC capitation payment. With that, they would have to buy a high deductible plan with a maximum \$6,000 deductible, which, I guess, would cost about \$2,000 on average for premium for the minimum benefit outlined in the bill. They would be able to keep the rest of that payment.

The 1996 AAPCC is about \$450 a month, which works out to \$5,400 a year. In 1996, they would be able to basically pocket the difference of \$3,400 a year on average. They would not pocket it, however. They would put it in an MSA, which they would have to maintain at 60% of the deductible. Any nonqualified expenses they spend that take it below that 60% level would cause them to incur a tax penalty of 50% of their marginal income tax rate.

That AAPCC is not uniform across the country, it is much higher in some areas. For example, in New York City it averages around \$720–750 a year, which works out to something around \$8,500–9,000 a year. Even if you adjusted the premium that

they would have to pay for the high deductible to \$3,000, that means these people would basically have \$5,000–6,000 in available cash.

In Table 6, we see the distribution of income and perceived health status. We also see about 6% of the people are healthy and wealthy. People in the over-age-65 population who have an annual income of less than \$20,000 and regard their health as good to excellent, represent about 50% of the population. If I am in a situation where I am offered this high deductible plan, \$5,000 cash, my income is \$10,000 a year, and I am barely scraping by, I am going to have a fairly high probability of taking that.

TABLE 6
INCOME AND PERCEIVED HEALTH STATUS
IN AGED (AGE 65 AND OVER) POPULATION

Annual Income	Perceived Health Status					Total
	Excellent	Very Good	Good	Fair	Poor	
Less than \$10,000	5.0%	9.5%	14.4%	12.2%	7.5%	48.6%
\$10,000 to \$20,000	4.3	6.3	9.9	6.1	2.5	29.1
\$20,000 to \$35,000	3.1	4.0	5.0	2.4	0.9	15.4
\$35,000 and over	1.8	1.8	2.1	0.8	0.4	6.9
Total	14.2%	21.6%	31.4%	21.5%	11.3%	100%

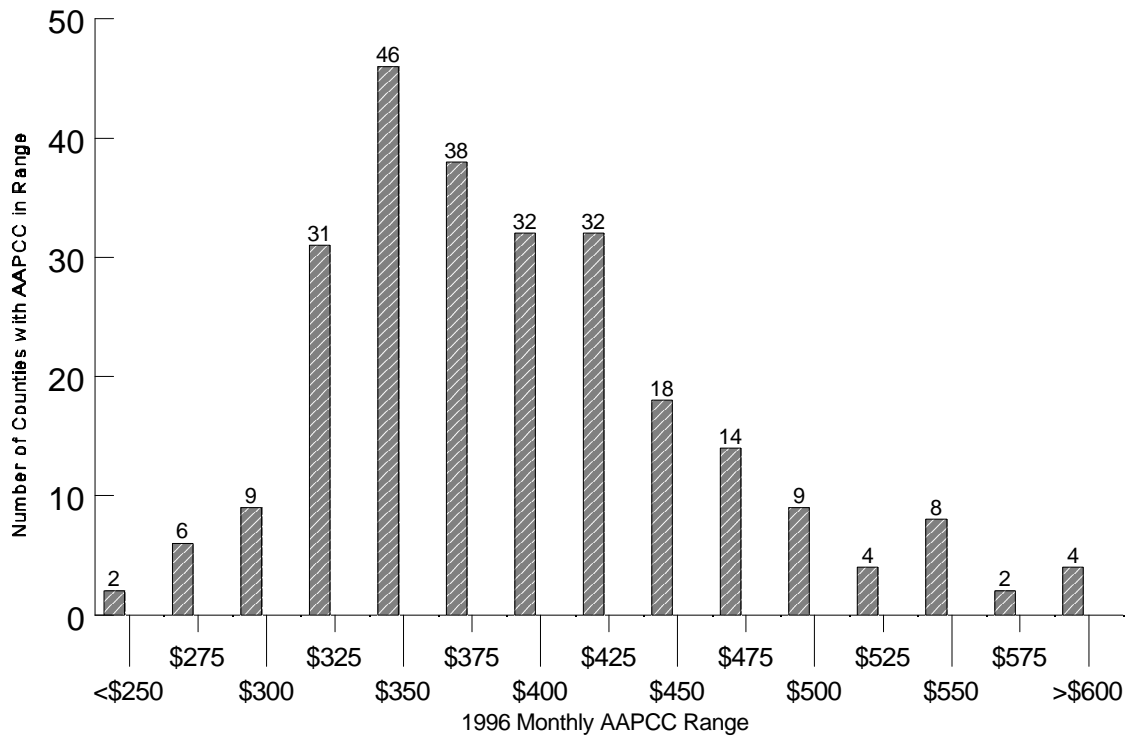
Sources: U.S. Bureau of the Census and 1989 National Health Interview Survey.

Many of the projections that I have heard project that only 1% or 2% of the over-age-65 population would take that MSA option. I think it would be much higher. I have put together my own study of the bill and I ran it through a model. My best estimate is that the MSA proposal, in the absence of the fail-safe cap, would cost about \$70 billion over seven years.

Another problem with the MSA proposal that was given in the bill is that it opens up the possibility for a great deal of fraud. The payments that would be made are based county by county and they would have a great deal of variation. Chart 8 shows the distribution of 1996 AAPCC payments for one state, Texas, which I selected because it has a large number of counties and it is fairly representative. The variation of payments goes from a low of \$219 a month up to a high of \$881 a month, which is a huge variation. You get this payment based on where you live, and where you live is where your mailing address is. I have this feeling that if this happened, the postmaster in Loving County, Texas would have a very hard time getting enough post office boxes to accommodate all the people who would be suddenly moving to Loving County to get that \$881 12 times a year. That's over \$10,000 a year. That's not to mention all the people who would be moving to Houston, which comprises the other three counties that are in excess of \$600 a

month. That \$70 billion that I mentioned does not even include that, which I think is a major problem in the proposal as it stands.

CHART 8
 RANGE OF AAPCCS IN TEXAS
 1996 COMBINED PART A AND PART B



Also, because of the way these high-deductible plans would work, and because of the way the bill is outlined, the coverage that people would be buying would be essentially worthless. As shown in Table 7, which is a hypothetical claim of a coronary bypass, which has a retail value of about \$40,000, the fee schedule from HCFA typically is about 60% of retail. The high deductible plans would only have to recognize what HCFA would pay plus whatever the beneficiary would have to pay in deductibles and co-insurance if the beneficiary was still under Parts A and B. If a beneficiary were under Parts A and B and had this procedure, HCFA would only recognize about \$24,000. There would be, say, \$2,000 in deductibles and co-insurance, so HCFA-covered benefits would be about \$22,000. So when this person checks their coverage and gets their payment from their insurance coverage, he or she would be responsible for \$22,000 rather than \$6,000. If the person maintains his or her MSA balance at the minimum 60%, he or she would still be out over \$18,000 beyond that.

TABLE 7
BENEFIT PAYMENTS FOR MEDICARE PART C
"HIGH DEDUCTIBLE/MEDICAL SAVINGS ACCOUNT" PLANS
BASED ON A HYPOTHETICAL \$40,000 (UCR) CLAIM

	Parts A & B	Benefit Payments: Plan Counts	
		Minimum Benefits*	Covered Charges*
Total UCR Charges	\$40,000	\$40,000	\$40,000
HCFA-Allowed Amount	24,000		
Part A & B Deductibles	800	800	800
Pat A & B Coinsurance	1,200	1,200	1,200
HCFA "Covered Benefits"	22,000		22,000
Failsafe Reduction (20%)	<u>4,400</u>		
HCFA Payment	\$17,600	<u>\$17,600</u>	_____
Payments Counted by Plan		\$19,600	\$24,000
Plan Deductible		6,000	6,000
Plan Payments		13,600	18,000
Patient Out-of-Pocket		26,400	22,000
MSA Payments (60% of Deductible)		3,600	3,600
Patient Net Out-of-Pocket	<u>\$6,400</u>	<u>\$22,800</u>	<u>\$18,400</u>

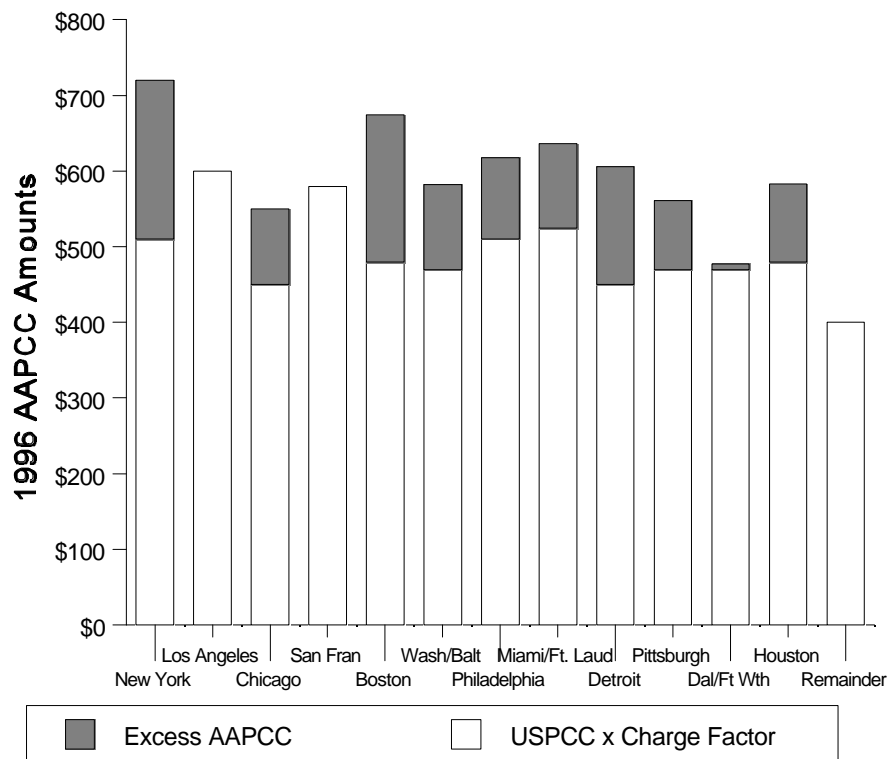
*Minimum benefits under Section 1859 (b)(2)(A)(iii)(I)

Also, if the fail-safe mechanism was in there, then the way the bill is worded, this insurance plan would only have to recognize what was paid after the fail-safe mechanism reduction in payments. In which case, if there was a 20% reduction in the fail-safe mechanism, then the plan would only have to count less than \$20,000 and the patient would be responsible for over \$26,000 liabilities for this, not counting their MSA balance, which is more than HCFA would allow in the beginning for the whole plan. For the beneficiaries, in my opinion, this is a bad deal. They are not getting much from that coverage.

In the risk contracting plan, I am in favor of expanding that. I think there is the potential for a great deal of savings to Medicare. The problem is that there is currently no mechanism for feeding the savings back to Medicare, and there is nothing in the proposal to put in any sort of feedback mechanism, which would probably take the form of the competitive bidding. Currently, to get an idea of how much money is being lost through the Medicare risk contracting, look at a comparison of these AAPCC payments versus what the costs should be if you applied the geographic charge level against the national average.

Chart 9 shows the 12 metropolitan areas with the largest Medicare populations, and the dark portions of those bars represent how much the AAPCCs exceed what the charge level should be with a charge level that I calculated, which is based on the M&R Health Cost Guidelines. This is a rough estimate. When I calculate this for these 12 metropolitan areas alone, that is about \$900 million a year in overpayments to these metropolitan areas for the Medicare risk beneficiaries. These areas represent something like 60% of the enrollees in HMOs in the country.

CHART 9
COMPARISON OF AAPCC LEVELS WITH HEALTH CARE CHARGE LEVELS
12 METROPOLITAN AREAS WITH LARGEST MEDICARE POPULATIONS

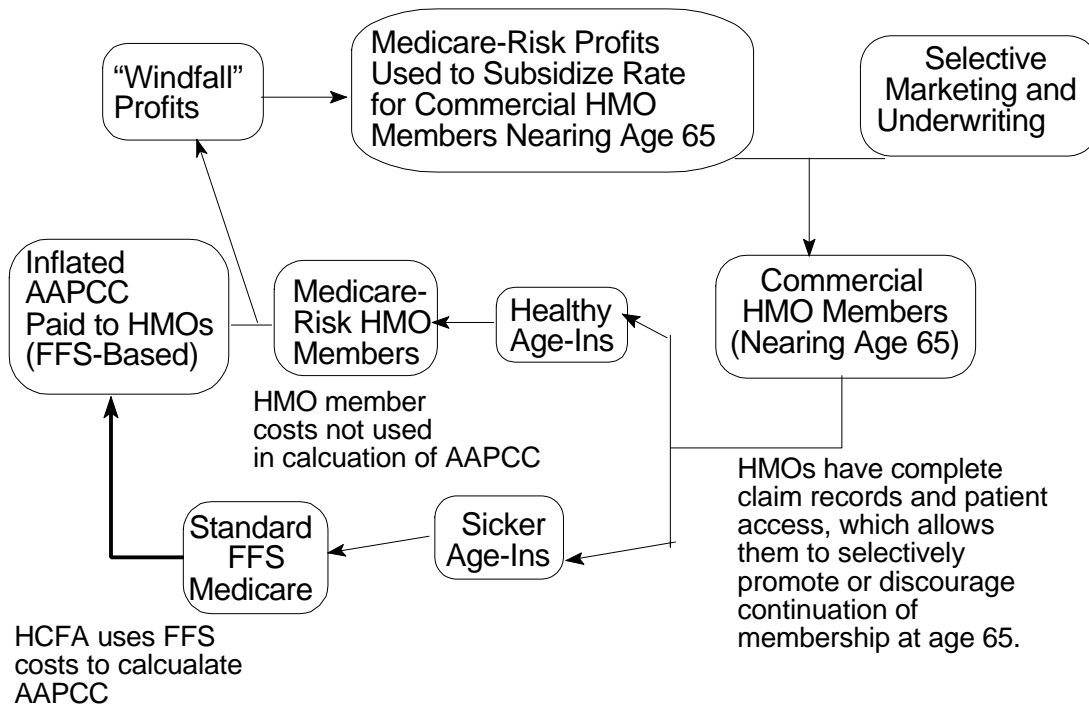


Note: Charge factors based on M&R 1996 Health Cost Guidelines does not reflect any direct savings due to utilization.

A big part of this problem is in the current calculation of the AAPCC. It is based on the costs for those beneficiaries who remain in the fee-for-service side because there is selection occurring. The healthier beneficiaries are going into the HMOs. As Rick mentioned, the HMOs basically are getting paid the same amount to take care of the healthier beneficiaries as they are to take care of the sicker beneficiaries.

Chart 10 shows how HMOs can do this. I am not saying there is an HMO in particular that is doing this. I know that each item on this flow chart is being done, at least individually in some areas, because I have anecdotal, second-hand information that indicates some Medicare risk contractors are doing this.

CHART 10
HOW RISK CONTRACTING HMOs ARE ABLE TO "CHERRY PICK" MEDICARE



The HMOs are making profits on these Medicare-risk contracts. Many HMOs are using these profits to subsidize their commercial side, especially at the older ages, and getting pre-Medicare-risk enrollees in. HCFA has very strict regulations on selective marketing or underwriting for Medicare beneficiaries, but those regulations do not apply to anybody under the age of 65. People who are just turning 65 and going into Medicare are the major source of new enrollees for Medicare HMOs.

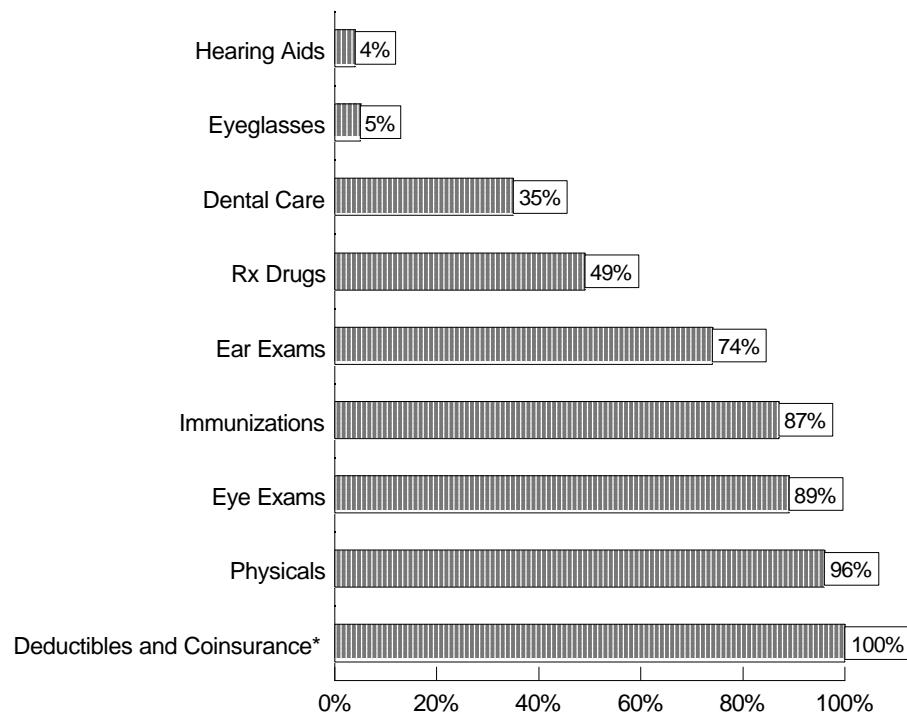
When these plans recruit new enrollees who are getting close to Medicare age, they are able to do selective marketing and underwriting, so they are getting some selection there. The HMOs get these numbers in there. They have the enrollees in there for a while, and they have complete claim records on them, so they know who is healthy and who is not healthy and they do not have to do really overt selection. It can be fairly subtle and achieve a good result.

The HMOs can selectively promote or discourage the continuation of aging into their HMO program, so they get the healthy age-ins coming in, and the sicker ones are going to fee for service. Because the AAPCC is based on the cost for the sicker individuals, the selection spiral shows that AAPCC continues to go up. Meanwhile, the HMOs are getting the healthier people, generating more what I call "windfall profits," because to me that is what they are. The windfall profits can then be used

to subsidize more and get more of the selection going on. So a nice self-perpetuating circle is achieved.

This is basically how many HMOs are able to achieve artificial selection, in addition to what I guess you could call the natural selection of the healthier people going to HMOs, because that is the way people behave. The healthier people are more willing to have their care managed. The next two charts have already been mentioned by Rick. Some of the results of this show that the HMOs give good benefits to their beneficiaries; they are very lavish benefits in many cases as shown in Chart 11.

CHART 11
EXTRA BENEFITS PROVIDED BY MEDICARE—CONTRACTING HMOs
(1995)

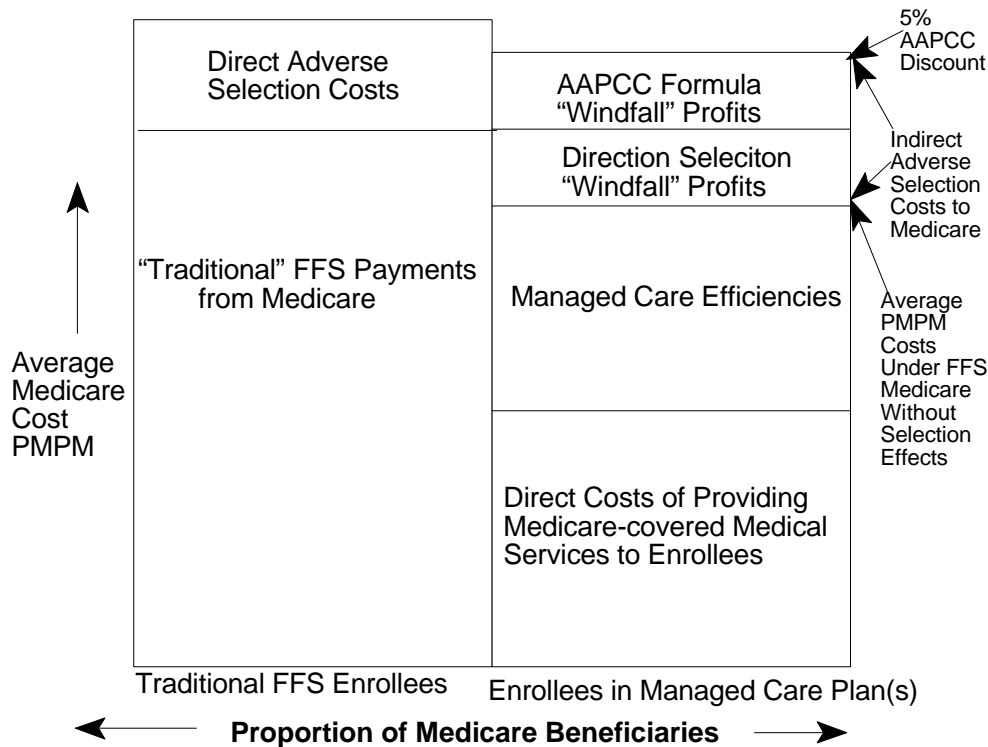


Percentage of Medicare Risk—Contracting HMOs Providing Benefit
*Plan covers usual Medicare deductibles and coinsurance.

Chart 12 is a graphic representation of the money that is being wasted currently. The left side is the traditional fee for service. This light line near the top is where the average cost would be if there was no selection. But as the adverse selection drives that side up, the AAPCC payment is driven up with it. Their positive selection brings the cost from the right side down. So the top two boxes on the right side are the windfall profits that the HMOs are enjoying. I am not saying the HMOs are wrong for this. I am also saying that this is not the way to go. It is just that the system as it is set up is resulting in waste. I think moving the managed care

and putting the care more into the private sector is the way to save money, but we have to change the way that managed care is being paid to feed these savings back to Medicare; otherwise, it is just going to drive Medicare into the ground faster and faster.

CHART 12
ALLOCATION OF MEDICARE COSTS UNDER
CURRENT MANAGED CARE RISK-CONTRACTING ARRANGEMENT



Mr. King: Although I agree with much of what you said, Rob, I disagree strenuously with your analysis of MSAs. My experience with the Medicare program for 20 years is that there is virtually no fraud associated with Medicare beneficiaries. There is virtually no instances of Medicare beneficiaries defrauding the Medicare program. It is the providers who defraud the Medicare program. That would suggest that if there is any potential for fraud in the way people report their addresses, that it is much more likely to occur with a provider such as we have now under the current risk program and that we would have under the Medicare Plus program.

Second, my analysis shows that even the average Medicare beneficiary has no financial incentive to risk select against MSAs. That's not to say it will not happen. It certainly happens now with Medicare risk plans. The single most important factor for Medicare beneficiaries when they become ill is not finances; it is free access to any provider they want to see. That is what the current risk program limits most severely. An MSA, however, would not do that.

Table 8 shows the substantial behavioral changes and the reductions in spending that occur when Medicare beneficiaries face the current, very modest, cost sharing in the Medicare program (as opposed to facing no cost sharing when they have a Medigap policy). The reason I used employer-sponsored Medigap policies is because it is a double protection against any selection affecting these numbers. In other words, it is all based on the behavioral effects rather than the selection effects. You also have a comparison by health status. Even on the basis of self-reported health status, the reductions are substantial.

TABLE 8
 MEDICARE SPENDING PER PERSON FOR AGE 65 AND OVER

Health Status	Medicare Only	Employer Medigap	Ratio
Excellent	\$ 705	\$1,217	172.6%
Very Good	905	1,490	164.6
Good	1,713	2,347	137.0
Fair	2,462	3,236	131.4
Poor	4,684	6,477	138.3

Source: HCFA Medicare Current Beneficiary Survey

Table 9 is a five-year analysis comparing how well off Medicare beneficiaries would be if they had an MSA with various levels of deductibles, a Medigap policy, or if they had Medicare only. There is no adjustment for interest, so it does not matter during the years in which they occur. But a multiple-year analysis is appropriate, because people cannot opt in and out of MSAs as they can with risk plans every month. It is only yearly and people have a tendency to stay in one plan.

Table 9 shows an average Medicaid beneficiary who was healthier than average during four of the five years and then sicker than average during the fifth year. You can see that the worst possible financial result is buying a Medigap policy. The best possible financial result is buying an MSA with a high-level deductible, and then Medicare is somewhere in between.

Once people get sick, they are not going to be able to leave the MSA and go into Medigap, because Medigap can underwrite. It is only at age 65 that Medigap cannot underwrite. So the Medigap plans are well equipped to protect themselves against unfavorable selection. The latest study from the physician payment review commission indicates that the HMOs are well equipped to protect themselves against unfavorable selection too, because the average person joining an HMO only costs about 58% of what the average comparable person in the fee-for-service sector costs. Those are fairly large favorable selection results. I know that these are very controversial issues.

TABLE 9
 MEDICARE CURRENT BENEFICIARY SURVEY WITH INDUCTION FACTORS

Year	Medigap	Medicare Only	MSA with \$10,000 Deductible	MSA with \$5,000 Deductible	MSA with \$3,000 Deductible
1	\$986	\$ 206	(\$2,385)	(\$ 866)	(\$49)
2	986	206	(2,385)	(866)	(49)
3	986	206	(2,385)	(866)	(49)
4	986	206	(2,385)	(866)	(49)
5	986	1,553	5,296	3,405	2,326
5-year Total	\$4,930	\$2,377	(\$4,244)	(\$59)	\$2,130

Mr. Antos: The example proves that if beneficiaries can change every year, the intelligent beneficiary who has good foresight will change at year four. I would like to think that everybody is honest, and I think generally people are, but when you put an enormous financial incentive in front of almost everybody, it is really easy to pick out the saints from the rest of us. It seems to me that this calls for a major change in the MSA legislation that was talked about. Let's have a longer lock-in period. Why one year? Because, politically, one year was all that could be attained.

Mr. Bachman: The only issue that was raised that I had some concern about is the idea of income-based premiums—once you start to receive the benefit under Medicare, you would somehow pay if you are able to pay. You should not get that if you are wealthy versus not, but to me you paid this tax, especially for the Part A coverage. You pay that your entire life and people have no income cap on it. So the wealthy are already paying premiums in excess of their share, and after they retire, you are going to hit them again and say, "Well now because you are wealthy you've been paying more than your fair share in all these working years." I have a serious concern about how progressive, if you will, that schedule really is and how unfair it is.

Mr. Lynch: I agree, Ron. They walk a fine line because right now Medicare is a social insurance program. When you start income-relating premiums, it moves Medicare in the direction of becoming more of a welfare program; then public support for that program is undermined. The conventional wisdom in Washington is that you cannot get to the right of the American people. You cannot be more considerate to the American people on welfare programs like Medicaid. There is virtually no public support for Medicaid. The politicians can cut it as much as they want, and the public is not going to be that concerned about it.

I would like to respond to your rebuttal. Your point that the fraud does not come from the beneficiaries is true, but I do not think it is applicable because up to this point, the program has been benefit-based. There has not been opportunity for beneficiaries to be involved in any fraud because they are only getting benefits. The money has been going all to providers. Under the MSA proposal, the money would be going to the beneficiaries. You are fundamentally changing the nature of this from a benefits-based program to a cash-based program. I think you are going to find much more gaming going on. There would be nothing illegal about opening a post office box in Loving County, Texas. Nothing would be illegal, so even calling it fraud would be somewhat marginal.

Mr. King: They would have to drive there to pick up their social security checks and their mail. It is just as unthinkable that it would occur under that proposal as it would occur under current law.

Mr. Lynch: I would drive far to pick up a \$10,000 check, and my income is much higher. Also, Presidio County, the low-end county, is only 50 miles from Loving County. Residents would only have to drive 50 miles to pick up that extra \$10,000 a year.