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Current Medicare Issues And How The American Academy Of Actuaries Is Involved

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Summary: The American Academy of Actuaries is engaged in several projects that proactively examine the future status of the Medical Program. This session presents the findings that have resulted from these efforts.

Mr. William F. Bluhm: I'm currently the Academy's Health Vice President. Within the Academy's health organization, there are four different areas now. You won't see it organized this way in the *Yearbook* because the reorganization is more recent. One of those four areas is the Medicare work that we're doing, and we have four people who are heavily involved in that effort. We five are going to give you some updates of what's going on, give you a feel for public policy that we're working on, what's in progress, as well as what has been done.

Tom Wildsmith is the chairperson of the Medicare Expansion Working Group for the Academy, co-chairperson of the Congressional Response Group, and overall chairperson of the Medicare Committee. The other three are functional. Medicare was such a big issue this year that we created a whole separate effort for that, and Tom is now chairing that working group.

Within that organization there are two generic groups called the Cost-Saving Group, and the other is the Expansion of Choice Group. We also have a couple of specific

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task forces for responses addressed to specific initiatives. These are the four major areas that we're working on, which the speakers will address. Tom is also the policy research actuary at Health Insurance Association of America.

Donna Novak is a senior manager at Deloitte & Touche. She is the other co-chairperson of the Congressional Response Group. Tom and Donna are chairing that group which is responding to some specific requests we've had from congressional representatives to help explain some of the funding issues, the future projections, and funding of Medicare. Donna also chairs the Federal Relations Committee of the Academy which is one of those other three areas that I mentioned.

Jill Stockard is a senior consultant and health actuary in the Chicago office of Coopers and Lybrand. She has been with Coopers since 1992, and her experience includes consulting with employers, insurers, health maintenance organizations (HMOs), and state governments on various health care issues. Before Coopers, she worked two years at Towers Perrin as a pension actuary. Jill is a member of the Academy's Federal Health Committee and has served on several of the Academy work groups including the Expanding Choice for Medicare Beneficiaries Work Group, which is one of those two subsets that I was talking about under Medicare.

John Trout is the director of public policy for the Academy and has 20 years at Social Security Administration, 10 years at the Health Care Financing Administration (HCFA), two years at Department of Health and Human Services, and worked on medical and Social Security policy and operations. He has been with the Academy heading up the public policy area since December 1997.

Mr. Thomas F. Wildsmith: I would encourage all of you to pick up a copy of the AAA's Issue Brief on Medicare expansion. We put a good deal of work into it, so it would make us feel good if the copies disappear. The Clinton administration recently proposed expanding Medicare, which grows out of a series of attempts towards incremental reform of health care. As we all know, the Clinton administration proposed a massive structural reform of our health care system several years ago. There was a great deal of interest in it, but ultimately the nation decided not to take that approach. Since then people in both political parties had been picking off at incremental changes to the health care system. Some of the enacted changes include the Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislation, the Children's Health Insurance Program, increasing the deductibility of health insurance for the self-employed, and, in a number of states, some state health high-risk pools. Typically these had been focused at discreet population segments where we perceived that there's a problem with a lack of insurance. A couple of new proposals include the Medicare expansion and also

some proposals to provide tax deductibility for premiums for all individual health insurance purchases. This is, of course, targeted towards solving the problem the nation has with people who lack health insurance.

We're looking at people between the ages of 55 and 64 (near elderly). Those are people who are presumably coming towards the ends of their career but are not yet eligible for Medicare. When we look at who's uninsured and the percentage of people who are insured by age, people who are younger are less likely to have insurance than those who are in the near-elderly. Once you reach age 45 the percentage who are uninsured drops to about 13%. Still, there's some particular concern with this age group because, as you age, your health deteriorates. There's some concern that if you lose insurance at that age, you may be less able to find insurance than a younger, healthier person would be.

Let's look at it by income, and this is going to be a key issue. People who are uninsured are put into an age category, by family income as a percentage of the federal poverty level. The federal poverty level for a family of two, a couple, then their children are gone, is around $21,000. It's not a heck of a lot of money. In the near-elderly age categories roughly half of the people who are uninsured are at or below two times the federal poverty level.

What has the administration proposed? There are two buy-in proposals. There's COBRA 1986 expansion, and then there are some proposals dealing with fraud and abuse. The proposal is that anyone age 62–64 who does not have access to employer-provided coverage would be able to buy into Medicare paying a premium. Individuals between the ages of 55 and 61 who lose their coverage due to loss of job, being displaced, laid off, or the job is eliminated, would also have the option to buy into Medicare. Those who lose their postretirement health benefits because their employer shuts down the plan basically would get expanded COBRA to tide them over until they're eligible for Medicare. Now, we're going to talk about this some more, but the package that has been proposed is intended to be budget neutral. To do that, a number of initiatives were included in the package to cut down on Medicare fraud and abuse. By incorporating those savings from those fraud and abuse initiatives you do get a total package that has been projected to be budget neutral, but those fraud and abuse savings are being used in some sense to pay for the Medicare buy-in.

The premium structure for the buy-in is particularly interesting. For ages 62–64 there are two very different kinds of premium. There's a current premium that you pay during those years that you're receiving coverage. You buy into Medicare at age 62. You pay a monthly premium each year until you become eligible for

Medicare at age 65. That premium, roughly speaking, is calculated on an average risk basis. It's calculated as if everyone in that age group were in the Medicare program. Most likely the individuals who buy into the Medicare program are going to be a bit less healthy than average. To make up the difference an amortization premium is going to be charged after age 65. It's an additional monthly premium that would be paid each month from age 65 for the next 20 years, through age 84. That premium is calculated basically to amortize the loan of the excess cost of those relatively unhealthy people who are being given an average risk premium. So, one way to think of it is the Medicare program would be extending a loan to these individuals to pay off their excess morbidity.

The buy-in for ages 55–61 is a lot more straightforward. There's a single premium that's paid while the coverage is in effect. By single premium I mean there's no follow-on amortization premium. It's a premium that's paid each month, and it's going to be based on the experience of the program. Most estimates are that for the age 62–64 buy-in the monthly premium would be a bit over $300 a month. The monthly amortization premium for each year that you were in the program prior to age 65 would be somewhere between $10–20 a month, and that the monthly premium for the age 55-61 buy-in would be, roughly, $400 a month. Now, those premiums would all vary geographically, but they would not vary based on personal health status.

The key conclusions of the monograph are really the bottom line. The first conclusion ought to be screamingly obvious to all of us, but the cost of the program is really going to depend on who chooses to participate, and, honest to goodness, we don't know who would. It's very difficult to predict. One of the primary reasons for that is nothing like this amortization premium approach has ever been tried before. It's very innovative, but no one's done it. We really don't know how individuals would perceive this. If they make their decision by primarily looking at the current monthly premium that looks very much like an average risk premium, it's going to look like a relatively good deal. You may have a relatively large number of people participating who would be relatively more healthy. If, on the other hand, they really look at that amortization premium or if they look at it as taking on a significant loan obligation, they might not view it as quite as attractive a deal, and you might see a little more severe self-selection and a little higher cost on each individual participant. Again, we really don't know how people will look at it. There's some reasons to believe, looking at 401(k) plans and other things, that most adult Americans have a surprisingly short financial planning horizon. On the other hand, as people reach retirement age, they tend to view their finances differently and tend to become a lot more conservative. So, we really don't know which way that would go.

I must admit the Academy has not done any modeling on this point, but if we look at the estimates that have been done by HCFA and by the Congressional Budget Office (CBO), it appears that there would be a relatively small impact on the number of uninsured Americans in this age group. There are roughly three million Americans between the ages of 55 and 64 who are not insured. The CBO estimate is that roughly 320,000 would choose to participate in the Medicare Expansion Program, of which roughly two-thirds are already covered through private programs. So, you get a relatively small net increase in the number of people who are insured.

Now, it appears that the age 62–64 buy-in program could become self-supporting over time. The first few cohorts are likely to have a little higher morbidity than later ones because relatively healthy people probably already have their private insurance or have considered and made plans for it. But over time, if the program works as it's anticipated, and you don't have real change in enrollment patterns, it could easily become self-supporting. The timing of the amortization premiums, however, is going to affect the size of the Part A trust fund. Medicare is, in essence, making a loan. When these people buy in their claims are going to be paid on a current basis, but not all of the premium is going to come in. It's going to be a bit over 20 years until that premium's paid back. Because of that the level of the Part A trust fund will decrease somewhat, and if you want to become apocalyptic about it, it would have the result of causing the trust fund to be exhausted somewhat earlier than it would have otherwise. To be fair, this is going to be a relatively minor part of the Medicare program, and there are large enough problems elsewhere. So, I don't think we should fixate unduly on that, but it will have an impact on the trust fund.

We believe age 55–61 buy-in is going to generate ongoing losses. In structure it looks very much like COBRA continuation or high-risk pool or conversion coverage where people are intended to pay their entire freight. They're expected to be higher than average risk individuals, and without some sort of external subsidy we don't understand how you could get a stable premium that would cover all of the cost. Finally, it appears that savings from the fraud and abuse programs will be necessary to make the entire program budget neutral.

Ms. Donna Novak: A few years ago at the Society meetings we all wore buttons that said, "Ask An Actuary," and we've taken that message to Washington. We saw a lot being done where economists were being brought in, politicians were being brought in, and we asked the government to ask an actuary. The good news and bad news is they asked us. One of the congressional members brought a proposal to us a little while ago saying that he had some ideas on maybe what could be done

with Medicare that would keep the trust fund solvent longer into the future, if not indefinitely.

It was really three-pronged. First was the whole Medicare inflation to gross domestic product (GDP) plus population changes. Actually, the Balanced Budget Act has gone a little bit in that direction since we were asked to look at this proposal. Congress has made some steps in that direction. Another leg was to increase the payroll tax, say, 1–2% of payroll. The third was to increase the beneficiary cost-sharing from approximately 10% of the program to 15–20%. We needed to look at all of the affected groups on Medicare and see what we can do if we change each one of the group a little bit, if we decreased payments to providers, if we increased the payroll taxes to those under age 65, and if we increased the beneficiary cost-sharing. This was one proposal that was brought to us. We've actually been talking to the Medicare Commission recently. They're getting some background information on how Medicare differs in plan design from those under age 65 and looking at some other proposals and developing their own. We're going to be helping them a little bit with that. I was handed another proposal that we may be using this model for.

Anticipating that this wasn't going to be the only proposal that they were going to ask us to look at, we are doing a 75-year projection, and we're providing for modeling of other alternatives. I'm going to go through some of the assumptions that we've built into the model by category, and what type of factors we've built into it. If any of you want to offer any ideas at the end of the meeting as to any factors that we haven't taken into consideration or that we should take into consideration, please feel free to bring those to my attention. Remember that we do have a rule at the Academy: anyone that comes up with an idea is responsible for implementing it.

First we started out with our population assumptions by age and gender, both in total and then by institutionalized Medicare and working population. After that, we looked at participation rates for the aged and disabled by the three categories, Part A, Part B, Part C, and medical spending account. The model handles all of those population and participation categories. We also have assumptions on the wage base that is split by age and by gender. As the demographics change, we can look at what the effect is going to be on the wage base and relative health status. We also look at the Medicare trust fund on the miscellaneous income that comes into the trust fund. We're taking into consideration all of the elements that actually affect the trust fund that we don't usually think of such as voluntary enrollment or interest on the trust fund,. Then we consider participation rates for the aged and disabled. We also look at GDP and Gross Product Income (GPI) because much of

the trustees' report is tied back to GDP. We have assumptions in on growth in GDP and GPI.

We have a set of adjusters built into the model. Not only do we have our assumptions, but we have a way to adjust at any point in time the wage base, the GDP growth, participation rates, claims cost, and administrative cost. The model is a large Lotus spreadsheet, and this allows us to play with any of the assumptions. Part of our modeling philosophy was that we wanted to start with a base that matched HCFA's trustee report. Then we would know that for any elements that we were modeling or any aspects of proposals, we would be just looking at the difference between what HCFA was currently estimating and the proposal. So, we have spent quite a bit of time balancing our assumptions back to either what was in the trustees' report or we've been working with the chief actuary, Rick Foster, at HCFA for some of the underlying assumptions to the trustee report. The Medicare trustee report and assumptions are based upon the population in the Social Security trustees' report. Social Security and Medicare underlying assumptions match. We went to the Social Security trustee report to balance the population projections. We went to Part A and Part B cost in the Medicare trustees' report. Part C of the Medicare trustees' report has the participation rates. It doesn't have the cost. So, we balanced the participation rates for Part C, and then the miscellaneous income matched up. All of the points that we could find to match to HCFA's current work would match up with our model.

There are additional elements that we've built into the model because we anticipated that they would be part of other proposals. One is an increase in the Medicare eligibility age. It just seems to make sense that if we're increasing Social Security eligibility age that increasing Medicare eligibility age will be proposed at some point. Increasing the Part B premiums and increasing Part C participation makes sense. Jill is going to be talking about Medicare Choice. There's very high interest in encouraging as much of the Medicare population as possible into the managed care alternative, and we wanted to be able to model what the effect on the trust fund was going to be of that migration if it was successful.

Lastly, I just wanted to give an update of what the status of the project is right now. We have verified the model against the trustees' report, and we're expanding some of the logic in the model to handle all of the alternatives that we want to address. Then the task force is going to get back together to project the first request and test the sensitivity of each component. One of the members of our group is a professor at Duke University, and he's helping us with some of the sensitivity testing and laying out a plan to look at what the model is sensitive to and, therefore, where we would get the biggest bang for the buck in different alternatives for Medicare. We

will then produce a report of our findings which, of course, would be available to the membership at that point in time.

Ms. Jill Stockard: The Academy is in the process of putting together an Issues Paper about the Medicare Plus Choices provision of the Balanced Budget Act, and I'm going to give you an update on some of the issues that we identified. The Balanced Budget Act of 1997 and, in particular, the Medicare Plus Choices provision of the Balanced Budget Act expands the number of health plan options available to Medicare beneficiaries. Going forward, the following will be available: risk health maintenance organizations which were an option prior to Balanced Budget Act, provider-sponsored organizations or (PSOs), preferred provider organizations, medical savings accounts and private fee-for-service options. Not all the detail among the options have been very well-defined to date, and the implementation regulations have not been put out, but they're both underway.

In the fall of 1997, after the passage of the Balanced Budget Act, the Academy put together a work group to read through the legislation and identify some of the issues. The issues that we identified and that I'm going to speak to you about are the impact of changing the adjusted average per capita cost methodology(AAPCC). AAPCC is the capitation rate that Medicare pays to risk plans. I'm also going to discuss the role of risk adjustment with respect to the AAPCC, how the Balanced Budget Act impacts the employer market, what consumer quality standards and marketing information may look like, and, finally, the impact of PSOs as a Medicare choice.

As I already mentioned, the AAPCC is the capitation rate that Medicare pays to health plans, and, prior to the passage of the Balanced Budget Act, it was based on 95% of Medicare fee-for-service claims experience, and it was calculated on a county-by-county basis. However, there were some problems with the capitation payments. In the past, there were particular areas of the country that received very high capitation payments, and in those areas there were many health plans that were competing for Medicare risk business. Then there are other parts of the country that received very low payments, and there was very little or no health plan participation. The methodology to come up with those rates smoothed out some of the differences and encouraged health plan participation in areas of the country that had been historically underserved.

Under the Balanced Budget Act, the new payment methodology is the higher of three, different components, a floor which was set at $367 per month per member in 1998, a 2% increase over the prior year or an area-specific rate, and the national average. Then overall the new rates will be subject to budget neutrality which essentially means that aggregate payments for Medicare under the new AAPCC

methodology will be no more than payment rates under the old methodology. The rates are to be risk adjusted in the future, starting in the year 2000.

Some of the issues that we identified with respect to the AAPCC were with respect to future cost variations by geography which really won't be taken into account. In the past, the capitation payments were based on fee-for-service claims experience, but going forward we see that the prior rates were already set with a little bit of tweaking. So, any future variations will not be recognized. What will be the impact of budget neutrality? Will those historically low payment counties see much of an increase? What will be the relationship of the blended rates versus the 2% increase versus the floor? Again, will there be many counties that see much of an increase? Finally, one of the key drivers behind changing the methodology was to encourage new entrants into Medicare managed care. Will this new methodology actually accomplish that? Next we looked at the role of risk adjustment. The methodology is to be proposed in spring 1999, and it's to be implemented by the year 2000. The issues that we added into our paper were actually taken from prior Academy work that was submitted to Congress.

Risk segmentation occurs when health plans enroll beneficiaries that are significantly more or less healthy than average, and there's more risk segmentation that takes places as more options are available to beneficiaries simply because different types of options attract different types of people. An example of that is a health plan that offers very robust wellness benefits or has vouchers for health clubs might attract more healthy people on average, but a health plan that strongly and aggressively markets to these management programs may attract less healthy individuals. So risk adjustment is a mechanism that tries to manage the degree of risk segmentation by paying plans appropriately for the types of risk that they attract. There have been some prior studies done by both the Society and HCFA that show that age and sex, which are two of the current risk adjusters in the current payment system, do not sufficiently adjust for the degree of risk segmentation. Further study needs to be done on risk adjusters.

Under the Balanced Budget Act the intent is to get more entities contracting on a risk basis, and under the Medicare Plus Choice's provision, there are more options available for beneficiaries. Both of those points really make risk adjustment imperative. Risk adjustment should promote competition among health plans based on efficient delivery of health care versus marketing to the appropriate people. It should compensate plans fairly, in particular those that happen to attract less healthy risk than others, and it should protect the financial soundness of the system. Health planners not being paid appropriately for the people they're delivering care to are going to leave the market.

The paper identifies several criteria for risk adjustment methods. Payments to health plans need to be accurate. They need to reflect the cost of delivering well managed care to the appropriate population. The methodology needs to be practical and understandable. We need to keep administrative complexities low. Payments to health plans need to be timely and predictable. Health plans need to be able to budget for their future revenue. Finally, the system should not be subject to gaming.

We also looked at the impact on the employer market, which hopefully should be a positive impact. To date, most of the enrollment in Medicare Risk plans is on an individual basis. It's not on a group basis. I think there are some provisions of the Balanced Budget Act in the Medicare Plus Choice revisions that should help employers out. Current retirees are really not all that familiar with HMO concepts, and they may not be that comfortable in joining a closed panel of providers. However under the Medicare Plus Choices, there should be some options where they'll have fewer restrictions on their panel of providers, such as, a PPO, and perhaps they had a PPO offering when they were an active employee. They're a little bit more familiar with that makeup. PSOs may also encourage participation in Medicare Risk plans as well because if a retiree already has a relationship with their doctor, and that physician joins a PSO, chances are the retiree will be a little bit more open to joining the health plan as well.

National employers and rural employers, in particular, are having a difficult time moving into risk contracting right now if their intent is to offer uniform benefits to their retirees. As I explained right off the bat, under the old payment methodology there are different pockets across the country that have quite a few health plans that are offering risk networks, and there are parts of the country where there are no health plans at all. Hopefully, with the new payment methodology, the playing will level out a bit, thus encouraging national networks of risk plans.

Employers may also see a change in their 106 expense, and this change depends on where they are right now with managed care offerings to their retirees. An employer may actually see an increase in their 106 expense if they have their retirees fully in risk plans right now. One thing I haven't talked about since I'm just focusing on the Medicare Plus Choices provision is the Balanced Budget Act is providing relief to the Medicare system. It's taking money out of Medicare and it is reducing payments to providers. Health plans, in turn, may respond to that by increasing their premiums or decreasing their additional benefits. An employer who is 100% in the risk plans right now may see their expenses go up. On the other hand, and this is probably a little bit more typical, employers who are in indemnity programs or loosely-managed programs and move into risk contracting should see a decrease, at least in the short term.

Some additional issues that we identified for employers is employers will probably see some increased cost shifting, even if they're not into risk contracting for their retirees and even if they don't offer employer-sponsored retiree health plans. Like I said, the Balanced Budget Act is taking money out of the system, and you have to keep in mind our country has a health care system that's primarily sponsored by employers. They're probably going to be picking up some of the slack. Seamless coverage is a provision that refers to an option for pre-65 people to sort of roll in or opt into a post-65 risk plan. They have to make a positive selection to leave the plan. An employer may be thinking about this in their head. When they're out shopping for health plan vendors for their pre-65 retirees and they're active, they'll probably ask somehow through the request for proposal process if the service is into Medicare risk contracting, and if isn't, what are the intentions to do so? Finally, private fee-for-service is an option that employers need to be a bit wary of. This is an option for beneficiaries to privately contract with a physician, but when they do so the physician is not allowed to receive payments from Medicare for two years. So, employers need to be aware of this and make sure that they're not paying for services that Medicare used to cover in the past.

Next we looked at quality standards and marketing information. HCFA is going to make comparative health data available in the fall of 1998 and then add onto the data requirements by fall 1999 for their coordinated open enrollment campaign. At the time that this paper was put together we did some brainstorming on the types of information that we thought may be collected and some of the issues around the data. First is benefit plan information, and these data are actually available publicly right now on the HCFA Web page through a Web site called Medicare Compare. We also thought that managed care restrictions should be disclosed, and they should be very easily understood. Keep in mind a lot of people who are over the age of 65 don't really know what hospital pre-certification means, and so we have to make them aware of any benefit limitations that they may come across. We thought disease management programs should be highlighted, but, again, the risk adjustment methodology that's going to be put in place needs to compensate plans appropriately if they tend to attract poor health risks.

Participating providers and service and satisfaction metrics may be collected, as well information on health outcomes. In order to make the health outcomes data useful as a comparative tool we need to be careful that health plans are using the same methodology to collect this information. We also need to be careful when we're analyzing the information and be aware that different health plans may have different health outcomes because of their population. We thought that there would be some external accreditation requirements such as those of the National Committee For Quality Assurance.

Finally, the last issue that we discussed was that PSOs in the Medicare Plus Choice. For essentially the first time, except for a demonstration program several years ago, PSOs are being allowed to contract with HCFA directly on a risk basis. Not only is this the first time they are on a risk basis, but the requirements to participate are lower or different than other health plans. They have lower minimum enrollment thresholds, and some may have different licensure requirements. I think PSOs will be a positive addition to the Medicare program. It may encourage the development of Medicare Risk plans in rural communities, and it also may eliminate the middleman in health care delivery.

Some of the issues that we identified are very important because they're being allowed to participate for the first time, and their standards for participation are lower. Capital and other solvency requirements have been a subject of much focus and heated debate. My understanding is that HCFA is coming very close to finalizing these requirements. We need to be aware of the fact that PSOs for the first time are being asked to handle some operational functions that they have not had to deal with such as claims processing and customer service. In areas where the capitation payments are very high right now, they can move in and make a short-term profit, as can those who want to move into the market and build up enrollment now before their competitors come in and take away market share. Finally, we thought about how PSOs would impact beneficiaries, an overall thought that it would impact on them in a positive way. They may see an increase in the quality of their health care since their provider is the owner of their health plan going forward, and they will have more choice among health plan offerings.

Mr. John Trout: So, I'll just talk in general about the cost savings monograph that we're thinking of developing, working on developing, and may get out some day.

I do have a bit of a history with the Medicare program since I was hired to work on it three months after the bill was passed in October 1965, and the cost issue, as many of you may know already, is not a new one. It didn't develop yesterday. There was a conference in 1967 under the Johnson administration about the rapidly rising costs of the Medicare program and how to get them under control which in those days was done by something called jawboning (just talking about the problem and hoping people would do something about it). During the 1980s, there were several legislative initiatives mostly aimed at cutting provider costs and payments. There were major changes such as the prospective payment system and the resource based relative value schedule for physicians. It seemed like every year or every other year there were budget reconciliation bills with numerous cutbacks in Medicare payments.

Throughout this period was, it seemed, it was like squeezing a balloon. The costs were cut back in one area and they would balloon out in another area. If you tried to cut back on inpatient payments for Medicare, suddenly there were lots more out-patient facilities, and costs rocketed there. If you tried to cut back on nursing home payments by providing more payments under home health, then home health payments skyrocketed. Somehow, no matter what was done legislatively or through regulation or through other initiatives, there were ups and downs, but overall the costs kept going up.

Jill has talked about some of the major changes that have come under the 1997 legislation, the Balanced Budget Act, which added six years to the life of the hospital insurance trust fund and a substantial reduction in the long-term issue. Nonetheless there still remains a huge issue to be dealt with. Of course this legislation also included provisions setting up the bipartisan Commission on the Future of Medicare. This commission has started meeting. It includes several senators, congressmen, some physicians, a former HCFA member, a former head of the Council of Economic Advisors, and so on. It's a pretty high-powered organization, and they have been starting to make a little progress. They had a modeling task force which agreed on a couple of baselines which were partly inspired by Rick Foster's certification letter in the trustees' report which suggested that the trustees' three options may have been a little bit optimistic. The commission tentatively agreed on a more conservative baseline which will, in effect, drive them toward more action to try to control costs.

I don't want to try to be a political Cassandra or any kind of crystal ball reader, but when you observe these meetings, and I've attended all of them so far, you can see a very strong partisan split. It's still a very open question whether this group can get its act together and come to any consensus on any kind of solution, with regard to tax increases, benefit cuts, or anything else. The Academy has tackled the overall question of Medicare cost savings a number of times. In 1995 there was a monograph put out on social security and Medicare solutions which went over a range of options, including tax increases, benefit cuts of various kinds, and, of course, it didn't take a position. More recently the Academy has issued a monograph, financing the retirement of future generations, which includes a section on Medicare but overall takes the position (if the Academy can be said to take positions) that the issues of future generations of retirees should be addressed in a comprehensive way. In other words don't just look at Medicare, don't just look at pension taxation, don't just look at social security. They all affect the same group. Look at them across the board. This is getting some response in Washington. We haven't gotten headlines like we did on the Medicare buy-in proposal, but we're getting requests from all over the Hill for copies of it. The Senate Committee on

Finance is scheduling hearings which actually began last week which are addressing these very issues. The Committee on Finance covers Social Security, Medicare, taxes, and it has invited the Academy to present testimony and later on to appear before the committee to discuss the various options. The other recommendation basically in this monograph is the problem gets worse the longer you wait to address it. So move now and move comprehensively. I think we're actually getting some sympathetic response to that message.

A few other things are going on. Jill had mentioned the PSO provisions of the Balanced Budget Act. HCFA has actually issued one regulation, an interim final regulation, and the reason I mention it is that they define an actuary for that purpose as a member of the Academy of Actuaries. So, if you don't otherwise have a reason for joining up as a member of the Academy, that's a reason. Donna mentioned, too, that she had appeared or dealt with the commission. The way I would characterize it was that the commission actually reached out and invited the Academy which was a different thing. We're often knocking on the door's of various organizations in Washington, but now they're beginning to come to us and ask us to either testify or to prepare an analysis or otherwise work with them to help out on various issues. Risk adjusters is another issue. HCFA has asked the Academy if we would work with them and prepare comments on the report that they're going to develop under the Balanced Budget Act. We've started discussions with them and are starting to get material from them about what they're coming up with. We also have a work group on the managed care patient rights issue which is one of the hottest issues in Washington right now. In fact, there was a little squib on it in the front page of *The Wall Street Journal* recently about how the proponents of the legislation are getting ready to try to force a vote and how some parties are trying to get their act together. It's a very high stakes political game.

I would just conclude by saying that the options presented for dealing with the cost issues in Medicare are not new. I don't know that there's a new idea that's going to come out of any of these discussions. You can raise taxes. Obviously that will solve the problem, however unpopular that is. You can cut benefits in various ways. So far most of the benefit cuts have been aimed at providers. You can also increase the eligibility age for Medicare, similarly to what was done for Social Security. You can increase deductibles and co-payments. All this stuff has been discussed for decades. There is a lot of talk about changing Medicare from a defined-benefit to a defined-contribution program and using medical savings accounts, vouchers, and that kind of stuff. Of course, there's a demo in the Balanced Budget Act to do that. Whether the Congress would be able to get its act together to go all the way on that is again more speculation that I won't take the risk of getting into. But the real problem as I see it, as a policy analyst and not an actuary, is the need to develop a political consensus in Washington and around the

country. I mean in terms of the Social Security issue, various groups are having forums all around the country, and they're actually having quite an effect. The Medicare Commission is also planning to split up and meet in subgroups all around the country to have a similar kind of debate and try to get public support for the kind of changes that are going to be needed. It probably won't be all that popular unless they're sold as a package with some agreement among both people and politicians. But your Academy is right in there participating in all this, and I hope pretty soon we'll have a monograph that sums all this up.

Mr. David C. Sky: The comment was in regards to the negotiated rulemaking that Jill referred to. My take on it, with respect to PSOs, was that the PSO has to first come knocking on the state's door. Only if the state requirements for licensure are more stringent than HCFA requirements or the PSO licensing process is unduly delayed will HCFA undergo some kind of expediting licensing process. In our state a lot of entities are waiting to how the state reacts before deciding how to proceed in the market. For the monograph that the Academy's doing are you considering any impact on current Medicare supplement options that Medicare Plus Choice would have on traditional Medicare supplement insurance? I know a lot of the regulators on the Accident and Health Working Group at the National Association of Insurance Commissioners are very interested in this issue I just was wondering if there are any synergies there.

Ms. Stockard: Actually, that is one of the issues in our expanding choice for Medicare beneficiaries, but the section is underdeveloped, so I didn't speak about it right now, but it will be in our final paper.

Mr. Bluhm: We also haven't mentioned that there is a separate Medicare Supplement Working Group under this whole Medicare subject at the Academy which hopefully we'll be having input on that as well.

Ms. Novak: Since you brought up Medicare supplement, the Medicare Commission meeting contained a lot of discussion on the pressure to increase utilization from having first-dollar coverage with Medicare supplement and the idea of somewhere between tweaking and eliminating Medicare supplment because of that. I don't know where that's going to go, but there's going to be a lot of discussion. That's one of the things that's looked at in the monograph that Bill just mentioned. As John mentioned, there's a lot of partisanship around the table. Do we want to micromanage this? There'll be some interesting discussions going forward.

Mr. David W. Wille: HCFA already announced that they plan to use the diagnostic cost group method of risk adjustment, using inpatient hospital data and the principal

inpatient diagnosis. With this method of risk adjustment how does that fit with the Academy of Actuaries' list of all things that a good risk adjustment method should do? Does this meet some of your criteria for what a good risk adjustment method should be?

Mr. Bluhm: I don't know the answer.

From the Floor: I know it starts with the risk adjusters. Has HCFA come up with a standard for encounter data collection?

Ms. Novak: I don't know the answer to that. Your update was news to me.

Ms. Leslie F. Peters: HCFA sent out several draft regulations. They're calling them drafts, but they've distributed it to all the Medicare risk contractors, but what they're going to do is get hospital inpatient data based on the UB-92 hospital form, and you have to transmit it electronically to your fiscal intermediary. For the first period, from July 1997 to June 30, 1998 discharges, you can send a shorter version, but for July 1, 1998, and later you have to send the complete UB-92 hospital admission form electronically to your fiscal intermediary, and they're going to use the diagnoses on that for risk adjustment.

From the Floor: Part of the problem would be if you were using the UB-92, some of the inpatient claims aren't associated with the UB-92 code. So, how would they account for that?

From the Floor: They said only the stuff on the UB-92 counts. That's all they're going to use for risk adjustment. So, that's all they're going to take.

Mr. Joseph Moran: In connection with the proposal for the optional buy-in to Medicare at ages 62–64, I assume that as a tail on the dog of any increase in the Medicare eligibility age that would suddenly become age 62–64 plus x, and that expansion of the range of ages might tend to sabotage the potential for cost balancing and budget neutrality.

Mr. Wildsmith: That's an excellent point. In fact, outside of the Academy process, I've had an opportunity to talk with some representatives of the administration, and one of the reasons they're giving for adopting this sort of buy-in proposal is the idea that ultimately the Medicare Commission is going to have to decide to raise the Medicare eligibility age and that putting this kind of program in place would facilitate that. So, they have not, as far as I've been aware, talked about what impact that would have on the cost of the buy-in, but putting this in place as a way of facilitating or raising the Medicare eligibility ages is part of their line of reasoning.

From the Floor: Second facet of the question of the evaluation of the financial implications of the optional expansions of Medicare. What was the situation as to the variation in price charged by the state to recognize such particular variables as the degree and impact of regulation of the marketplace with respect to non-Medicare business within a state?

Mr. Wildsmith: I'm not sure they've gotten that far. They've been very up front in saying that they will need to vary the rates by state. They have said that it will not necessarily be the same method used with the Medicare Risk contracts, and, as far as I'm aware, that's about all that has been said. That is a good point, however. The attractiveness of this program relative to private insurance will depend on the rating rules in the private market. In a state like New York where you have flat community rating, the dynamics would be very different than they would be some place else.

From the Floor: A further aspect of the same question on the feasibility of the optional buy-in is do they include protections against offloading high-cost risks from employer groups into the Medicare population?

Mr. Wildsmith: Nothing explicit. There are some general rules about you have to opt-in at your first opportunity. You can't jump in and back out.

Ms. Novak: I'm not aware of anything that has been written in which would protect against that. Again, we're trying to get the Medicare Commission to look at the whole picture and talk about Medicaid and employer buy-ins to some of these programs and what the effect on the cost would be. So, it's something that the Academy keeps bringing up, that you have to look at the whole picture of all of the coverage that is provided to this group and what the effect is going to be.

Mr. Bluhm: Presumably you're talking about a subset of people who are not now retiring and who would retire because this became available. With the existence of COBRA extensions and so forth, it might not be as severe as it might otherwise be.

Ms. Novak: I think there's a concern that some employers may eliminate coverage, especially small employers, because there are other options available in the marketplace.

From the Floor: I was thinking about the terms of special early retirement programs, as to what the impact is on the health care benefits. Employers might set up different rules depending on the extent to which they could offload the high-cost risks.

Mr. Bluhm: That point we have made.

Mr. John J. Schubert: Bill, there was another point that we brought up when we were working on the issue brief. If someone gets into the expanded Medicare and then becomes re-employed, what kind of checks are in the system to make sure that the new employer doesn't say, "Let's keep you in the expanded Medicare because of your medical conditions and not put you into the group coverage,"? That has to be part of the program, too.

Ms. Sally Vernon: I've actually worked on the HCFA proposal for the buy-in. I wanted to address a couple of these issues. We worked very hard to put protections into it to keep things from happening like with the COBRA expansions, and you can't just put part of your employee group in. In order to be eligible for the buy-in you cannot have access to any employer-sponsored insurance. So, employers would have to drop their entire retiree coverage. They couldn't offload subsets of it. We've looked at as many protections as possible to keep selection against the program from being any greater than any other government program it's subject to.

Mr. Bluhm: Would any of you care to comment on what your perception is of the current political theme as it relates to these various proposals such as the likelihood of passage, how things are stacking up on the buy-ins or other issues, such as the patient rights and that sort of thing?

Mr. Trout: It's an election year. This is sometimes in Washington referred to as the silly season because things can get a little wild, but at the same time you can actually see things getting passed because of the competition between the parties either to get credit for passing something or to develop some blame that they can use against the other party. This is both sides. I'm not picking on one or the other. For example, the Medicare buy-in proposal which doesn't seem to be discussed very actively right now could be offered as a floor amendment, as we get closer to the election. It would be an attempt either to try to get it passed or to embarrass people who vote against it. If you think back a couple of years ago, there was a proposal from the democrats to increase the minimum wage, and the other party opposed, but right before the election enough of them turned around to pass it because their polls back home indicated that people wanted it, and they didn't want to run against it. Same sort of thing could happen in the short run with some of these current proposals (managed care patient rights and the buy-in) unless the administration decides strategically they want to save the buy-in to pair it up with increasing the eligibility age. That's the strategic question. I wouldn't have any idea what's going on inside the White House when they have time to discuss policy. Read into that what you like. On the broader issues of Medicare I just think that not much is going to happen. The Medicare Commission is not scheduled to report

until March 1999, and that's a perfect excuse for all the politicians to wait for this commission and see what they come up with.

Mr. Wildsmith: I think if Congress is going to do something on health care, the patient's bill of rights or some form of patient protection is politically much more appealing than the Medicare buy-in. One way to look at that is to think of the American Association of Retired Persons (AARP). They're a prime example. On the one hand you can join at 55. So, for their younger members the Medicare buy-in is a very attractive thing. On the other hand, for members who are over age 65 there would be a great deal of concern that nothing with the Medicare buy-in threaten the existing Medicare program for the people who are already in it. So, the AARP itself is politically quite conflicted about exactly what to do with it, and if it's not a clear winner for them, it's much more difficult to push than patient protection which, frankly, everybody except the insurance industry loves.

Mr. Bluhm: I would also add it's another example of what I would consider one of the scarce positive trends that we see on Capitol Hill with respect to this stuff, of a lot of the more recent proposals need to be self-supporting over time, and them being self-supporting makes it a lot harder for people to decide whether they like it or not, and personally I think that's a wonderful thing to have Congress face the costs as well as the benefits.

Is it perceived, particularly at the younger ages, that the buy-in problems would ever really be self-funding?

Mr. Bluhm: It's not perceived that the premiums would support.

Ms. Peters: Is it still sort of politically alive, given that it won't really impact the number of uninsured dramatically? It will be significantly expensive, not self-supported through the premiums and inherently attractive to a sicker population. Is it still politically viable?

Mr. Wildsmith: It's not active. It's not dead. It's gone into limbo where it has been proposed. Nothing has killed it. No one seems terribly interested. But, like John said, if suddenly it become tactically good for someone to give it a little juice, it could spring back to life.

Ms. Peters: Is it perceived as a whole package or would they ever go with the 62–64 amortization and get rid of the buy-in piece?

Mr. Wildsmith: This is real interesting. Legislation has been introduced. The buy-in piece is a separate bill from the fraud and abuse piece. These things can always be split apart, but there's already a structural split between the buy-in pieces and the fraud and abuse that's going to generate the savings.

Ms. Novak: I'm relatively new to watching what's happening in Washington. For about three or four years, I've been involved in some of the Academy work, and I've noticed a couple of things. First, for something to really get through and be solid it's going to have to be bipartisan because if one party introduces it, the other party will resist it, and so the bipartisan efforts are probably the ones that'll be most successful. Second, in order to get through the political process it has to be pretty vague; therefore, you really aren't going to know what's going to shake out until the regulations are written. One of the things I've seen, is you don't really know what you've got until it goes through the rest of that process.

Mr. Brian G. Small: My recollection was that the Part A trust fund was scheduled to go bust in 2000-something. What's the latest prediction?

Mr. Wildsmith: 2008.

Ms. Novak: Everyone is closely watching the trust funds. It's just a matter of what they believe as far as the assumptions, if they believe they're optimistic or pessimistic, how close they think it is on the radar screen.

Mr. Bluhm: I would not quite agree with that.

Ms. Novak: You wouldn't?

Mr. Bluhm: I think they're not watching it as closely as they were a little while ago when it was two elections away instead—and it's now five elections away.

Mr. Wildsmith: The year 2002, was the earlier projection, which was just barely within the political planning horizon I think 2008 takes it outside most politicians' planning horizon.

Ms. Novak: Well, and as John said, it's in committee now. Once it's in committee, the committee handles it.