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Session 61PD
Medicare Reform: What Has Happened and What Can Happen?

Track: Health
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Moderator: ROLAND E. (GUY) KING
Panelists: FREDERICK B. ABBEY†
RICHARD S. FOSTER
HARRY L. SUTTON, JR.
Recorder: ROLAND E. (GUY) KING

Summary: The audience will be given an update on changes to the Medicare health program over the last couple of years. In addition, the panel will discuss the merits of additional proposed changes from the White House and both sides of the aisle in Congress.

Mr. Roland E. (Guy) King: I'll introduce our panel in the order in which they will speak. Our first speaker is going to be Rick Foster. He is the chief actuary of the Health Care Financing Administration (HCFA) and a former deputy chief actuary with the Social Security Administration. Rick has a long history with social insurance programs. Rick will tell us about the current financial status of the Medicare program, and how we got there.

Our second speaker, Fred Abbey, is a partner with Ernst & Young, and he was also formerly an official in the HCFA and in the Department of Health and Human Services (HHS). Since he has been at Ernst & Young, he has been involved directly in health care, and, of course, Medicare has been a big part of that, so he has a long history with the Medicare program. Fred is going to lay out for us the broader context in which the Medicare reform debate is going to continue.

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†Mr. Abbey, not a member of the Society, is a Partner of Ernst & Young in Washington, DC.

Our third speaker is Harry Sutton. Harry is senior actuary for health care with Allianz Life and he's been active over the years with issues related to Medicare. He has been active with regard to the development of a capitation rate for the risk-based Medicare program. He was on the technical review panel of the Social Security Advisory Counsel, which reviewed the Medicare projections several years ago. He has also been a very active member of the Medicare Work Group, which is currently talking about and evaluating Medicare reform initiatives.

Mr. Richard S. Foster: As Guy said, I am going to try to set the stage for this discussion by giving you the background on the financial status of the Medicare program as shown in the most recent annual report of the Board of Trustees to Congress. I'll focus primarily on the hospital insurance (HI) program, but we'll also say some things about Part B of Medicare, known as supplementary medical insurance (SMI). Currently Medicare covers about 37 million individuals. Only about 22% of HI beneficiaries actually incur services for which Medicare pays some amount of reimbursement. Contrast that to Part B, in which about 84% of the people in a given year have covered services. HI covers inpatient hospital care, skilled nursing facility care, home health care, and hospice care for terminally ill beneficiaries. SMI, on the other hand, covers physician services, outpatient hospital care, and certain other things like lab tests, durable medical equipment, and so forth.

The financing is very different between the two parts of Medicare. The HI program is financed by a portion of the Federal Insurance Contributions Act (FICA) payroll taxes that you all pay. In particular, the tax is 1.45% of earnings, paid by both you and your employer. The maximum amount on which you pay this contribution was eliminated starting in 1994, so you now pay the hospital insurance tax on all of your earnings, no matter how high. There are some other sources of income for the HI program. These are small by comparison to payroll taxes, but they include some revenue from the income taxation of Social Security benefits, and we also get some interest earnings. The 1.45% tax rate is scheduled in the law, and it's not scheduled to ever change. So Congress would have to take further action of some kind in order to change that rate.

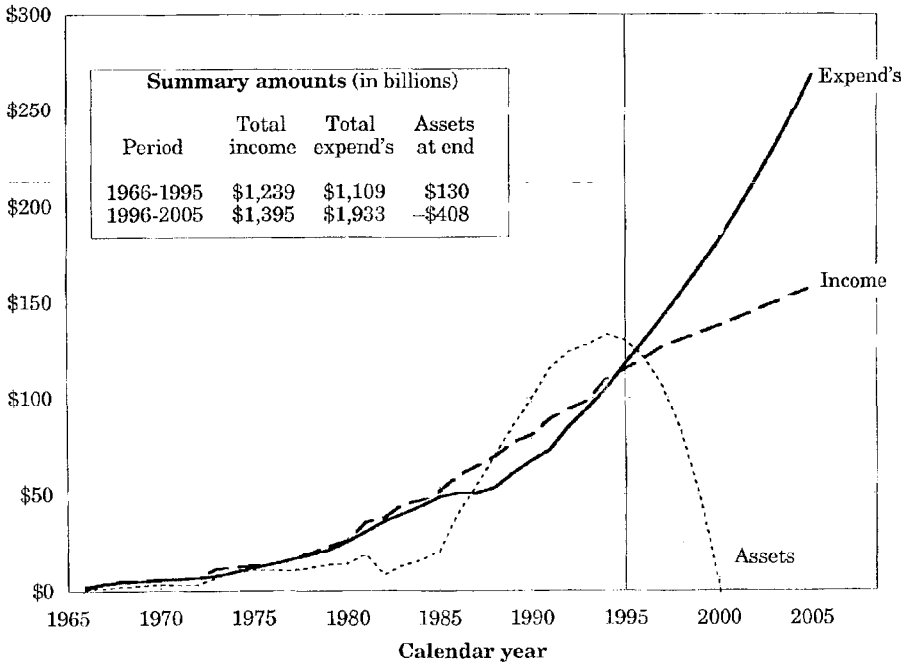
In contrast, for Part B of Medicare, the financing comes in part from monthly premiums that are paid by the enrollees, and those premiums cover roughly 25% of the cost of the program. The other 75% is paid for from general government revenues. The premium for 1996 is $42.50 per month, and the federal general revenue matching rates are about $127 a month for aged beneficiaries, and about $168 for the disabled. Notice that both groups pay the same premium even though their costs are different. The financing for Part B is reset every year. Remember, for HI, the tax rates are in the law and they won't change unless Congress acts to

change the law. On the other hand, the Part B premium rate and the general revenue matching are reset every year to match the expected cost for next year. For example, it was recently announced that the premium for 1997 will be $43.80.

Each program has a trust fund and the financial oversight for these trust funds is provided by a Board of Trustees, made up of the Secretary of the Treasury as the managing trustee, the Secretary of Labor, the Secretary of HHS, the Commissioner of Social Security, and two public members, one of whom is Steve Kellison, an actuary. The trustees, with our help, include projections for the short-range and the long-range financial outlook for the Medicare program in their annual reports to Congress—one for Part A and one for Part B. In the trustees report are three different sets of economic and demographic assumptions. These are designed to help illustrate the sensitivity of future costs to the underlying trends, and also to give some idea about the uncertainty associated with these projections.

All the projections we'll talk about here are based on the intermediate set of assumptions. We'll first look at the short-range financial outlook for the HI trust fund. Chart 1 shows three curves. The thick solid one represents the past and projected expenditures for the HI program. It compares with the thick dashed curve which represents the income to the program.

CHART 1
HI INCOME, EXPENDITURES, AND TRUST FUND ASSETS



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

Notice that throughout the history of the program, dating back to 1966, income and the expenditures of the program have been quite close together. That illustrates that the program is operated on a pay-as-you-go basis, and the taxes collected in a given year are intended to be sufficient to just about cover the expenditures for that year and have something left to maintain a trust fund at an appropriate level.

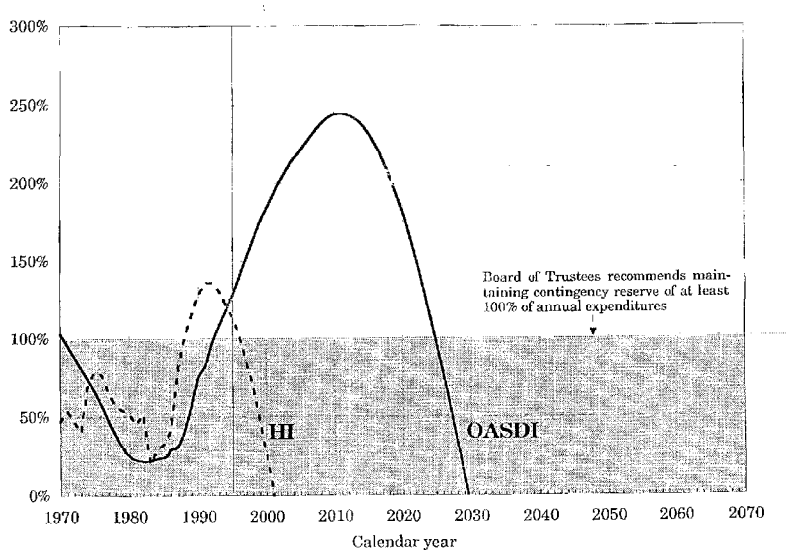
Any difference or any positive surplus of income over expenditures is used to purchase special federal Treasury bonds, and that represents the assets of the program. The thin curve is the level of assets in the past. You can see it built up significantly following the Social Security amendments of 1983. You can also see that it peaked in 1994, and we ran a small deficit in 1995, and we are running a larger deficit in 1996. In particular, notice that the expenditure curve for HI, starting in the early 1990s, began to increase at a significantly faster rate than the income increases. We project that will continue to occur in the future without corrective legislation. That's the crux of the short-term problem.

We have HI expenditures growing about 8% or 9% a year, but income, mostly from the payroll taxes, is growing only about 5% or 6% a year. That's not the end of the world immediately because we can temporarily draw on the assets of the trust fund to cover the gap. But the assets won't last forever. The assets, in fact, are projected to last just barely into the year 2001. It’s obvious that something needs to be done between now and then.

Chart 1 is based on dollar amounts, and dollar amounts, as every good actuary knows, over a period of time, have limitations. We like to use a relative measure rather than looking at just the nominal dollar amounts. We like to compare the assets of the trust fund to the annual expenditures and get a relative measure that can be used at any point in time. That's what we see in Chart 2.

Chart 2 shows the so-called trust fund ratios, the ratio of assets to annual expenditures, for both the HI trust fund and, for comparison, the OASDI or Social Security program. The Social Security issue is well known. Most people know that, in fact, the fund is building up and that it will reach a peak some time in 2010 or 2011. Then with the baby boom retirement, it would come crashing down and would go broke under this set of assumptions in about 2029. Contrast that with HI, where, in fact, the fund ratio has already peaked, we are already coming down, and we're projected to go broke long before the baby boom ever starts to retire. The gray shaded area on this chart represents the goal for financing as established by the Board of Trustees. It has recommended that not only the HI trust fund, but also the Social Security trust funds maintain assets equal to about one year's expenditures, on an ongoing basis, to serve as an adequate contingency reserve.

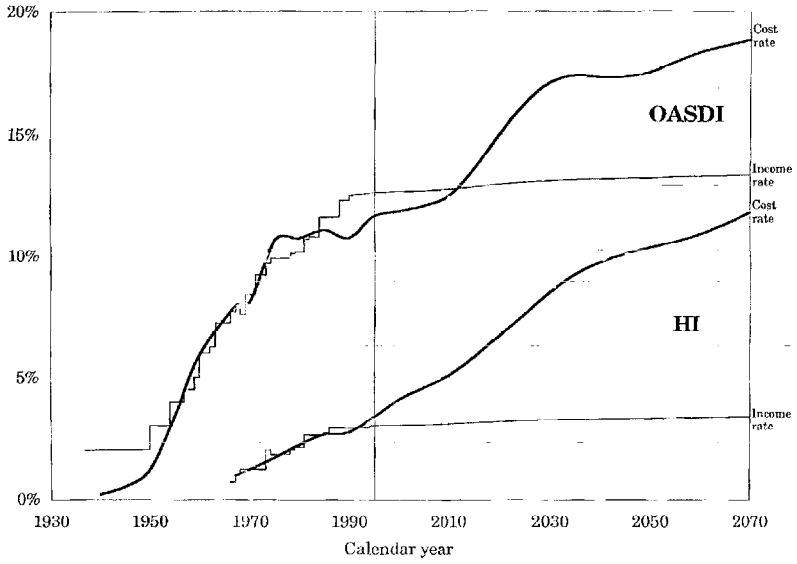
CHART 2
TRUST FUND ASSETS
(AS A PERCENT OF ANNUAL EXPENDITURES)



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

This is bad enough news, but let's look at the long-range financial situation for HI (Chart 3). I might point out that, of course, we know that these projections will not come to pass exactly as projected. What we hope to show is that under reasonable assumptions about the future, this is how the program would operate.

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



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

Here we have 75-year projections for the HI trust fund, as well as the OASDI trust funds combined. For HI, notice the thin curve which represents income to the program as a percentage of taxable payroll. You can see, in the past it has risen in steps as the tax rate has been adjusted from time to time, but notice for the future that it's not projected to increase very significantly as a percentage of taxable payroll. Remember what I said earlier—the 1.45% is not scheduled to change. The income rate shown is nothing more than the 1.45% that you pay, plus the 1.45% your employer pays, for a 2.9% total, plus a little bit from the taxation of benefits. The curve does increase slightly over time because the taxation of benefits grows slightly over time.

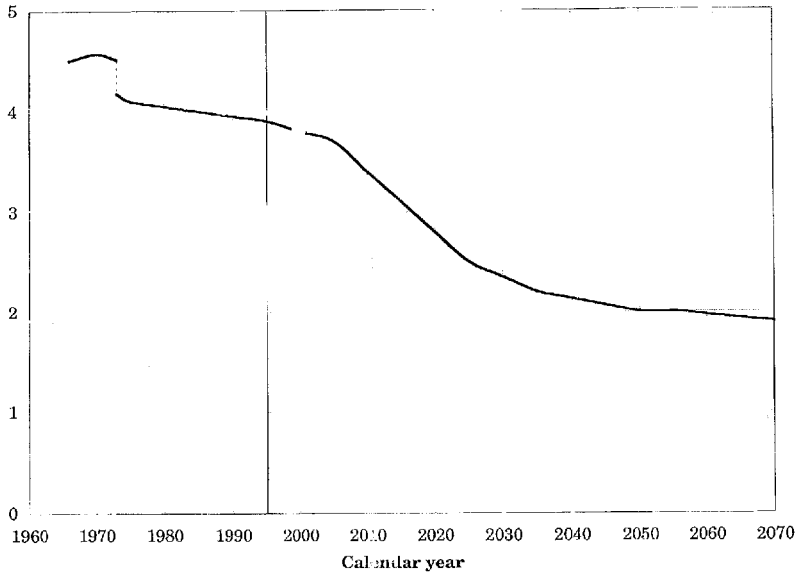
You can contrast that to the expenditure curve, the solid or thicker curve. This shows the expenditures of the program as a percentage of taxable payroll. Notice that it's not projected to slow down from its historical level, and it may even accelerate somewhat starting in 2010 with the baby boom retirement. It just keeps increasing throughout the projection.

By comparison, if you look at the history of OASDI financing, in the mid-1970s the expenditures were significantly above the income. That's the period of deficits that led to all the consternation, all the drama, all the excitement, and, eventually, to the 1977 and 1983 Social Security amendments. All that drama and excitement came from what appeared to be a relatively small period of deficit. Compare that to the deficits projected for the HI trust fund in the relatively near future.

If we wanted to close that HI deficit and bring the program back into financial balance for just the next 25 years, we would have to either raise the income by about 63% or reduce the expenditures by about 39%, or some combination of the two, starting immediately. So, just for the next 25 years, it would take adjustments of that order of magnitude to close that gap. As you can see, over the longer term, or over the full 75 years, the adjustments would have to be considerably larger than that.

Let’s take a quick look at the demographics. Chart 4 shows the number of covered workers paying into the HI trust fund, per hospital insurance beneficiary. You can see that back in the early days of the program when it first started, there were about 4.5 workers for every beneficiary. Currently, the figure is about 3.9. That's not a dramatic change over that period, but with the retirement of the baby boom starting in about 2010, this ratio will change substantially, and by 2030 it would be down to about 2.2 workers per beneficiary, and continue declining thereafter at a somewhat slower rate, eventually getting down to only two workers per beneficiary.

CHART 4
NUMBER OF COVERED WORKERS PER HI BENEFICIARY



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

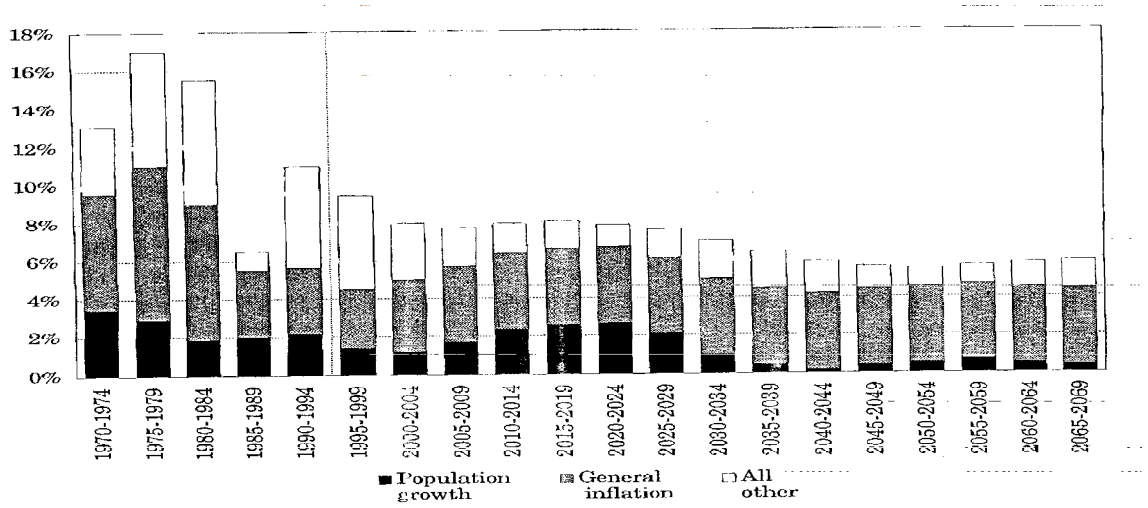
In a program that's financed on a pay-as-you-go basis, other things being equal, that means that you would need to change your tax collections by that same ratio if everything else stayed the same. So the implications are fairly clear and fairly dramatic. What else goes into these cost increases besides demographics?

Chart 5 summarizes the key projection factors. There are actually quite a number of these factors, but we boiled them down to three categories: the number of beneficiaries, general inflation as measured by the CPI, and all other factors. Now you can see that for some years after about 1980, the enrollment of the program was growing at roughly 2% a year. Notice also that right now, and for the next ten years or so, the enrollment will grow more slowly than it has in the past. That's because the people turning 65 today were born during the depression years when birth rates were fairly low. So, demographically, we're currently in a slightly better-than-usual position. You can see the effect of the baby boom showing up in the enrollment and how that grows. Eventually we baby boomers pass on and are replaced by the baby bust generation that followed with much slower growth rates in enrollment.

The CPI is assumed to increase 4% per year, and a little higher than current rates. You can see that over the first 25 years or so we assume that this all other category will improve somewhat relative to traditional past levels. We don't assume it's the

best it has ever been and we don't assume it's the worst it has ever been, but we definitely assume that over 25 years it gradually comes down to a more sustainable long-term level. Some might characterize this as an optimistic assumption, and in many respects it is.

CHART 5
HI EXPENDITURE GROWTH FACTORS



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

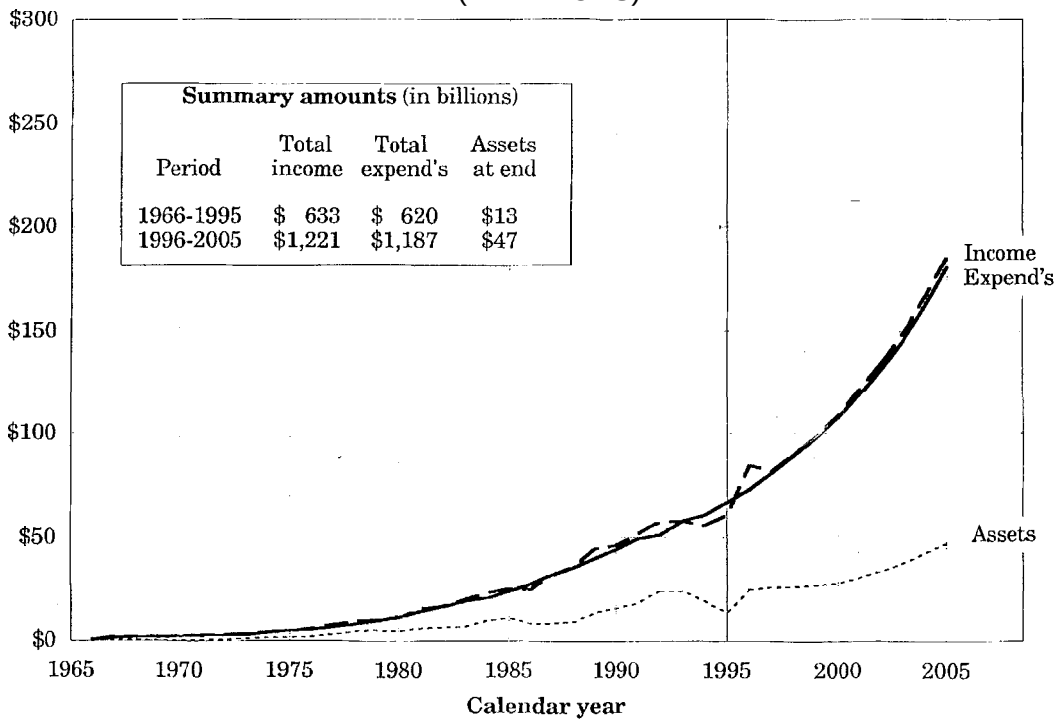
On the other hand, it's one of the situations where judgment is necessary because the worst of what has happened just cannot continue indefinitely. After the first 25 years, changes in this all other category reflect demographic effects. When the baby boom first starts retiring, that tends to pull down the average utilization for the beneficiary population. As the baby boom ages, however, utilization increases, and then eventually returns to an average long-term level as the baby boom disappears.

Let's take a quick look at the other part of Medicare; SMI. Chart 6 is nearly identical to Chart 1, with one important difference. Notice there are similar income and expenditure curves. In the past they've been very close together. In the future, the expenditures continue to increase, but the income stays with it. That's because the premiums and the general revenue matching amounts are reset every year to match the expected expenditures in the following year. So the good news is that we're automatically in financial balance. The bad news is we're growing by leaps and bounds. In particular, SMI expenditures have grown 53% in just the last five years, and that's more than 20% faster than the economy at large. So the SMI program has policymakers considerably worried because of the fast rate of growth.

Also note the asset curve—the thin dotted asset curve for SMI is considerably below the level of one year's expenditures, past and future. And if you think about it, that makes sense, and that's OK. For a program like HI, where the tax rates are written

into the law and they cannot be changed easily, you need to have a fairly hefty contingency reserve in case your projected future experience isn't right. For SMI, on the other hand, you're only making a projection about a year at a time for financing purposes. And, hopefully, you wouldn't be so far off in only one year as you might be otherwise. So you can get by with a much lower level of assets to cover any difference between actual and expected.

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



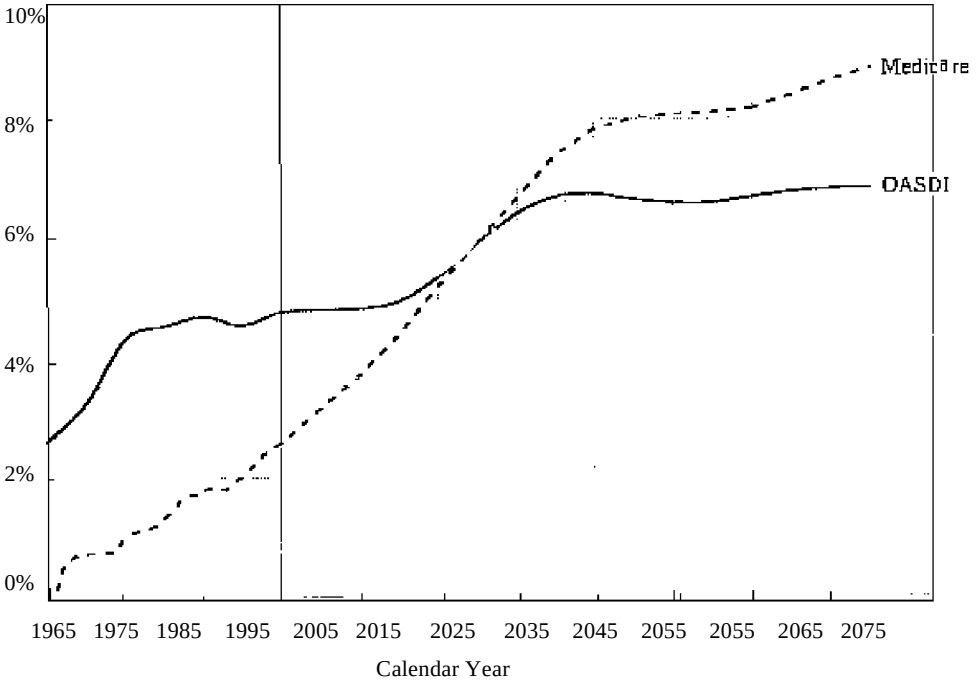
Note: Projections are based on the intermediate assumptions from the 1996 Trustees Reports.

There are long-range issues with SMI, as well, even though we tend to focus on the short range where the financing has been set. Chart 7 shows the long-range projection for SMI expenditures as a percentage of the gross domestic product (GDP), which measures the overall size of the economy. It goes up rapidly with increasing health care costs and then the baby boom retires, and it continues to go up quickly, and then levels off a bit as the baby boom dies. Notice, however, what happens to premium income, which is the lower curve shown at the bottom.

As we mentioned earlier, premiums represent about 25% of costs currently, but after 1998, under present law, the premiums will not be allowed to increase any faster than the Social Security benefit or cost-of-living adjustment. Given that traditionally medical care costs go up much faster than general prices, that's going

to hold down future premium increases after 1998, with the result that, under present law, premiums would account for a smaller and smaller share of the income to the program. Eventually, by the end of the projection period, premiums decline to a level of only about 6% of the total income. The implication, of course, is that the gap has to be met out of general revenue. So we see an increasing requirement, under present law, for general revenue financing for Part B.

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



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

We can compare the expenditures for Social Security or OASDI as a percentage of the GDP to the total projected expenditures for Medicare Parts A and B combined. For some period of time now the cost for OASDI, relative to GDP, has been fairly level. And that's projected to continue for another 10 or 15 years before the retirement of the baby boom. In contrast, the cost for Medicare has been increasing steadily, relative to the economy, and is projected to continue to increase steadily with the result that the cost of the Medicare program would actually exceed the cost of OASDI in 20–25 years. That tends to give one pause.

In conclusion, the HI program clearly has very serious financial problems, both in the short term and the long term. There are many proposals to address some of these problems and we'll hear some more about them. It's important to note that these proposals have not been raised in the context of fixing Medicare. The proposals have been raised primarily in the context of helping to balance the overall

federal budget. So none of them is intended to address these longer-term problems that we've seen, or really even to do anything more than just buy some more time or postpone the depletion of the HI trust fund for a while longer to buy some time to address the long-range issue. As we saw, SMI is automatically in financial balance, but the cost increases are racing.

I would say that, generally speaking, solutions are possible. These look like serious problems, and indeed they are, but solutions are possible. But two things are relevant here. To get to these solutions, we're going to need much better cooperation between the administration and Congress than we've seen lately. And, moreover, if you think about it for HI, think of the timing. Right now the income and outgo for the HI program are fairly close together. They're growing at different rates. So, overall, if ever there was a situation that called for fast action rather than action later on, this is it. In that regard, I'd like to suggest that all of you ought to take a part in that. We have, in the actuarial profession, a highly knowledgeable group when it comes to the financing of risk-based programs. So don't just read the paper and mutter and shake your head and complain about it. Be a part of the solution.

Mr. Frederick B. Abbey: My job is more fun. I get to talk about the future. In that regard, I also look forward to joining my panelists in some debate and hope you engage us in some lively questions. We need to do a better job in public policy to change the programs, but we also need to anticipate change.

I'd like to go over six drivers, or themes, in public policy that I will present in a way that I hope you will find amusing, and I also will discuss a way to view change in Medicare. We're talking about issues of perception.

What we're really talking about today is the issue of Generation X versus Generation Rx. Certainly there are ways to project what each of the population bases might be thinking, but we also need to think about how they vote, what are the issues of concern to them, what are the drivers in those particular issues. In particular, we are aware that the nation's elderly vote, and they vote prominently for their own self-interests. They are very much concerned about Social Security, they're very much concerned about the Medicare program, they're concerned about long-term care, and their own income security.

My first theme that I'd like you to recall is that the pace of change depends on the election 1996 result. It is not the direction. Public policy will address Medicare in the future. We need to reflect upon the Medicare program as one of changing roles. When the programs were adopted in the mid-1960s, they were a social safety net, a

continuation of the tenets that were enacted in the mid-1930s with Social Security. The government will be there for you with a guarantee or an entitlement program.

As we have changed and evolved the program over time, we see the changing role of government and the changing role of the individual. In the future, we'll see more prominent roles for individuals and a reduction in the importance of government. We created several short-sighted cost containment programs in the 1980s. They were not directed for the long-term solvency of the program, but rather for the short-term gain. Now we're beginning to see the program on a defined-contribution basis, something that the government can say has some overall limitations. The government in the future will provide a role, not as financier or payer or regulator, but as referee of a marketplace totally directed towards economic choice for the Medicare beneficiary. As the aging of the population moves forward, those choices will become more prevalent, in my view.

But what does this mean for the election in the second Clinton term? We can look in terms of what the public perceptions might be. One day Clinton is for a balanced budget and the next day he isn't. One day he's for cutting regulations and the next day he isn't. One day he's for controlling health care costs and the next day he isn't. One day he's for cutting entitlement programs; the next day he isn't. One day he's for energy efficiency; the next day he isn't. You know what you call that? A perfect reflection of the American voter.

When Americans are asked about what party they have greater confidence in reforming our health care system as well as Medicare, overwhelming majorities consistently have favored the Democratic party. What candidate does the public have greater confidence to solve the Medicare program problems and our nation's health care crisis? Bill Clinton. Does the public have greater confidence in the Democratic Congress or Republican Congress to deal with issues of the Medicare program? The Democratic party. Three out of four Americans think that the programs shouldn't be cut. But when Americans are asked whether the program will be there for them if they are not in the program right now, what do you think they say? No. Is health care an important issue for this presidential campaign? Have we heard much about it? No. We really haven't heard about the health care issue directly. However, the politicians recognize that it's on the public's mind, and that's why I believe further changes will occur in the next Congress.

Based upon polling data, education is certainly the number one campaign issue. Number two is drugs. Number three is balancing the budget, and number four is the health care issue. When asked specifically about other issues on polls, in terms of priorities for the next Congress, the number one issue is education. The number two issue is protecting our senior citizens.

We then begin to see the notion of economic security and health care security on the radar screen for the next Congress. The issue of public perception about health care has not changed. Forty-two percent of those Americans who are insured today feel that they might lose their insurance. Sixty-nine percent of those insured today think that the health care coverage crisis will continue to get worse. In fact, *The Washington Post* announced the results of a nationwide poll and 54% of Americans believe that the country would be better off if the Clinton health care reform plan was enacted.

Health care reform is going to come about. How is it going to be different than in the past? It's going to be different because they're going to recognize that we're not going to revolutionize; we're going to reform incrementally. Every major bill the Congress has put forward from Social Security to tax reform to the Civil Rights Act, was done with incremental change. Washington moves forward incrementally.

To use some very round numbers and some very gross illustrations, the Medicare program is roughly growing around 10%. We believe that in the next Congress it will cut that rate of growth to around 7%. In order to keep it in perpetuity and, more or less, political balance, the trust funds need to grow around 5%. We see a series of legislative changes to move the Medicare program forward, and they will become politically rationalized over time. Perhaps the most interesting aspect is what might occur after the turn of the century.

Just as we've seen in terms of the political debates, we will hear shock among the American public that the actuaries were wrong in the Social Security Administration. Politically, the Medicare program issues will be rationalized because the economic security of the nation's elderly may be threatened. We'll be putting the Medicare program on an accelerated change pace as we move forward from the legislation in 1997. Changes after the turn of the century will move forward to reform the Medicare program.

My second theme to you is that the path that Washington takes is never straight. Although the Clinton plan could have economically engineered the whole country and ignored some basic political aspects, Washington will incrementally move from a fee-for-service environment to a capitated managed care type of environment. It's doing this now by shifting financial risk from the government to providers and health plans and Medicare beneficiaries. It's doing it using a whole host of techniques, and that will continue over time. The concept that you might remember is that the government is looking at shifting risk by changing its payment mechanisms. It's making the fee-for-service system miserable, and will potentially put it in a death spiral. Everyone who is participating in the Medicare program will

be targets of cuts in the future. That shared pain isn't going to be enough to sustain the Medicare program in the long run.

The third theme I'd like you to remember is on that bridge to the future there is no exit before the toll. Everyone involved in the Medicare program will pay that toll for the bridge to the future if the Medicare program is going to sustain itself. It's going to sustain itself potentially with a new regulatory framework. This is the Republican view of tomorrow. It's very much like the Clinton reform plan.

The Congress had an opportunity to eliminate the government's role in Medicare. It didn't propose to do that. It enhanced it. Basically, what we're looking at is an opportunity for the delivery system and those who work directly with the delivery system. The Congress will enact medical savings accounts. There will be ways to shift financial risks by creating new provider-sponsored organizations contracting directly with the Department of HHS, and eliminating many of the state insurance laws today. But there will be competing health plans, and Medicare beneficiaries will exercise choice.

Those beneficiaries exercise their choice today with the Medicare risk products; they look at their benefits; they look at how much premium they'll be paying; they look at who's in the network, and how they get out of that network to a point-of-service arrangement; what copayments they have, and pie and coffee. Pie and coffee? Why is that? Because pie and coffee represents marketing. Organizations getting involved with the new entrance of the nation's elderly into the marketplace are going to have to learn how to market to the elderly like they have never done before. The elderly are demonstrating their ability to make choices.

We've done some projections in terms of what this might mean for the future, in terms of the future enrollment in Medicare risk products. The percentage of the Medicare population will continue to increase each month in managed care products, moving up from 10% or 11% now to almost a third of the population. An increasing number of organizations will accept financial risk from the government. Eventually, as many as 800 new risk-bearing entities will be there. The provider community will come together.

My fourth theme for you is, yes, it does take a village. It takes a village for the providers of care to come together and provide care to the nation's elderly and to provide a real choice for the Medicare beneficiary. So the message to Medicare providers is accept financial risk and move forward. What is very difficult to predict is the variety of initiatives that could move forward in the Medicare product area. What are the implications of the Medicare program changing its enrollment sequence? How will communications with the whole Medicare population change?

How will the reform of the whole payment mechanism impact overall participation in the Medicare program? These are the kinds of things that we need to anticipate and take into account in those enrollment projections.

We see that there is a great deal of interest in accepting financial risk. For those of you who are interested, I have a survey of integrated delivery financing systems—those provider-based plans that are accepting downstream risk right now. These integrated delivery financing systems could potentially roll over into becoming provider-sponsored networks in the future when Congress enacts that legislation next year. We see very troubling results, in that they are also in great need of actuarial assistance. Twenty-two percent of them are HMOs. The participating providers in their networks are not at substantial risk at all, so they're not performing like HMOs. Most, though, provide the whole continuum of care and pay on a fee-for-service basis for services outside of their network. Forty percent have experiences with Medicare and Medicaid lives, and, based on that experience, 71% of them want to become provider-sponsored organizations, without really truly understanding what a provider-sponsored network is, because the legislation has not yet been enacted.

Provider-sponsored networks are more or less owner/operator type of organizations that don't necessarily meet state solvency requirements. We look at their preparation for the future, based on their current book of business right now, and what do we see? They have a very limited infrastructure. They are financially unsuccessful, and they don't even know the basics about their business and the risks they are accepting right now. They just don't know their overall revenues, their utilization rates, their enrollment targets. Yet the provider community has been asking to accept financial risk, because it recognizes that the trend is very clear on the fee-for-service side—nothing but cuts. What it doesn't recognize is what will happen in the future. Once it accepts financial risk, Uncle Sam will put grandma on the bidding block, and ultimately he will reduce the amount of capitated payments. So even as providers are looking to escape the fee-for-service side, we're seeing the next change wave of competitive pricing being considered.

We tell our clients that they should consider that there is no place like home. Don't look to Washington for the answers to all your business problems, look at your community. Understand what financial risk means to your community.

In conclusion, we need to reflect on the fact that the debate that we're about to enter is whether Washington is mirroring public opinion. We don't know how much government we can afford and how much we want. We saw that in the last election. We're going to see that in this election as Bill Clinton is re-elected, and more Democrats are re-elected to Congress. We're going to ask ourselves how

much care can we afford, who pays for that care, and who's protected? Public policy will have to answer those fundamental questions. We need to remember that the pace of change is going to depend on election results. And that's the first change wave.

The second issue to remember is that change is going to be incremental. The path that Washington takes is never straight. Nothing is new in Washington. Washington doesn't innovate; it follows. It follows by replication. We see integrated delivery systems in the communities today accepting financial risks from employers. Those will be replicated in provider-sponsored networks. We're seeing organizations integrate so it takes a village. We see that in the future there is nothing but cost containment on the horizon, and there's no exit before the toll. A community needs to come together in order to accept that risk.

Mr. Harry L. Sutton Jr.: It's amazing how much I agree with Fred. I'm going to take a little different track and you'll see where I agree. I'm also going to take a historical look at the various proposals that have been made over the past 10 or 15 years to reform Medicare, or to reform the health care system, a number of which are not included in what Fred was talking about.

In the last presidential debate, both candidates said they will never cut Medicare benefits and were going to squeeze the savings by reducing reimbursement to providers. They didn't really talk much about the HMO as a provider. A question came up from the audience: why do we allow HMOs to decrease the quality of care? They both reacted by bashing HMOs and saying that we can't permit them to decrease the quality of care. Both political parties dislike HMOs, but they can't see any other way of reducing costs than transferring the risks to the provider systems. But neither of them would ever enroll in an HMO themselves. They bash the naughty HMOs. Of course, they don't like million dollar salaries, either. In the short term, we must save the Part A trust fund. Dole insists on repealing the excess tax on OASDI benefits from 50% to 85%, and when you look at the trust fund, there's approximately $4 billion in excess Social Security taxes that go into the HI trust fund. So, you're going to throw $25 billion or $30 billion out of that trust fund if you discontinue that tax. I don't know how many people are complaining about it. Nobody that I talk to complains about the tax, other than the higher income people. Maybe there's a great deal of complaining in Washington; I don't know.

The other thing in the trust fund that I always thought was of interest was that there's roughly $10 billion in interest on the accumulated bonds that are in the trust corpus. So the revenue and expenses are much further apart if you throw out the excess OASDI tax and the interest on the accumulated trust fund.

Everybody wants to set up a commission exactly like the 1983 commission. Dole was on it, so maybe he'll get on the commission again. He won't have anything to do, probably. I think incremental reform is probably the way we're going. When I get to the end of this, I'll tell you what I think is going to happen for the next two years. In the 1980s there was a big move to major social expansion with the Pepper Commission and others. On the other side of the table, there were people worrying about how to pay for Medicare and some of the proposals were extreme.

Before I wander off into the discussion of these, I wanted to talk about one other thing that I know Guy has been interested in, and that's the question of generational equity. You saw Rick put up charts showing that in terms of the OASDI tax base, the total cost would be somewhere between 30% and 35% once we are 30 or 40 years into the next century. We can't afford to have a 35% payroll tax, it's just unrealistic to think that anyone in Congress would ever pass an increase in tax that would cover those costs.

These are some of the suggestions: catastrophic protection; cover prescription drugs in Medicare; long-term care (estimated to cost $48 billion in the year 2000); reduce deductibles and co-insurance; merge HI and SMI and standardize benefits; and reduce skilled nursing facility copayments. Medigap has been a problem in the last ten years. They said, with a 30% to 40% administrative cost, why not governmentalize Medigap and let people buy it from the government at a 3% administrative cost? Just think how much money people would save. Decrease the eligibility age. People can retire on OASDI at age 62 but they can't get Medicare until age 65, so decrease the age for Medicare so that when people want to retire they can get Medicare. Of course, Congressman Stark's bill proposed that the whole population be covered by Medicare.

There were many reductions. Medical IRAs were suggested to replace the HI tax so people could just accumulate their own money to help pay for their Medicare expenses. Sin taxes have been proposed. I really think we have to think about passing more of the cost onto the seniors. When we talk about the privatization or the shifting of the risk, the cost indirectly will then be passed on. There's no reason an HMO or an accountable health plan can't raise the premiums to the public. That way the pressure charged would be off the government.

The government can lower the price it's going to pay out to the provider systems, but if the providers can't live on it, they can charge a supplemental premium to the Medicare eligibles. It's similar to cutting Medicare benefits; you don't save anything because the Medigap premiums will rise to cover the holes you put in the benefits and keep the whole system the same, except the cost will be transferred to the person buying the Medigap coverage. The government passed the Baucus

amendments and fattened up Medigap coverages. And when they saw how much Medicare costs underneath that went up, they wanted to enact confiscatory taxes on Medigap premiums, but they've never done that.

One of the major problems is just how to raise the money. One way of coming up with $100 billion in taxes would be to tax the employer contributions to group health insurance, and tax the value of Medicare benefits to the Medicare beneficiaries. For beneficiaries who weren't paying any income tax, it wouldn't be any different. It's a way of indirect means testing, similar to the tax on excess Social Security benefits.

We have the Medicare Catastrophic Act of 1988, which limited Part A deductibles, imposed a limit on the out-of-pocket maximum, had a high deductible coverage for prescription drugs, had a $4 Part B premium increase in 1989, and income tax increased up to $800 per year on high income Social Security recipients. Because of the hassle over the income tax, they repealed the whole thing at the beginning of 1989. That was incremental reform. People objected to paying income tax for the same benefit that people already had through their Medigap or had free from their employer.

In the 1990s we had the advisory commission. The commission recommended that we rationalize HI and SMI, change the deductibles, and put the catastrophic limits back in. We proposed selected contracting with providers; we made the HMO the sole provider of Medicare benefits in a certain area and so on. There were low-tech and high-tech options put in so we didn't spend so much money to keep people alive when they will die anyway. Often changes were to mandate HMO options with negotiated rates and a defined-contribution plan, the voucher plan, which is the same thing that we are talking about today. We can increase the wage base, too. A few other small changes were recommended.

What happened? We had another incremental change. The HI tax base went to unlimited. It had already been raised to $125,000, and it was supposed to go up with inflation. The high-income seniors are currently taxed up to 85% of the Social Security benefits. SMI premiums were fixed at roughly 25%. In the early years of SMI, it was 50%, and the statute fixed it at 50%. As was pointed out, unless Congress acts, the premium will drop down to close to 5% 70 years out because it's going up by the general inflater. A recent change is the government discontinued allowing health care prepayment plans (HCPPs) HMO plans, which had existed since the early 1970s. Those are essentially a form of cross contracts with HMOs, although some of the providers are police clinics, union-owned plans, and other organizations that really aren't HMOs.

Employers can still have an HCPP, and of course, no HMO can cancel out an HCPP member. They can't enroll anymore except through employers. The HCPP always has a fairly sizable premium because it essentially reconstructs the HMO cost into a Medicare-like cost and benefit plan. The last item is a recent change that is probably going to reclassify some totally disabled people to remove people whose primary illness is alcoholism or drug addiction without any other problem.

Fred mentioned the Medicare Preservation Act (MPA). Essentially, the many payment reductions and the fail-safe reductions of the MPA would reduce reimbursement so much that probably no doctor would ever sign up for Medicare. The MPA has many different options, with annual open enrollments. Arbitrary premiums are being paid by the government. Essentially the capitation rates would be severed from the current costs of for-service Medicare. The high-cost areas would be reduced one way or the other and the low-cost areas would be increased. It won't be a national community rate, but gradually they would move together.

That would probably get rid of the adjusted average per capita cost system, and, because the Republican plan proposed to reduce the rate of increase, they're going to just lower the rate of increase in the premiums or vouchers they're going to pay to the HMOs. If the HMO can't survive with that, they have the ability to reduce the excess benefits they provide, such as partial prescription drugs, or they can add a premium. They are given more flexibility to give back the Part B premium if they want to. The Clinton proposal was similar but relied more on fee for service. He would preserve the Part A trust fund by transferring $60 billion out of Part A and into Part B (and not increase the Part B premium to reflect that either). Based on the way the trust fund looks, I don't think $60 billion will balance it out.

Essentially, they are trying to privatize Medicare and have the government contract with health plans at a fixed, negotiated premium. There would be annual open enrollment, and people could switch and keep the fee for service as the last site for people who can't or won't switch. What happens if you get a very small population in fee for service and the cost is ten times what it is now? This is likely to happen, and I don't have an answer.

The government would have to do something for those people. This is what I project would happen. By my calculation, if we raise the HI tax to 4%, 2.7% each from 1.45% each, I estimate we could keep the fund solvent for approximately ten years without changing anything about controlling costs. We could freeze hospital reimbursement and hold it constant for five years, and transfer home health out of Part A. Home health has been among the most rapidly increasing benefits. I'd have to check that one to see; I don't know if it's possible to freeze hospital reimbursement exactly, meaning pay the same diagnostic related group for five

years. It may not be possible, but it's an incremental step. If we transfer $30–$50 billion a year out of the OASDI fund and into the HI fund, I think that would keep it in balance, for about ten years also. However, it won't help the long-term solvency of the OASDI system.

None of these things, with the exception of the first one, raising taxes, would have any effect on the federal budget. The federal budget deficit would increase unless you actually have a tax increase. These other solutions just shift the money around but don't change anything.

Competitive bidding is another option, but it has been very hard to get it going. I think Clinton will still go with competitive bidding. The problem is the HMOs like to get the same amount of money they are getting now, so they don't want to change. Even one of the states where we proposed to have it, Maryland, didn't like it because it thought it might disrupt its hospital universal pricing system. It's the only state left that has an all-payer rate regulatory system.

I'm not sure a small excise tax on Medigap premiums is feasible, because Medigap premiums are already rising so rapidly. We're getting up towards of $1,500 a year for any kind of comprehensive plan. Everybody, including the American Association of Retired Persons, is complaining about the rate increases. Maybe it's impossible to even put a 10% excise tax on, although it would produce some money. The last estimate I saw of Medigap premiums was $27 billion. A 10% excise tax would add $2 billion or $3 billion a year to the funding.

I also think they will raise SMI premiums to 25%. The public seems to accept that. I thought Clinton should not have reduced the premium in 1996 when he could have left it where it was last year. Maybe he couldn't have politically. I think we would have a shot at income-related increases in Part B premiums; it has been discussed. There won't be changes in benefits because I don't think they can do that under the political environment. If they had a commission that was redoing a whole bunch of things, they maybe could change that. They will not reduce the tax on the high-income people for the excess OASDI benefits between 50% and 85%. A combination of these things, I think, would represent incremental change. I don't know if raising the HI tax by 0.55% would be considered incremental, but they haven't changed it in a long time and everybody's concerned about it.

I think if I were going to do it, we should raise the HI tax. Politically it is feasible. If everybody is so concerned about HI going bankrupt, this would keep it solvent for ten years. That's a way to give yourself time, if that's the only thing they're worried about. It doesn't do a darn thing to control cost. That's an easy way around it to gain a few years and not worry about it.

There are many options that I didn't have time to talk about in any kind of detail. Some of them are considered too far out in right field, or employers would object, or unions would object. For example, I think we should tax all health insurance that we get from employers. There's much resistance to taxing health insurance contributions by employers, but it would produce money, and might produce change in the way employees think about their health benefits. I think the metropolitan statistical areas are a way of trying to do that. Make people pay more out of their own pockets and think about what they spend.

Mr. King: I hope that gives everybody food for thought.

From the Floor: My first question is for Mr. Abbey. He made the statement that the Clinton health plan would have reformed Medicare. Could he please elaborate on this and how it would have affected Medicare and done something to fix it?

Mr. King: While Fred is thinking of an answer to that question, there's one thing I might point out about the Clinton health care plan. The Clinton health care plan would have reduced expenditure growth in the Medicare program by more, over the same period of time, than the Republican plan that the president vetoed. The reductions would have been made mainly by reducing the updates in payments to providers, reducing payments for certain items like hospital reimbursement for graduate medical education, reducing the DRG updates, and reducing the increases in resource based relative value scale payments to physicians.

From the Floor: Isn't this cost shifting? And isn't this something that happened during the 1980s under Reagan that caused the percentage increase for the rest of the medical health care world to go up dramatically?

Mr. King: Cost shifting is another issue. I would certainly agree that it isn't reform. It only reduces the rate of growth in the year in which the cut in payments to providers occurs, but it doesn't actually reduce the rate of growth in years after that. Rick's charts indicate we don't have just a short-term problem that can be solved by a few cuts in payments to providers. We have to find a way to reform the system that is going to reduce the rate of growth not only in the next few years, but for the next 75 years. Fred, do you want to add anything to that?

Mr. Abbey: Yes. In addition to the incremental cuts that would have promoted other changes on future legislative cycles, there's a striking similarity between the Clinton reform of the health care system for America, and what the Republicans are proposing for the Medicare program. One similarity is a prominent role for the federal government as policymaker. A second similarity is the notion of creating a framework for people to choose. And a third similarity is that the choices are

among health plans rather than a fragmented kind of delivery system that you manage yourself.

Mr. Sutton: If I remember it, the concept was to build local Health Insurance Purchasing Cooperation (HIPC) and affordable health plans, and the Medicare people were going to pour into it and were subject to the same benefit plans that everyone else would be subject to. One of the reasons big employers liked it was it took the Medicare benefits out of the separate domain that it's in and would eliminate their *Financial Accounting Standard (FAS) 106* liabilities, which for the big three auto companies would have been over $50 billion.

In the beginning, the big auto companies thought it was great until they thought about some of the other things that were involved in it and then changed their mind. But, in effect, they would have local pools that included Medicare. Everybody had to be enrolled, and would include employer groups up to 5,000, in order to get a big enough pool to average the rates down. I'm not sure if Medicare would have paid different rates in HIPCs than everybody else. It was suppose to be a community rate, but I can't remember whether Medicare was thrown into the community rate or not.

Mr. King: I think what was finally adopted is that Medicare wasn't part of the HIPC, but there was some additional savings to Medicare resulting from the current Medicare secondary payer provisions. Every employed Medicare beneficiary would have had private insurance, so that the savings from the current Medicare secondary payer provisions would have been higher.

Mr. Robert J. Myers: Harry Sutton has given an interesting list of possibilities for solving, at least for the next decade or so, the financial difficulties of the HI trust fund. I wanted to build on one of them slightly to what I think might be a little better. What I would do, quite simply, is reduce the OASDI tax rates to 0.6% to the employer and to the employee, for a total of 1.2%, and I would reallocate (as has often been done) that money to the HI trust fund. According to my calculations, and I think that the actuaries at the Social Security Administration and HCFA agree, this would be a win/win proposition. The OASDI trust funds wouldn't build up too large a figure as they would under present law. They would have a fund ratio of around 140% during the entire period which I suggest. Do this reallocation for 1997–2009. The OASDI trust funds would have a fund ratio of about 140% during the entire period, which is more than ample. The HI trust fund would have a fund ratio of about 100% during virtually the entire decade, and then would decrease afterwards. The only trouble with this proposition is that it gives too much time for the Congress or a national commission to get together to decide what to do to solve the long-range problem, which my proposal, of course, does not do.

Mr. James C. Shake, Jr: I have a question regarding the other side of the coin, particularly in regards to the health insurance program and the quality of care issue. With all focus on the financial deficits, consider the providers of that service—the hospitals themselves. I know, particularly in New York State, they're being pressed. They are going into a more competitive environment. They are going to be going through many changes. What, if any, reassurances are there about the level of care Medicare will provide? In our rush to make sure Medicare doesn't go bankrupt, where does the quality of care come in on this issue?

Mr. Abbey: I think your example is a good one in terms of the stresses on the delivery system in a market like New York—a highly regulated state that has moved incrementally to deregulate. If you look at the differences between what that delivery system performs and how well it performs versus California, you see a dramatic difference in the pathway of care, not in the quality of care. I suggest that there is going to be a great deal of emphasis in those areas, particularly in the hospital side where their user rates are substantially higher than in highly penetrated managed care markets. The regulated environment will allow the entree of home health and other kinds of caregivers to go in and maintain the quality of care. So, nothing will be stagnant. The delivery system wil evolve and the quality issues will continue to be comparable.

Ms. Marla C. Pantano: When Mr. Foster spoke about the SMI trust fund, he said the revenues are forced to equal the outgo. That's assuming that the public is going to stand for some substantial income tax increases, which, in my mind, they aren't. Or we can get the huge budget deficits going forward, which isn't really any different in my mind than going to a higher tax on HI. So why are we concentrating so much on just the HI side? Isn't it eventually going to be the same thing?

Mr. Abbey: As Ms. Pantano points out, for HI, you do have to have a change in the law in order to chnage that tax rate. For SMI, the law is very clear. You are going to appropriate this money. You are going to have to get it from somewhere. Now, it takes an appropriation bill and, over time, as you pointed out, that would get harder and harder. Where does the general revenue come from? It comes from general government taxes, which are primarily income taxes, or from borrowing. At some point, if the SMI program's needs, together with all the other needs of general revenue, reach some critical point where you just can't do it, that's every bit as much of a problem as a 36% payroll tax. There's a limit in both cases.