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Medicare Commission Recommendations

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Moderator: HARRY L. SUTTON JR.
Panelists: DICK ANDERSON[†]
JAY P. BOEKHOFF
HARRY L. SUTTON JR.
Recorder: HARRY L. SUTTON JR.

Summary: The National Bipartisan Commission on the Future of Medicare was unable to reach an agreement, but there is much information about the draft report, as well as other proposals for changes in Medicare.

In addition to a review of the major elements of proposals and the possible effects of these on Medicare, the panelists will address the following:

- *The role of prescription drug coverage in stalemating the commission*
- *Possible effects of major proposals on the HMO industry*
- *Possible effects of the major proposals on the Medigap industry*

Mr. Harry L. Sutton Jr.: We're discussing the report, or nonreport, of the National Bipartisan Commission of the Future of Medicare (NBCFM), which still hasn't been published.

I'm the moderator. Dick Anderson, vice president of health policy for the Kaiser Foundation Health Plan, is one of the panelists. For ten years he was a member of the Physician Payment Review Commission, which is an organization that regulates physicians' reimbursements under Part B. Dick was chairman of that commission for one year. In his earlier life he was vice president of Medical Economics, which analyzes and sets the financials and rates for Kaiser. Since then he's moved into politics.

Our other panelist is Jay Boekhoff of Reden & Anders, formerly with Tillinghast. A longtime consultant for the American Association of Retired Persons (AARP), he still works with that organization to some extent, consulting through United Health Care, which has taken over the AARP Medigap coverages from Prudential.

[†]Mr. Anderson, not a member of the sponsoring organizations, is Vice President of Health Policy at Kaiser Foundation Health Plan, Inc. in Oakland, CA.

The session is structured into four small pieces. I'm going to provide an introduction going back to the Balanced Budget Act of 1997 (BBA) to review what's happened in Congress and to Medicare since 1997. I'll review proposals in the draft report of the commission that were never passed. Jay Boekhoff will talk about the changes in Medicare reimbursement and the potential and actual effects on Medigap coverage that have resulted from the BBA and the move towards Medicare+ Choice. Dick Anderson will look at the effects of the BBA Medicare+Choice on the HMO industry, particularly the reimbursement system used by the Health Care Financing Administration (HCFA). Dick will discuss the political situation in Washington—why nothing is happening, and what may happen. Finally, we'll try to leave some time at the end for questions.

Medicare reform is a very complicated subject, so this is a limited overview with some insight into problem areas. We hope you'll participate with questions at the end.

The thing that put Medicare in crisis in the last few years is the fact that the Part A Trust Fund looked like it was going under. The real emphasis in Congress was balancing the federal budget, which subsumed the wishes of Democrats to provide more social services and the wishes of Republicans to give a huge tax rebate. The two sides are fighting, but the federal budget deficit is critical. A major part of the problem is that if Medicare spending trends continue, there may be huge federal budget deficits 10–15 years out.

Congress has glossed over the situation for the moment with the BBA. It's estimated now that we spend slightly over $200 billion a year on Medicare; however, by the year 2010 we'll be spending $500 billion a year on Medicare, at which point Medicare spending will surpass payments under Social Security. Ten years after that, expenditures are estimated to be around $1 trillion a year (without major changes to the system). By the year 2030, annual expenses will be $2 trillion dollars; Medicare spending will comprise one-third of the federal budget, whereas now it's just over 10%.

Another view of the problem is that the number of workers paying taxes covering Part A of Medicare will drop to just over two active workers for each retired Medicare member. The number of Medicare eligibles by 2030 will be double the current number, but the number of working people will only have gone up by 15%. That also creates a generational equity problem. To make the Part A Federal Insurers Contribution Act (FICA) tax cover long-range Medicare Part A expenditures for 30 years, the payroll tax rate must nearly be doubled right now.

The issues are the things that you've been reading about Social Security and Medicare—the same problem of the huge retirement bulge beginning in about ten years. Added to this is that, since Medicare passed, there's been an increase in life expectancy of approximately six years for both men and women. That means everyone is living longer, and the subsidy required to finance this is much greater because Congress has not adjusted the tax rate for some time. However,

Congress did legislate that the Medicare part of the FICA tax now applies against unlimited earned income.

The national debt is currently about 50% of gross domestic product (GDP). By the year 2010, this balance will start changing, and by 2030 it may be up to 100% of GDP according to the Congressional Budget Office (CBO). GDP is increasing, but the debt will rise even more rapidly. If national debt gets to 100% of GDP, that will be the highest it's been since about 2 years after World War II, which was the previous peak.

Let's take a brief look at what happened with the BBA. To solve the budgetary problems with Medicare, the law provided for controlling provider fees, reducing hospital reimbursement (or not increasing it), and reducing fraud and abuse. Seventy percent of the language in the BBA was related to fraud and abuse. That's not necessarily the most important part of it, but it's the messiest part. Some Part A costs were gradually shifted to Part B, which permitted the Part A trust fund to stay solvent longer, although my memory indicates that Congress didn't increase the Part B premiums immediately to reflect the shift. There were modest benefit changes, mostly with respect to outpatient screening, pap smears, mammograms, PSA tests, etc.

The major substance of BBA was Medicare Part C or Medicare+Choice. It attempted a voluntary privatization of Medicare. In other words, the government will revert to premiums and prepay other organizations for care delivered. HCFA will reduce its costs by controlling premium rates and eliminating open-ended reimbursement, except in the fee-for-service system when the Medicare recipients won't switch. Congress expected huge increases in enrollment at:

- HMOs
- Provider-sponsored organizations (PSOs), which might be regulated directly by the federal government rather than states
- PPOs and Medicare Select
- Private plans, where insurance companies could duplicate Medicare benefits and sell private insurance
- Medical savings accounts (MSAs)

Of the last 3 options, except for Medicare Select, which has perhaps 100,000 eligibles covered, there are no takers that I know of. There's only one PSO, I think, licensed in New Mexico, although there are a couple of applicant PSOs stalled by regulatory problems.

There were other important, and some not so important, changes. Health-risk adjusters take effect at the beginning of the year 2000. Many of the health plans proponents are running around arguing, shouting, lobbying, and trying to get rid of risk adjusters or delaying the implementation thereof. The government finally relented and said that it's only going to use 10% of the risk-adjuster effect, which has quieted down concerns. There's a tremendous amount of data gathering, and there's going to be even more.

With respect to the high-deductible Medigap, I don't know that any carrier even issues it. Theoretically, there's a $1,500 deductible Medigap policy that's supposed to be available. Because of regulatory questions, states have not figured out how to deal with this yet.

Competitive bidding projects is a key change that is built into the commission's report. Congress mandated that there be seven competitive bidding projects, including in rural areas, over five years. I happen to be, for better or worse, working at it. HCFA is trying to set up competitive bidding arrangements in Phoenix and Kansas City. The resistance is vocal in many areas, and less vocal in others.

My final comments are a very brief summary of the NBCFM's draft proposal called the "Premium Support System," modeled after the Federal Employee Health Benefits Program (FEHBP). The Office of Personnel Management (OPM) gets FEHBP bids from some 400 private health plans, insurance plans, and HMOs. Some are experience-rated, but most are community-rated. The government will average out the prices weighted by the number of people in each plan to develop an average cost of the base to determine how much to contribute. It may pay the average bid. This would mean that a Medicare beneficiary who picks a plan whose cost is less than 85% of the average wouldn't have to pay any Part B premium.

Under this proposal, the federal government sets up fee-for-service Medicare as a health plan, budgets for it, and has a premium charge for it. The proposal doesn't discuss what happens if this premium charge is much higher than those of the HMOs or other plans: Will the Medicare recipients have a fallback with no premium, or will they have to pay a premium to get into the fee-for-service benefit plan? The proposal gives the managing agency the right to negotiate with providers, throw some providers and/or hospitals out, and act like a freestanding health plan. Some providers may be excluded from the Medicare fee-for-service plan.

The long-term financial plan is the way the budget is supposed to run ad infinitum. The Medicare-eligible recipient would pay 12% of the basic plan premium cost, excluding prescription drugs. Medicare taxes would cover 48%, and the general revenue would cover 40%. Whenever the budget for general revenue for the next year exceeds 40% of the total cost, HCFA must tell the government that Medicare is bankrupt. The 12% is roughly the Part B premium. Right now the Part B premium is supposed to be 25% of the Part B cost, and government general revenues cover 75%. FICA taxes currently cover the Part A cost, mostly inpatient hospital care. This is the split that they came up with. This cost split is now fixed but will not remain so for long. The government will finance prescription drugs for

people below 135% of the federal poverty level and administer that through Medicaid presumably.

Eight Republicans and the two chairmen voted for the bill and everybody else voted against it, so it was very bipartisan. Many Democrats wanted full coverage of prescription drugs for all Medicare recipients, including the fee-for-service ones. The NBCFM leadership felt that it would be a budget-buster. They tried to retain all the money that people are already paying for prescription drugs through Medigap, employer-based retiree coverage, Medicaid, and so on to reduce the cost to the federal government of expanding Medicare. They are going to provide it for very low-income people who tend to be sicker than average. But that just didn't go over with the "liberal left."

A final word about prescription drugs, which is probably the most agitated Medicare issue. Is it really necessary to put it into Medicare? If you listen to the drug industry, it wants to be left alone to do research and make profits. However, on the medical care side, drugs are a major part of health care today.

I'll cite a few studies. A National Academy of Social Insurance (NASI) report estimates that 65% of the Medicare population already has some kind of prescription drug coverage. Some are covered by their private Medigap coverage; others are covered through employer plans (85% of which have prescription drug coverage); 96% of HMO enrollees have prescription drug coverage; and most Medicaid plans include drug coverage. Coverage varies from $500 to almost unlimited, depending on which plan you happen to be in.

Inflation rates, according to a recent study by the Employee Benefit Research Institute, in drug benefit plans have averaged almost 20% per year for the last 3 years. This reflects increases in both utilization and prices. The same study shows that between 1995 and 1997, the prescription drug increases were half of the inflation trend. If the general inflation trend was 8%, the drugs were 4% or half. Universal drug coverage could increase Medicare costs from 7% to 12%, according to NASI estimates.

Why are drug costs going up? Here is one reason: California mandated that all HMOs cover Viagra. Kaiser estimated that, in California, where they have 6 million total enrollment, that would cost $100 million a year. Public drug company and Internet advertising for prescriptions are greatly interfering with doctors, medical practice, and plan formularies.

Assume that drug costs will go up about 8% a year. If you go out to the year 2030 and assume that the other healthcare costs go up about 4%, prescription drugs would then comprise 25-30% of the total cost of Medicare. The study assumes a 10% discount in prices, and use is based on Medicare samples. The future guesses may be inaccurate, but this is an illustration that, when we get to 2030, adding the prescription drugs would add another $500 billion to the Medicare bill. That could cause the whole U.S. to become insolvent.

Mr. Jay P. Boekhoff: Harry mentioned when he recruited me to speak: "It will be a fairly straightforward topic because the NBCFM will have released all its comments in March, and you'll have some time to think about it. I'd like you to talk about how this is going to affect Medicare Supplement plans or fee-for-service plans."

It's not fairly straightforward, of course. As you know the NBCFM didn't formally release any recommendations, and we don't have much in the way of a formal proposal. We've agreed that I'll talk about some background information as it may affect fee-for-service plans, some specific changes caused by the BBA in terms of Medicare reimbursement, and the effects that they've had on Medicare Supplement in particular. Then I'll provide more overview for those of you who aren't familiar with the FEHBP. That seems to be a prevailing model, and we can discuss how Medicare might work in general in this scenario.

In terms of background statistics, I want to start with information from the Medicare Beneficiary Survey. About 13% of the Medicare-eligible beneficiaries are covered through managed care plans. The remainder, which is really the topic of my discussion, is the larger piece, the ones who are receiving fee-for-service.

Table 1 breaks down the fee-for-service beneficiaries by type of supplemental coverage, if any. Individual Medigap represents about 30% of the non-HMO, Medicare-eligible individuals. Note that employer-sponsored supplements have a greater share at 32%. This is an important part of the whole political debate. The employer part in Medicare hasn't been considered much previously; it would be a mistake to omit employers in this context again.

TABLE 1
DISTRIBUTION OF MEDICARE BENEFICIARIES
BY SUPPLEMENT STATUS

Type of Supplemental Coverage:	Percentage
Individual Medigap	30%
Employer-sponsored	32
Medicaid Total	18
None (Medicare-only)	13
Both Private Types	5
Other	2

In a typical Medigap Plan F, based on statistics from the Medicare 5% sample, we can review the cost breakdown, as shown in Table 2.

TABLE 2
APPROXIMATE DISTRIBUTON OF
MEDICARE SUPPLEMENT EXPENSES
(PLAN F)

Type of Service	Percentage
Physician	38%
Outpatient Hospital	29
Inpatient Hospital	19
Skilled Nursing Facility	9
Other	5

Both the 38% piece for traditional physician and 20% coinsurance and 29% piece for outpatient hospital relate to Part B expenses. The hospital outpatient piece has really been a wild card and has been inflating quite rapidly. For reasons that I'll talk about as we look at projected Medicare Supplement cost, this is an important one to keep an eye on.

Skilled nursing facilities (SNF) is the piece that has inflated the most quickly in the last ten years. At one time, it was only about 3–4% of overall cost, but it's now about 9%, and it is inflating at rates of 20% or more. The hospital piece has been relatively stable, as you might imagine, with the hospital admission rates and the cost per copay being fairly stable.

As Harry mentioned, a key point in the discussion of the proposals for improving Medicare has been the magnitude of the prescription drug problem and the cost of prescription drugs. President Clinton gave a speech in February 1999 saying, based on government estimates, that over half of the people pay more than $6,000 per year in prescription drug costs and 10% pay more than $24,000 per year.

These are pretty eye-popping figures, except I think they're wrong. The Pharmaceutical Research Manufacturing Association (PhRMA) reported shortly thereafter that, according to its statistics, 50% pay more than $400 a year and about 10% exceed $1,700 per year. Data that we've had from a variety of sources, managed care and others, seems more consistent with the PhRMA estimates. This data still indicates a fairly costly process, where 50% or more of the people pay roughly $400, and 10% pay $2,800 or more in prescription drug costs.

Let's look at the breakdown of prescription drug costs by quartiles, which I think is useful, particularly from a voluntary insurance perspective. About a quarter of the people have a relatively small amount of prescription drugs that cost under $50 a year. The next quartile average is about $200 a year and the one after that is about $700. But 1 quartile does have fairly expensive prescription drug costs of well over $2,500 a year.

The point, from a voluntary insurance perspective, of course, is that there's no problem if we get all four of these quartiles. But if we offer a voluntary plan, we'll price at a cost that anticipates some mix of the quartiles. The people at the high end are the ones who have the most knowledge of their prospective prescription drug cost, and they will end up purchasing a plan that will be extremely high-cost. In my view, it's an all-or-nothing event in terms of prescription drug coverage. One of the key initial proposals was that Medicare Supplement carriers would be forced to offer prescription coverage on a non-underwritten basis, and I think that would be a very costly endeavor.

Finally, I want to refresh our memory about the last time we tinkered with Medicare. Most of us remember the Catastrophic Care Act of 1988. It did a lot of the right sorts of things:

- It provided some limitations on inpatient copayments so that the out-of-pocket maximum for members who were institutionalized would be reduced.
- It capped Part B expenses.
- It tinkered a bit with copayments for skilled nursing care.
- It provided a prescription drug benefit scheduled to start in 1990.
- It phased in an income tax on seniors.

Do you remember Dan Rostenkowski, then Chairman of the House Ways and Means Committee? The Congressman, an advocate of Medicare catastrophic health insurance, was hounded near his home in Chicago by the elderly. I still have a memory of a picture in the newspaper of him being in a car and people pounding on the outside of it. I remember that well.

The point is that there were many people who had coverage already through their employer plan who were left out of the debate. They ended up with additional taxes without any additional benefits. The 32% employer portion of the Medicare-eligible population is an important one in the political debate. Finding a way to adjust for retirees with employer coverage will avoid negative reactions.

I'd like to quickly review some of the BBA changes that have affected the fee-for-service market. It's something hospitals live with all the time.

A key change affecting Medicare Supplement is the fee reduction in some diagnostic-related groups (DRGs). There are about ten DRGs for which payment is reduced when a patient is discharged early into an SNF. Hospital administrators transfer patients early into SNFs but receive the fixed prospective payment. They often control the SNFs as well and get additional Medicare reimbursement.

Also, there's been a reduction or an elimination of certain outlier payments, so the hospitals are getting squeezed on that end. Most of these have impact in terms of the Medicare Supplement plans because, if the hospital reimbursement for extended stays is reduced, then the Medicare Supplement liability for the copayments on the extended hospital stay is reduced as well.

There are some changes that don't clearly affect Medicare Supplement. DRG payment rates were frozen in 1998 and had a low increase in 1999. Supplementary hospital reimbursement for disproportionate share, graduate medical education, and some other additional payments to hospitals were reduced. There has been substantial financial pressure put on hospitals. This may affect hospital admission rates and other services affecting Medicare Supplement plans.

Medicare outpatient hospital expenses are important. There seems to be a disparity in the reimbursement for hospital outpatient care. Medicare reimburses 80% of cost for the hospital outpatient, while Medicare Supplement plans reimburse 20% of charges. Based on data from the Medicare 5% sample in terms of actual dollars paid, the 80% that Medicare pays and the 20% that insurance companies pay, or a member pays, seem to be about the same. That's a huge difference in the payment base, and this is recognized in the BBA. The basis for the coinsurance is frozen until HCFA develops prospective payment rates for outpatient hospital services. Given that a large portion of the Medicare Supplement claims is driven by outpatient hospital expenses, the inflation trend should lessen for these expenses.

Outpatient therapy coinsurance has been limited to 20% of a fee schedule. As for other outpatient hospital services, hospitals were allowed to bill carriers 20% of their normal charges. In some cases, there may be a reduction in outpatient hospital claims.

For SNFs, payment rates were frozen. Prospective payment will be developed by HCFA. These changes will ultimately affect admission rates and administrator incentives to admit patients to SNFs. Of significant impact is the $1,500 cap on physical therapy in an SNF. Physical therapy was sort of the trigger for eligibility for other health nursing services in the SNF. The $1,500 cap, which seems arbitrary, may then end up reducing other payments as well.

On the physician side, we'll have to learn a new acronym. We have gotten accustomed to volume performance standards. Now we have sustainable growth rates, and the physician fee charged will be on the medical economic index. It's not clear how those factors will work together. The sustainable growth rate as currently calculated would likely result in a reduction in physician fee schedules for the year 2000. The changes are still being debated.

Other changes affecting Medicare Supplement include the general paranoia surrounding fraud and abuse. Once the video of Columbia HCA being invaded hit the other hospitals, the general concern about coding, or upcoding, has increased. Medicare has implemented some tightened certifications of nursing facilities and home-health agencies, and has enhanced screening to identify fraudulent providers.

All these changes in a small way have indirectly been affecting Medicare Supplement plans. Several carriers have seen some improvement in cost trends for Medicare Supplement beginning in 1998 and continuing on into 1999. It's likely to be a sharp cliff down and then back up, as has happened before. So far, at least all these factors have had a beneficial impact on Medicare Supplement care.

There are some bits of bad news. First, the prospective payment for the outpatient hospital services and SNFs ended up getting delayed because of backlogs associated with the Y2K problem at HCFA. Also, there are rumored backlogs in terms of Part B payments as they may flow through to the carriers. Some carriers have observed some lengthening of claim lags and the necessity to make some special adjustments.

In terms of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), there are issues associated with Medicare Supplement guaranteed issue to enrollees who had Medicare Supplement plans, went to a Medicare+Choice plan, and returned to fee-for-service; for individuals applying who came from a terminated group plan; and for a number of other categories. In addition to the normal open-enrollment period, within six months after eligibility for Medicare, Medicare Supplement carriers are being forced to accept enrollees at other times later in the process, generally when they have terminated other plans.

The provider outcry is evidenced from all the headlines. Here are examples of headlines that have just crossed my desk. Around the country, the hospital industry blames financial deterioration on the 1997 BBA. This article went on to talk about a $72 billion reduction in hospital payments. Wisconsin Hospital officials say Medicare is the culprit and may mean layoffs and closings for their hospitals. In Ohio, Medicare payment reductions take their toll on another Ohio home-health agency, which was forced to close largely because of the $1,500 limit.

These, of course, have two implications for us. Most of the carriers that deal in markets beyond Medicare feel that the cost shifting of the 1970s is likely to occur again. Many blame this, in part, for the increased cost trends we saw late last year and early this year. It may have some favorable short-term effect on trends for Medicare Supplement plans. My guess is that it will be a one-shot occasion, and we'll end up seeing trends taking off again as they had in the past.

Finally, I want to spend a minute talking about the FEHEP Plan. This is the plan that covers about 4.2 million federal and postal workers.

The way it works is there are about 260 HMOs that participate in the plan nationally. They're allowed to set rates based on their community rates in the areas where they're located. There are also ten employee-sponsored plans and a national Blue Cross plan that provide coverage on a national rate basis. This creates, in the view of some of the national carriers, some disparity in equity because they have to charge the same rate in every market. The rates heavily influence participation.

The plan is administered by the OPM. In March of every year, OPM issues a call letter that specifies objectives for the coming year and mandatory benefit changes. In late May, the carriers submit their proposed rates, and there's a period of negotiation for the coming year. We've just gone through this for the year 2000 rates.

Carriers can participate on either a retrospective basis—that is, an experience-rated basis—or a community-rated basis, including a most-favored-nation pricing structure. All of the fee-for-service plans and about 30 of the HMOs use the retrospective experience-rating basis. The remainder of the HMOs use a community-rating basis.

The government contributes 72% of the weighted average of the premium rates, based on enrollment in the prior year of all participating plans. There is a cap of 75% of any plan's cost, so the member always has to contribute at least 25% of the plan cost. If national plan rates are above the average, which is the case, then in low-cost areas competing against HMOs with locally set rates the national plans tend to be disadvantaged. Conversely, in high-cost areas where the indemnity plan rates are set based on nationwide experience, the local HMOs tend to be disadvantaged.

Why is this model popular? First, the federal policymakers are all covered by the plan. They know it. Second, for the most part it's been working reasonably well. Of course, it's been working reasonably well because, in the past five years, the inflation in premiums has been relatively low. Generally, the programs are viewed favorably, but the premium contribution is highly leveraged. For the plans that are above the 72% level, all the excess dollars will end up getting passed on to the members. As we get into a period of higher inflation, depending on how the increases develop and whether OPM raises the 72% subsidy, the federal plan may not be as favorably viewed.

Mr. Dick Anderson: A lot of people in this country believe Medicare is broke, and that's in both senses of the word. But there's not much agreement about what to do to fix it. I want to talk first about some of the managed care issues. If you think about the NBCFM, its centerpiece had to do with market-based approaches, relying heavily on managed care. Then I want to talk about my outlook on where some of this is going.

Medicare managed care did not start with the BBA. In fact, Kaiser Permanente first became involved in Medicare back in the mid 1960s. We had enrollees over age 65 before Medicare passed, and we wanted to continue to treat them in a seamless way and not make this new program something that disrupted them. But we had to accept open-ended cost reimbursement. There was no mechanism at that time for capitation. In fact, until 1981, there wasn't any feasible mechanism for prospective capitation payment in Medicare.

Then we got the Medicare risk-contracting provisions in 1981, and I'm sure that you in the audience, the actuarial community, loved the adjusted-average-per-capita-cost (AAPCC) mechanism. You have to start out figuring out average cost for fee-for-service in an area. Then, if the HMO didn't exist, and all these HMO members went fee-for-service, what would they have cost? That meant doing an actuarial assessment based on age, sex, institutional status, welfare, and disability. Then you took 95% of that, and that was the deal. It saved the government 5% off the top, in theory. But the problem that everyone recognized is that AAPCC

doesn't explain very much. It only explains about 1% of the variance between expected and actual cost per individual. Actuaries have understood for a long time that it's a flawed payment mechanism.

This thing went bubbling along for about a decade, and then all of a sudden it really took off in the early 1990s. Over a five-year period, the total number of plans tripled. There was actually close to 30% growth in the year prior to the passage of the BBA. There were 12.5% of Medicare beneficiaries at that time enrolled in managed care. In 1994, the Congressional Budget Office projected managed care enrollment doubling in five years.

One of the major problems was that most of the growth was in urban areas. Six states had most of the beneficiaries. They were the usual suspects: California, New York, and Florida. And guess where the growth was? It was in the highest payment areas. If the capitation was high, that's where a plan was going to be. HMOs avoided totally rural areas.

Public policy concerns were the following: (1) cherry picking (we're going to give you this high capitation and you're going to enroll all the healthy persons and maybe do a little stinting on care in the process); (2) zero-premium plans became the order of the day in the high-payment areas (all the Kaiser plans in Los Angeles were the zero-premiums, free-drug-coverage type of plans); and (3) unequal benefits.

The question that I want you all to think about is, did Congress intend that, with managed care, you should have free coverage for a lot of extra things for Medicare beneficiaries? You can understand why it was attractive. The issues about inequity arose because, in low-payment areas, beneficiaries couldn't have any of these extras.

Let's talk about some of the policy objectives, and I want to keep it confined to the managed care area. Congress wanted managed care to help move Medicare toward solvency. The BBA was about trying to do a down payment on getting to solvency. The target year was 2002. Let's balance the budget then and try to keep it balanced while we think about long-term reform. Congress also wanted to modernize Medicare to take advantage of the kinds of things that private sector employers were doing with managed care and other initiatives—the so-called "value-based purchasing."

One of the most important underlying objectives in the payment area for managed care was to improve the distribution of payments across the country to make them more attractive in lower-payment areas for managed care to grow. This meant raising floors to some minimum level and narrowing geographic differences. In 1997, the lowest to the highest paid county-per-capita Medicare payments differed by a factor of four times. Nobody in this audience, I think, would be able to justify those kinds of differences based on basic input price differences in those areas.

Then there is this terribly difficult issue of risk selection. I call it the "Achilles' heel of capitation." If you can't deal with compensating for differences in risk when there is a choice of different competing populations, capitation is not going to be a workable method. There were also several other policy objectives, such as protection of beneficiaries and improvement in quality and access.

We have Medicare+Choice; that's the new moniker. In the payment area, if you thought you had fun with the AAPCC, now we have a really arcane payment formula. We have a floor that you have to take into account in the calculations. It started out at $367. Then you blend national and local payment rates; the national rate is an input price-adjusted rate, so that's challenging. An interesting factor in this was heavy lobbying from our own industry to ensure that everybody would get at least a 2% increase. It was sort of a hold-harmless provision for the plans in the high-payment areas. Each year nobody could get less than a 2% update in a county.

Then there are some provisions about carving out graduate medical education that's being phased out over five years. New risk adjusters are being phased in over a period of five years. These are fun things to calculate and compute. A million assumptions all have been at issue at one point or another.

Harry has already talked about the alphabet soup of standard choices. I think it's relevant to mention that this is a difficult information challenge for HCFA. It spent a lot of resources and time trying to do something last year that I think most people, retrospectively, feel didn't work very well. They had to mail out 35 million new Medicare booklets, each 50 pages long, that apparently not very many people read. HCFA put a lot of data on the Internet, including performance results for plans. One survey showed that only 15% of the Medicare beneficiaries even knew how to get onto the Internet. How do you inform beneficiaries adequately about choices to make them smart enough to know what they're getting into? There are terrible communication issues with elderly people.

HCFA has also implemented some new protections. One of the most difficult areas was coverage for emergency care. The new rules say, if you're a prudent lay person and make your own decision about emergency care, it's covered. That's something that we've supported at Kaiser Permanente.

Now it's a year-and-a-half later since the BBA passed. Is it working? We have some early returns.

What do we know about payment increases? The fact is, in 1998 and 1999 every HMO in the U.S. only got a 2% increase. All the variations on Medicare+Choice only got 2% increases each year. That's not quite keeping up with general inflation. It is keeping up with what's going on in regular Medicare. Last year, 1998, was a historical year. It's the first time in the history of Medicare where from one year to the next, 1997–98, there was no increase at all in per-capita Medicare total outlays in the U.S. In fact, I think in the first quarter of this year, total outlays for Medicare

actually were reduced compared to the first quarter of 1998. There are a lot of reasons for that.

Then there is the interesting question, how much of that is sustainable for the longer term as opposed to being only a notch effect? My own view is that most of it is a notch effect. The administration did some funny things with the bookkeeping, for example. It started having more lag in payment. On a one-week extension of the lag, HCFA can take about 5% or more out of the total Medicare outlay. HCFA is actually being quite effective in its fraud and abuse campaign, which could also delay claim submissions.

But the real question is, where are we going? If we're going to have virtually no inflation, with Medicare claims being flat at the moment, why bother with all this long-term solvency stuff?

What happened to HMOs? If everyone is guaranteed a 2% increase, and Medicare overall increases are about that or less, maybe even slightly more, you can't do some of the other things that are part of their policy objectives, such as narrowing the geographic range of payments through this so-called blend process, for example.

There has been a lot of resistance in our industry about risk adjusters, mostly because of uncertainty about the effects on payments and serious concerns about bias in the personal injury protection/diagnostic cost group model that was introduced.

I want to comment briefly about another manifestation. HCFA was handed a very big plate of things for the BBA. In 1977, HCFA had a $21 billion budget for Medicare and 4,000 employees. Twenty years later they had a budget 10 times that much for Medicare and still had only about 4,000 employees. HCFA was not only handed the BBA, but also the HIPAA legislation. It's also facing some pretty hefty Y2K challenges. Frankly, HCFA is stretched so thin you can see through it right now. We must keep that in perspective when we consider delayed results. Health plans have been very dissatisfied, and actions do speak louder than words.

Probably all of you read the press accounts about plans bailing out of counties and leaving Medicare beneficiaries stranded. Actually, 400,000 Medicare beneficiaries were affected by what happened, with plans either reducing or leaving service areas.

The net result is that beneficiaries are confused about managed care. They don't understand it and they're scared. If they make the choice to go into it, they don't like it. What options do they have? Can they get back into fee-for-service and Medigap? You can see how that plays out. Providers are sitting tight, too. I don't know if they trust the PSOs and MSA options, even though they're very consistent with where I think the American Medical Association and other representatives of providers want to go.

What are the concerns and why have plans been pushed back? A lot of it is about inadequate payments. The floors are still too low. There has been no progress in reducing these geographic disparities. The American Association of Health Plans (AAHP), which is the trade association for HMOs, is on a tear right now about something called the "fairness gap." What it has done is taken the BBA and rate provisions and projected them out, looking at the highest payment areas where most of the beneficiaries are. AAHP says, "By 2002 the gap between the average payment to managed care and average fee-for-service payments is going to widen. Two-thirds of the beneficiaries are going to live in counties where the gap is going to be more than 15%." It calls this the fairness gap, but it's really only unfair from its perspective.

If you take the other side of the argument, there are specific policy objectives to hold the higher-payment areas flatter, relative to lower-payment areas, and bring the lower areas up. You can carve out graduate medical education and implement risk adjusters and other things. It may be directionally where things should be going, but I'm not going to take sides on that issue.

What's the reaction to the new risk adjusters? "Too much, too soon" is basically the problem. Harry pointed out that they're only going to implement 10% of the adjustment next year. No plan is going to be affected by more than 1% in their average per-capita payments. But five years out, the implementation could be pretty serious for some of the plans, especially new, rapidly growing plans that may tend to have favorable selection early on.

The biggest problem, from my point of view, is that the model is biased. You only get points for health status adjustment if you hospitalize patients. Everybody in this room understands that's the wrong incentive. We need to modify the system to make the incentives more neutral. Many managed care patients use services performed outside of the hospital. If we have a congestive heart failure patient with a disease-management program outside of the hospital, we don't get any payments for that person other than a demographic base payment—the default payment. If we move that patient into the hospital, depending on the exact condition, we get anywhere from about $15,000 to $40,000 extra per patient. That's a huge incentive to learn how to gain by upcoding and admitting patients. You name it!

Then there are very daunting data requirements. If you think they're bad now, HCFA wants to move to a new risk-adjustment model called hierarchical coexisting conditions (HCC) diagnostic cost groups, or a variation of ambulatory diagnostic groups (ADGs), in 2004. Full-encounter data is something that's just simply not available to most of the variants of managed care. To collect all of that information is going to be a very difficult and onerous task.

One approach we're pursuing now is to select a few common illness areas, such as congestive heart failure, to measure. Knowing we will never get to a full-encounter model, let's start in sort of a staged way to see if we can get some improvement in the bias of the model.

Let's go back to HCFA and its challenges. The first version of the regulations that I saw last year was 400 pages long, just for the BBA provisions, with smaller print and 3 columns. It's still a lot of words to read.

I want to comment briefly on what I call "label management." Does anyone remember managed competition? It's sort of lost its cache. Nobody can say he or she supports that idea anymore. The competitive pricing demonstrations have been an interesting chapter. If you put a different name on it, it would sound a lot like premium support.

The BBA involves the notion of moving from defined benefits to defined contributions (DCs), but you can't say DCs anymore because in the Medicare context it's a bad idea. People have labeled it "structured competition" or whatever. We're talking about market-based models where there's a fixed contribution. If your premium is higher, the beneficiaries have to pay the difference out of pocket. That's pretty scary for some of the people who worry about vulnerable populations in Medicare.

I think that the NBCFM backed into this euphemism called "premium support" because it sounded like support. My prediction is that, in six months, that will be a bad term too when they figure it out.

The competitive pricing demonstrations looked a lot like that. Congress created the competitive pricing demonstrations to test variations on competitive bidding in local markets. HCFA tried to do it on a voluntary basis earlier and got so much objection from plans it just wasn't feasible. It tried it in Denver and everyone sued, so they finally stopped. Congress said, "OK, we'll make this possible. We'll mandate up to seven demonstrations." One big problem conceptually is leaving fee-for-service out of the mix. It isn't a plan with a premium now. If you don't have fee-for-service in the mix, you're only competing among health plans to the extent that the limited competition really does work.

I believe our industry believes in competition. However, the fear is that, despite companies' own best interests, they'll bid too low. There will be lower premiums, lower Medicare payments, cuts in benefits, and an exodus of people to fee-for-service plans in this scenario. The way it plays out is: "Not in my backyard." Everybody in Arizona, every living and breathing thing inside the borders including gophers, is against competitive pricing there. I think the atmosphere is so toxic in that state right now, I don't know that it could be possible to have a good demonstration. But HCFA is still pursuing it.

Where is BBA going? Here are some gratuitous suggestions about what would help in the short term. We do need stability, predictability, and adequacy of payment. That's the sine qua non of being able to effectively operate as a managed care organization. HCFA has a lot of discretion in how to administer these payment rules. I think that it just needs to keep its eye on that concept as much as possible.

Another part is protecting people who are already in managed care. The variation in payments could do some fairly disruptive things, and, ultimately, the beneficiaries may lose benefits or have significant increases in cost sharing. It's kind of breaking an understanding with beneficiaries over the short term.
HCFA must "fund the blend," or reduce payment disparities. It's important to narrow the geographic cost range to make it more possible to offer Medicare+Choice in the lower payment areas.

In the longer term, there is a really difficult issue about parity. I was involved for years in discussions about whether we promote or only neutrally provide alternatives to fee-for-service medicine. The policy community always said, "Let's make them neutral. Don't try and promote one versus the other." But if you're going to have parity, you must treat both sides fairly so one doesn't gain an advantage over the other. How do you define that? Does it mean equal percentage increases for each of them each year going out? If that's the case, I submit you can never make much progress in narrowing the geographic range of payment.

And there is this question: How do you make capitation work generally? Will risk adjusters be up to it? The question before us, the struggle that the NBCFM had is: "Will this competitive-market-based model or premium support work?"

Let's broaden the breast stroke here a little bit. What do you think about BBA? Was it a bust? A lot of people are complaining; physicians are complaining, hospitals are complaining, home-health agencies are complaining. Was it a success? I think it's too early to tell. Everybody is fighting over table scraps. It's a zero-sum game right now. If we're going to have movement towards achieving solvency, every one has to take a little piece of the pain.

Let's look at beneficiaries. How do they think about it? Notwithstanding the fact that the general American public feels that Medicare is broke, Medicare beneficiaries like it the way it is. They don't want it to be changed, at least in terms of higher premiums, reduced benefits, or increased eligibility age—the kind of things that the NBCFM was talking about. Seventy percent of them will vote for somebody who supports adding prescription drugs to Medicare. You can tell where the politics are going. AARP is a very effective lobby.

How about providers? Stop the bleeding! No more cuts! If you're an academic medical center, you want no more cuts. Hospitals want no more cuts. They also want to be put back in the driver's seat. They're concerned about the direction that managed care is taking in limiting their autonomy, so they want to put the brakes on managed care. Some of the policy initiatives the providers are pursuing are only to curb the growth of managed care.

Let's talk about the politics on both sides of the aisle in Congress. For Republicans, this is like a dance, and their role is to lead the dance to make the initial foray. They have done that. They've come forth and are working out a lot of the details and saying, "Here's our plan." They're emphasizing reducing costs, which is not

surprising on the Republican side. They support tightening payments and increasing the eligibility age. They want to cut costs and strongly rely on competitive forces. They like premium support; it was a partisan support in the "bipartisan" commission. They do like this movement toward individual purchase and place strong emphasis on MSAs linked to high-deductible plans. They want to keep government out of the marketplace. Even when they talk about drugs, it's private-sector models of Medicare drug coverage that they're supporting.

The Democrats say, "Let's wait until after the election," and they have nothing to lose by waiting. Medicare is a higher risk business politically at the moment, and has been for four or five years, shortly on the heels of the Hillary Clinton disaster. The Republicans one year later got into the same mess. They tried to pursue some health initiatives and got terribly crunched for that. The thrust of the Democrats when they get more clarity will be: "Let's assure adequate funding. Let's assure that we maintain what we have—the traditional safety net, the default program, Medicare. Prescription drugs for everybody! Be wary of market solutions, including Medicare+Choice. Let's maintain a strong role for the government." That's not surprising for the left side of the aisle.

But where is President Clinton on all this? Has anyone seen his bill yet? "I'll show you mine after you show me yours." He did disclose in his State of the Union message earlier this year that he'd like to use 15% of the future budget surplus to shore up Medicare. I can tell you that's the biggest shell game in the world. You can expect his agenda will be similar to that of the Democrats.

We heard from a comment recently that the President would like to see a managed care competitive model with local competitive bidding where maybe not everybody gets to play. One thing that's hard for me to understand is that I think President Clinton, as much as anyone, kept the Democrats in line in the NBCFM. He made it impossible for them to advocate premium support, and now, by the way, he's advocating a competitive model for managed care with no fee-for-service component.

Finally, what's the outlook? Everybody wants more for themselves, but not for everyone else: "You give me an increase. I'm going to figure out every way I can, maybe through some kind of little amendment to a budget reconciliation act this year, to get my cut restored or to actually get more payment, and I don't care what happens to you." That is what's going on right now.

There isn't any possibility, in my view, this year or next year to achieve bipartisan consensus about anything fundamental regarding reform. Congress and the President will wait until after the elections before we get reform. Where do we end up with what we think about the NBCFM? My simple thought is that it's not what they resolved, but the debate itself that was an important legacy.

Mr. Ronald E. Bachman: I'd like your thoughts on what are the best aspects and the worst aspects of the NBCFM's recommendation. The best aspect, it seems to

me, is the unifying of Part A and Part B under more of a comprehensive type of plan, with or without prescription drugs. It seems to make more sense.

The worst aspect seems to be the increase in the age from 65 to 67. The numbers that I saw from CBO showed the savings from the age change to be about $11 billion over the next 10 years. Further out it tends to grow. The total NBCFM savings, I believe, were about $173 billion over the next 10 years. Then they spend about $70 billion on their prescription drug recommendation. But the minimal actual savings from what seems to be the most controversial and potentially dangerous change, especially to the Republicans in the upcoming election, doesn't seem to support increasing eligibility from age 65 to 67. This makes no economic or political sense to me.

Mr. Sutton: I'd like to defer to my compatriots here because I didn't get into the restructure of the Medicare benefits by combining Part A and Part B within a single $400 deductible. Personally, I used to be in favor of that from an actuarial standpoint to reduce costs. Part B costs at that time were increasing much more rapidly than Part A costs, but now that I think more about it, I'm not so sure I like it. The problem is, and I'd like to defer to Dick, is that the $400 deductible may really decrease Medicare eligibles' access to primary health care because they're going to resist spending the $400 to go see their physician. We've had a lot of questions about access and benefits, increasing copayments by HMOs, and so on.

I agree with the comment that changing the age, at least in the short term, doesn't do much. Not only that, they're trying to figure out a way to bail out people between 65 and 67 in case they can't find coverage. The government will pay for it another way, anyway. It was simple for them to say, "We'll make the same age changes as we have already in law for Social Security." The thing is, under Social Security it's easy to reduce benefits based on actuarial tables of mortality, but the same simplicity does not apply to Medicare.

Mr. Anderson: Let me take the eligibility age first. I agree it's politically difficult to get support for that among the Medicare age group. There are questions about what younger people will like and vote for in this whole issue of generational cross-subsidies. As I understand it, since the beginning of this century the average life expectancy has increased by 30 years. Sooner or later, maybe we have to face up to at least getting Medicare in sync with the direction Social Security is going on increasing the age. That's my thought on that.

On the question of combining the deductible, it's consistent with what the NBCFM is trying to do—combine the two aspects of the program. The Part A versus Part B distinction is going to become increasingly illusory over time. The question about the deductible itself, and the degree to which there is a barrier to care, depends on what happens with Medigap insurance or the ability of people to have other mechanisms to buy out the deductible.

Mr. Sutton: I think that the NBCFM didn't want Medigap to cover the deductible.

Mr. Boekhoff: Relating to another aspect of the changes, any time we talk about financing prescription drug benefits, one of the major beneficiaries will be the employer plans. The employer medical plans many times provide fairly comprehensive coverage for that now. The employer plans would also be adamantly opposed to extending the eligibility age because they'll be providing primary coverage for those people who are early retirees. It's somewhat of a trade-off between the pros and cons for the retiree plans. That may have been one of the motivating factors for it.

Mr. Robert G. Lynch: I have a couple of comments I'd like to make concerning the payment formulas, the blend in particular, and how they have affected participation by plans. One is that the original intent of the law, as I interpret it, was that the blend would take effect fairly quickly. The big problem was that nobody sat down and had the numbers ahead of time, so everybody was caught off guard in 1998 when all the counties only got 2%. This was especially to the dismay of people in Minneapolis, Seattle, and Milwaukee, who really got hammered.

We saw a repeat of that in 1999 because the budget neutrality adjustment is very sensitive to the rate of Medicare inflation. Since, for 1999, we had one of the lowest projected inflation rates, only 2.5%, we still got stuck with no blends in 1999, much to the dismay of the same areas.

Now we're starting to see more reasonable blends. When I run the numbers and project using inflation rates on the order of 4.5–5%, the blend over the next two years kicks in with a vengeance. Within a couple of years, places like Seattle, Minneapolis, and Milwaukee are going to finally get the benefit of blending.

To see how that's affected plan participation, one can analyze the list of the counties where plans pulled out entirely or shrank their service areas. Almost without exception, every one of those counties is a blend county, where the plans were getting already below average participation, and then got hurt even more, unintentionally. If you go down the list, that is just about without exception.

When I got that list, I saw nothing on it that surprised me at all. But, in the future, I think that will even out. Is there any feedback on this analysis? On the fairness gap, as far as the fairness of the urban areas getting their payment rates cut and having to draw up the prescription drug coverage for free or charge for it, being from Wisconsin where people on Medicare Supplement can't even buy prescription drug coverage, I have a little bit of difficulty sympathizing with areas in that position.

Mr. Sutton: I might ask our panel about the filings for the Medicare-adjusted community rates due July 1, 1999. In Kansas City and Phoenix, the competitive bidders must have bids by July 15, 1999. We don't know at this time if the competitive bidding is going forward. Do our panelists have any idea whether there's going to be a flood of HMOs dropping out again? Or, since some of the low areas have been increased substantially, is it going to be status quo? Plus, there

are always greater fools signing up for Medicare programs. Twenty-five new health plans are signing up for Medicare+Choice. Any comments?

Mr. Anderson: I don't know. I don't have any inside intelligence on what our industry is going to do. Organizations are holding their announcements pretty close to the vest. I expect we're going to see some variation on what we saw last fall, which was a relatively small proportion of 35 million people, if you think about that, or even the 6 million people who were in managed care at the moment.

Just to go back to the gentleman's comments, the average increase next year for managed care on a per-capita basis is going to be 5.2%; then they're going to do some stuff with risk adjusters, but it won't affect things very much. Some of the areas in which Kaiser operates, such as Hawaii and Portland, are going to have double-digit increases. That is a material factor in how you think about whether or not payments are sufficient. They're raising the floors even in the worst counties up to $400.

I'd be surprised if, in the pullouts, you'd see the same sort of shading toward where the payment rate is really low. They are going to get generous percentage increases next year.

Ms. Donna C. Novak: I have two questions. The first one is on Medicare Supplement. Jay, you talked about the 80/20 split and the basis being different for the 80% and the 20%. We have also seen something else happening. When Medicare is done paying for the nursing home services, the nursing home would increase rates significantly once Medicare Supplement was paying the bill. Is there anything you see in BBA that would disallow that going forward, or is that still going to be a problem?

Mr. Boekhoff: You're referring to the therapy services in the nursing home?

Ms. Novak: All the services.

Mr. Boekhoff: Most of the Medicare Supplement plans would provide coverage to the extent that it was an eligible service for Medicare.

Ms. Novak: But not necessarily at the same rate that's charged to Medicare, though, and that was the problem. The nursing home could increase the charge, just like the 80/20, once Medicare Supplement was paying the bill. It's something being discussed at the NAIC—a problem that the commissioner is going to encourage Congress or HCFA to solve. I was wondering if there was anything in BBA that would solve that problem.

Mr. Boekhoff: I'm not aware of it, no.

Ms. Novak: How accurate is the hospital data submitted to HCFA with respect to diagnosis codes, either fee-for-service or HMO? The risk adjuster is, with a few exceptions, driven off the primary diagnosis code. Is the health plan industry

looking at this? Forget upcoding, we just need appropriate coding for the data that's being sent to HCFA. Will there be a lot of change in the processing for computer systems?

Mr. Anderson: Ultimately, in a managed care organization, this gets back to the doctors' role in coding. In the past, at least in most HMOs that I know, physicians didn't get much in the way of negative financial consequences if they didn't code carefully. We had two kinds of coding problems. In Kaiser, we have things that aren't coded at all and things that are miscoded. We have been forced in the last 2 years to join the world of careful full submission of UB92 information and have been spending a lot of time in training activities, much of which are focused on the physicians.

With hospitals, we're doing tighter contracting. Ultimately, under managed care, if hospitals are going to get paid they have to meet our requirements, including data requirements for full reporting. There have been severe growing pains in the last year. A lot of this has to do with limitations in HCFA systems and the new fiscal intermediaries. They have atrocious error reporting and very cumbersome methods to feed back errors in the data submitted by the plans. Plans will get over that. The first year was like a practice year; what really counts is what is being collected now.

Ms. Novak: It seems like it would be quite an educational process for the physicians and the plans to understand the coding consequences.

Mr. Sutton: Wait until we do complete coding of all services. Any 1 of 7,000 codes can change the risk rating.

Mr. Mark E. Litow: I have a comment and would like your reaction. I've heard recent discussions in Washington indicating that consideration is being given to the idea of a combined deductible, but at a level perhaps of $500–800, and the addition of a drug benefit, which would tend to offset the reduction in benefits. The drug benefit could have an inside limit on it, or 80/20 coinsurance. I'd be interested in your reaction to that. Is it a good idea or a bad idea?

Mr. Sutton: If you interview Medicare beneficiaries, the thing they ask for the most is prescription drug coverage. Even if they already have coverage, they're still aware of the problem. I don't think there would be a snowball's chance politically of having one single deductible of $600–700. I think the senior organizations will feel you're really going to reduce access to primary care. It's bad enough even with the $100 deductible. The government is looking for ways to provide prescription drugs at no cost. They probably can't find one.

Mr. Dale A. Rayman: I have a question about prescription drugs. It sounds like the government is trying to provide that benefit because there's a huge need, but it is fearful of employers retracting what they offer right now. Actually, I'm trying to find the error in this thinking, that the government could provide the benefit and charge the retirees 90%, as opposed to 100% of the cost. The employers could

still maintain their current benefit coverage by paying that premium for their retirees or dropping their coverage. Along those lines, also, those who have Medigap drug coverage plans H, I, and J would now pay a higher cost for their Medicare benefits, but a lower Medigap premium with drugs cut out.

Mr. Sutton: The government's problem is that there's already a lot of money being paid for prescription drugs, and the government doesn't want to replace that. The NBCFM clearly wanted to mandate that every Medigap (including employer plans) coverage have prescription drugs and every HMO have prescription drugs, without defining the level of benefits. That way, if the Medicare beneficiaries are paying supplemental premiums, they're paying for it, employers are paying for it, or the HMOs would be paying for it out of their profits from their Medicare capitation. It was only the people with no coverage who were in the middle. Those with low incomes would get into Medicaid or a variant. There may always be a permanent gap in the middle, with people who can't afford to buy drug coverage. As Jay mentioned, except for the first 6 months, at age 65, most carriers underwrite for prescription drugs.

If the federal government mandates universal drug coverage for HMO plans and Medigap without adding drugs to Medicare, this could disrupt the coverage system. There's already quite a bit of antiselection involved.

The government has a very difficult conundrum: if employers feel they are held harmless between paying for prescription drugs and not assuming primary coverage of delayed Medicare eligibility, maybe they'd go along. It's a pretty tough evaluation.

Mr. Anderson: This debate is going to get more complicated. The pharmaceutical industry, I think, has a very good strategy. It's heavily into direct-to-consumer advertising. Bob Dole is pushing a so-called life enhancement drug in an ad.

The pharmaceutical industry has shorter lags from the time of discovery to the time that drugs go to market. It is strongly continuing to oppose the notion of formularies and generic substitution and promoting unitary pricing. If you think about it, this is alien to using leverage to get price discounts; it is basically the competitive model.

Then there is the backdrop of policy in state and federal government land about covering everything to make beneficiaries happier.

I think the question is, with the inflation that's occurring in the prescription drug area, what does Medicare do to leverage its 16,000-pound-gorilla purchasing status to help make this happen? How does this play out with employers? Employers may get creamed if nothing happens in this area. They're going to bear the brunt through all their supplemental coverage of all this stuff that the pharmaceutical industry is doing.

If HCFA works through some of the pharmacy benefit management options, possibly designating big national pharmacy benefit managers that employers as well individual beneficiaries can use to purchase discount prescriptions, maybe there's some helpful direction. As the drug benefit gets played out publicly, I'm not sure that the impasse is going to be resolved easily.

From the Floor: Doesn't that put the pharmaceutical manufacturers in a very difficult position because the pharmacy benefit managers then have significant leverage over the manufacturers, and it's a no-win situation for manufacturers?

Mr. Anderson: We'll see.