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Medicare Reform: A Presentation by the American Academy of Actuaries' Medicare Reform Task Force

Track: Health/AAA Health Practice Council

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Summary: Members of the Task Force provide an overview of their activities and the work they have completed over the past six months and discuss their examination of the financial implications of various Medicare reform proposals. The presentation addresses options for prescription drug coverage, structural issues involving Medicare's long-term solvency, and options for improving the program's efficiency by using private-sector competition techniques and market forces.

I am the Chairman of the Academy's Medicare Reform Task Force. We have a nice array of actuarial backgrounds on the panel. Dwight Bartlett is the Senior Health Fellow of the American Academy of Actuaries, a former Chief Actuary of the Social Security System, a former Insurance Commissioner of the State of Maryland, and other things, too numerous to mention. Bruce Schobel is currently an actuary with New York Life Insurance Company. John Bertko is currently an actuary with Humana. Carol McCall is an actuary with Allscripts, a dot-com company.

Bruce will discuss the Academy's financial soundness monograph. John will be talking about the Academy's competition monograph, and Carol about the Academy's prescription drug monograph. To begin, Dwight Bartlett, who lives in Washington and has been in that area for many years, will describe to us the political climate in Washington surrounding Medicare reform.

Mr. Dwight K. Bartlett, III: There's a rule of thumb when you talk about Medicare and Social Security, in particular, that Congress doesn't do anything unless they perceive a crisis. For example, the last major reforms we had for the Social Security program occurred in 1983, when the OASI trust fund was literally busted, and Congress had no choice but to do something significant at that time. Nothing much has happened with Social Security reform since then of any great consequence.

Well, what does that suggest, then, about Medicare reform? There is a perception now in Washington, largely guided by the most recent Trustees' reports, that we don't have any crisis in the financing of the program. This year's Trustees' reports projected under the intermediate assumptions that the Hospital Insurance trust fund would not be exhausted until 2025. That's a 10-year deferral of that date from the Trustees' 1999 report. This exhaustion date seems to determine how Congress makes judgments as to whether there is a financing crisis or not.

Unfortunately, that's not a very good way to make judgments about the financial condition of the program, as is pointed out in one of the monographs to be described in greater detail later. For example, if you consider the Hospital Insurance and Supplemental Medical Insurance programs on a combined basis, general revenue financing in the program already constitutes about one-third of the financing of the program. So I would suggest that, in fact, we already do have a crisis. But that's not the way Congress sees it. I think that the probability of them doing anything in terms of a general Medicare reform, during the next several years, is virtually zero.

On the other hand, there is a perception that there is a crisis on the benefit side of the program. We've all heard about the increasing percentage of the cost of medical care for elderly people that is related to prescription drugs. The Medicare program does not now cover out-of-hospital drug benefits; many say that something needs to be done about that. I think that there's a greater chance of there being something done on the prescription drug side of things, but not in 2000, because this is an election year, and also because Congress, frankly, is running out of time. They want to adjourn in early October so they can all go home and campaign for re-election in November. So while I don't think there's going to be much likelihood of anything getting passed by Congress this year, I think there's a fair chance that something will be done in the next several years in the prescription drug area.

What might be done? There are a lot of proposals floating out there, and let me describe the two principal proposals. One is the Clinton Administration proposal, which was put forth in 1999, which I'll describe as the Democratic proposal; the other is the proposal still being drafted in some detail by the Republican Congressional leadership, and for shorthand purposes I'll describe it as the Republican proposal.

What are the basic elements of these proposals? With respect to coverage, the Democratic proposal would cover all therapeutic drugs. Use of formularies would be allowed as long as they covered all therapeutic drugs. The Republican proposal, in terms of drugs to be covered, has not yet been specified.

With respect to cost-sharing by participants, the Democratic proposal would cover, in effect, 50% of the cost of drugs that are purchased by covered participants. Again, the Republican proposal is unspecified. The Democratic proposal, as originally announced in 1999, has caps. Covered drug expenses would be limited to $1,000 a year in the first year of the program, 2002, and then it would be phased

up gradually until it would reach $5,000 in 2008, after which it would be indexed to the cost of living. Again, the Republican proposal is unspecified.
On the catastrophic side, the Republican proposal apparently would cover catastrophic drug costs. The original Democratic proposal was not going to cover catastrophic drug costs; in other words, the caps would be what they are, and no drug cost would be reimbursed beyond that level. But the Clinton Administration was so beaten up by negative reactions to those relatively modest caps that, without specifying how the catastrophic coverage would be provided, did put some money into the budget proposal for 2000, to cover catastrophic drug costs.

Would plans be permitted to compete with each other to provide this coverage? Under the Democratic proposal, plans would be allowed to compete, but it is yet to be defined whether there would be only one carrier within each geographic area. The Republican plan would allow multiple plans to compete as long as they are on a so-called actuarial-equivalent basis. I assume that the reason for the actuarial equivalence is to try to minimize the anti-selection effects of having clients with widely different levels of benefits.

The Democratic proposal calls for participant premiums, which are intended to pay 50% of the cost of the plan, starting at $24 a month in 2002, and phasing up to $44 in 2008, and again, indexed beyond that date. With the Republican plan, participant premiums are apparently intended to pay 100% of the cost of the plan; however there would be an indirect subsidy, in the sense that the Federal Government would reinsure the plans in effect and, through this reinsurance program, pay catastrophic drug costs.

The Democratic proposal provides low-income subsidies for people below 150% of the Federally-defined poverty limit, with phasing out of the coinsurance and phasing out of participant premiums, so that for people below the 100% poverty level there would be no coinsurance and no participant premiums. The Republican plan apparently would provide low-income subsidy, but it is yet to be specified.

Both plans are intended to be voluntary. In other words, you don't have to take the coverage; you could elect in or out of the program. They are debating limits on when you can elect in or out of the plan, in an effort to control the selection. This is apparently yet-to-be-defined.

There are concerns that these proposals would cause employers to drop their existing prescription drug coverage for their retired employees. The Democratic proposal included a subsidy to the prescription drug coverage that employers provide to employees, to encourage employers to keep their existing plans in effect, and that subsidy would amount to approximately two-thirds of the participant premiums for the government programs. In other words, in 2002, where the participant premium is $24 per month, the employer subsidy would be presumably be $16 a month per participant.

There would be a procedure for decisions about coverage provided for in the Democratic proposal, it would be similar to the procedure under Medicare+Choice

programs. Again, it is unspecified as to how the Republican plan would work regarding existing coverage.

What's the cost? The original Democratic proposal was estimated by actuaries to cost $168 billion over ten years. That's the cost to the government, not the cost to participants. Then, when the Democratic proposal was attacked for failing to provide catastrophic coverage, they did put in their budget proposal for 2000 an additional $35 billion, to provide catastrophic coverage over a 5-year period. The Republican plan is apparently intended to cost $40 billion over 5 years.

Those are the main proposals. I think what is likely to pass is going to be some blending of these two proposals.

Mr. Jeffrey Sonheim: I see so much that is unspecified on the Republican proposal, which makes me wonder how they can come up with that cost estimate. A comment that I would like to make is, when you look at the one for five years, and the other for ten years; those prices seem roughly equivalent. Could you help me to understand how they could come up with the price tag of $40 billion?

Mr. Bartlett: Really, they are working backwards from the cost. They started out with the $40 billion figure, and in effect, they've asked CBO to help them define the trends to plan to fit in a $40 billion price tag.

Mr. Bruce D. Schobel: On top of that, the $40 billion is back-funded. Although it is measured correctly in a five-year time span, as Dwight said, some of the discussions have been that it wouldn't start until the third of the five years.

Mr. Ronald E. Bachman: Many senior citizens have prescription drug benefits through Medicare+Choice programs as an add-on benefit. What do you think about not including a prescription drug benefit in the standard Medicare benefit package, but instead providing financing from HCFA to plans that offer Medicare+Choice, so that prescription drugs could be added through that mechanism?

Mr. Bartlett: Well first of all, only a minority of Medicare participants are in Medicare+Choice plans, and many of those plans have either already dropped, or are threatening to drop, prescription drug coverage. So I don't think that is a viable strategy.

Mr. John M. Bertko: Having participated in the last two years in the competitive pricing demonstration, what Dwight is saying is absolutely true. There is a great sense of unfairness, expressed by folks from outlying areas, with Medicare+ Choice Plans; who they say if there is going to be a new benefit entitlement, however you want it, that it ought to be available to everybody in the country, in one way or another.

Ms. Alice Rosenblatt: The $24 per participant sounds a little bit low for a voluntary plan, and I'm assuming it does not include the catastrophic, because you

have added on the $35 billion at the end, but it still sounds a little bit low to me. Has the task force looked at that, as part of what you've done?

Mr. Ripps: No. We have not looked at any specific legislative proposals in any kind of detail.

I would like to move now to the first of our monographs. Bruce Schobel will go over with you the content of our monograph on fiscal soundness of the Medicare program in general.

Mr. Schobel: The Medicare program has two parts. One part is hospital insurance (HI), Part A, which mostly covers hospital costs, and certain other costs closely related to hospitalization. The other part of Medicare is Part B, the so-called supplementary medical insurance (SMI) part, which covers mostly doctor bills and other outpatient-related expenses.

The HI program is financed almost entirely by payroll taxes, which shows up on your paycheck as the so-called Medicare tax, but it really only covers half of the Medicare program. The SMI program is a voluntary enrollment program, although approximately 75% of the people eligible to enroll to SMI have done so, and it is financed now, one-quarter by enrolled premiums, and three-quarters by general revenues, which is general tax dollars collected by the Federal Government. Both funds also receive relatively minor interest earnings and other forms of income. The HI program receives some of the income from the taxation of Social Security benefits, for example.

An interesting point to make here is that the HI program is actually financed by workers, not by beneficiaries. When you get to be a beneficiary, unless you continue to work, the HI program is essentially free for you. The SMI program is not paid for by workers, except through the general revenue contribution, and people who enroll for SMI have to pay one-quarter of the cost through their premiums, which in 2000 is $45.50 a month.

Medicare, like Social Security, has a Board of Trustees; in fact, it is the same Board of Trustees. By law, the Board has to report annually on the financial status of the program. These financial reports in recent years have extended out for 75 years. Obviously, we actuaries understand how difficult it is to make projections 75 years into the future, and we have to take these numbers with a certain number of grains of salt; but obviously the numbers give you some sense of the trend of the program cost. They are not totally worthless, but neither are they precise.

The actuarial assumptions, and there are a lot of them, as you might imagine, are actually set by the trustees, but the Chief Actuary of the Health Care Financing Administration is required by law to certify the reasonableness of the assumptions. In the 2000 Report the Chief Actuary, Rick Foster, said that while the assumptions are reasonable, they may not be truly intermediate. That is the assumptions that are called "intermediate" may not actually be intermediate because there is a

greater likelihood of the cost being higher than the cost being lower. But at the same time, he said the assumptions are reasonable.

The reports follow one of the Actuarial Standards of Practice, Number 32, Social Insurance, that was issued in 1998. The annual reports are required to be sent to Congress by April 1 of each year, and in the year 2000 they actually made it, which they don't do very often. They sent the report to Congress on March 30. Then they found an error and had to modify the HI report slightly, but the original report was in on time, even if it was wrong.

What does the Trustee Report say? Well, it says the HI program is actuarially sound, in the short-range, under the intermediate assumptions. This is, actually, news, because this is the first time, in I can't even tell you how many years, that the report has said HI is actuarially sound. It has been 15–20 years, maybe. It's been a long, long time. For many, many years, every year when the Trustee Report came out, it said that HI bankruptcy is not very far down the road. In the mid-1990s it was just a couple of years away, and then it got a little farther away, six or seven years; and then a dozen years, and now it is actually 25 years away. That's far enough away that the program meets the test of actuarial soundness in the short range.

The long-range deficit is 1.21% of payroll. This is for a program that is financed almost entirely with a 2.9% payroll tax, so you get a sense of the size of the financing relative to the size of the deficit: the deficit is only a little bit less than half as big as the financing. So it's a significant deficit over 75 years, but essentially the whole of that deficit is in the last two-thirds of the 75-year projection period. Until 2025 the program is able to make do on the basis of its current income, and building off it, drawing down a Trust Fund. The Trust Fund gets up to almost half-a-trillion dollars, and then all of those government bonds have to be redeemed.

The situation is similar to Social Security. Social Security, however, grows much, much larger, and it takes longer to redeem the government bonds. Redeeming these government bonds is going to put certain burdens on the economy, which everybody recognizes, but no one quite knows what the impact will be. There's no real easy answer to whether those bonds will be redeemable or not, but no one can stand up here and tell you whether they will or will not be redeemed, although I can say the estimates in the Trustee Report assume that these bonds can be redeemed.

The SMI program, on the other hand, which is not quite as large as HI, but which has become a very significant social insurance program, is actuarially sound, both in the short range and in the long range, because of its financing basis. The monthly premiums are set every year; the program never can be actuarially unsound. All that can happen is that the premiums and the general revenue contributions can get very, very large, until you reach the point where people wonder if the program has become unaffordable for the beneficiaries, or for the government itself, since the government pays three-quarters of the cost.

So what do we do? There is really very little debate any more over the notion that something needs to be done. You can't simply leave this program running like a perpetual motion machine, and assume that these problems will take care of themselves. There might be a slight tendency to do that very recently, because each of the last several Trustee Reports has pushed the bankruptcy date for Medicare farther and farther away. Somebody made a joke and pointed out that the bankruptcy date moved ten years in the last year, from 2015 in the 1999 Report to 2025 in the 2000 Report. If we keep on going at this rate, by the 2010 Report, the program won't be bankrupt until 2200 or something like that. But that's unlikely to occur. I would not take that trend as an indication of what is likely to happen in the future.

There is a fairly short, reasonably well understood list of things that can be done to solve Medicare's financial problems. First, you can reduce the payments to the people who provide health care services, and this is something that the government has been doing for close to 20 years now. I think everybody understands that very well. Whether it is really possible to squeeze any more blood out of that stone, people have differing opinions on that.

Second, you can reduce the coverage for certain services. You could say, for instance, we're not going to cover home health care, or something of that nature. These proposals are not very popular. It's obviously much easier to add a benefit than to take one away, and I don't think that I've seen any real serious reform proposals out there that take away benefits.

Third, you can raise deductibles or co-payments, and that's been done from time to time; the SMI deductible now is $100 a year, and the SMI program pays 80% of covered services. If the original SMI deductible had been indexed for inflation, since 1966, when the program began operating, it would now be $1,500, and not $100. Obviously the $100 could be raised, but it doesn't go up, under present law. The HI program has a number of deductibles, and they do go up every year, based on changes in hospital costs, but obviously they could be raised beyond where they go under present law. Those types of changes have the effect of moving the program more in the direction of catastrophic coverage and reducing its first-dollar quality.

Fourth, you could expand the use of managed care, contracting out or other means of increasing competition. This is John Bertko's topic, and I'm not going to cover it at all, except to include it in my list, and to say that we think that this has a lot of possibilities; this is not a mine that has been exhausted at this point.

Fifth, you could go to the direct financing mechanisms, increasing the tax rate, which has been the same since 1990: 2.9%, paid equally by employers and employees. Obviously there are many commentators who say that Congress would never raise the tax rate, and speaking about the current Congress, I think they are probably quite correct. We have to take a longer view and realize that we have a new Congress every two years and, who's to say what a Congress might do in 2010 or 2020? Obviously taxes have gone up many times over the years, and this could happen again.

Sixth, you could increase SMI premiums. SMI premiums go up regularly, although the trend in the percentage of SMI costs they cover has been downward. When the program began, the SMI premiums paid half the cost for beneficiaries 65 and over; they now pay only one-quarter of the cost. So although the premiums have gone up in dollar amounts, they actually pay less of the cost of the program.

Seventh, you could shift benefits from HI to SMI, as was done three years ago with Home Health Care. This is basically a shifty way to get more general revenues into the program. You could eliminate shifting and just be direct about it by having general revenue transfers. These aren't terribly popular, but you could do it. There's a lot of general revenue financing going on already.

Eighth, you could raise the eligibility age for Medicare, as was done for Social Security in 1983. I think most people know Social Security's normal retirement age will be going up over the next 2.5 decades by two years. At present Medicare's eligibility age won't also be going up. It is staying at 65. This is something that a lot of people don't know. That age could be raised. I'll be talking about that in just a moment.

Ninth, you could require employers to cover employees under their health plans. This is obviously a very controversial proposal.

Finally, you could means-test either the premiums or the benefits. We've seen a lot of proposals along those lines, where wealthy people would pay more than one-quarter of the cost of SMI, for example, so they wouldn't get this general revenue subsidy or they would get less of it.

All of these reform proposals have very different effects on the Trust Funds, on the quality of care, or on intergenerational equity, in the sense of whether you are hitting workers, or whether you are hitting retirees.

The Academy makes several recommendations. One is to act now, not later, for obvious reasons. There will be a tendency on the part of the Congress to look at 2025, and say that's very far away, let's not worry about it for awhile. Dwight pointed out that it's hard to get Congress to act in the absence of a crisis. To the extent that we can have an influence on that process, we would like to get people to realize that acting now has advantages; the changes are less precipitous, you tell people what's coming. Who knows whether policymakers will follow our recommendation, but that is our recommendation.

We suggest evaluating Medicare's financial condition with HI and SMI combined, but not actually combining the Trust Funds, because the separate Trust Funds have resulted in a level of fiscal discipline that has been helpful, but it doesn't make a lot of sense to say one program is not financially sound, and the other one is. The boundary between the two parts of Medicare is not that high of a wall, as we've seen with the shifting of home health care, for instance, three years ago.

The most promising proposals in our view are increased beneficiary cost sharing and expanded use of managed care and competitive bidding. The not-recommended proposals might be surprising to some policymakers. We think that a lot of the proposals that are taken very seriously in some quarters would actually be relatively ineffective or counter productive. One example is raising the eligibility age. While that has a big impact for social security, it has a much lesser impact for Medicare, because 65- and 66-year-olds don't have high medical expenses relative to, say, 85 or 86-year-olds. If you raise the eligibility age by two years, you're going to save much less relatively than you did when the same proposal was enacted for Social Security. This is something a lot of people just don't understand. They figure that since it worked for Social Security, it will also work for Medicare. But it doesn't work nearly as well, and a lot of the 65-year-olds with the highest health care costs would be eligible for Medicare anyway, because they are disabled.

Similarly, we think that requiring employer plans to cover retirees would be a totally wrong-headed idea. You can't force employers to offer health insurance in the first place. If you force them to cover retirees, a lot of health plans will simply close up shop, and you'll end up actually taking away health insurance coverage from a lot of workers.

From the Floor: Can we pinpoint which segments are contributing most to that the projected crash in 2025? Is it perhaps the administration of the plan?

Mr. Schobel: It's not the administration. The administration costs almost nothing. If you reduce the administrative costs down to zero, you wouldn't change the financial picture in any significant way. Really, what is happening is that out-go is growing more quickly than the income. The income of the program grows with the economy and the working-age population, while the out-go grows with the beneficiary population. When the baby boomers begin retiring in 2011, the cost of the Medicare program starts to go up a lot more rapidly than the income goes up. So the lines cross.

Right now the income is a little bit higher than the out-go. Those lines will cross sometime around the retirement of the baby boomer generation, a couple of years beyond that actually. It takes a while for the baby boomers to have significant costs. After that, the out-go keeps on rising very rapidly, while the income rises much more slowly, and that's really what's going on. If you were to weigh what's really causing the deficit, I would say it's the growth and expenses. You have a choice. You can try to reduce the growth of expenses, or you could somehow try to come up with funding so that you can meet those expenses; but it really has nothing at all to do with administration, which is just a tiny percentage, roughly 2% of the out-go

From the Floor: The Academy's first recommendation is that there's a crisis and we need to do something now, not later. There has been a fair amount written about the notion that the Social Security, or the Medicare crisis, or both, are manufactured; that, in fact, there is no crisis. We are going to see more of this during the presidential campaign, and we seem to be in the position of putting the

Academy out there saying, no, this really is a big problem. What do we say in refutation of those economists who say there really is not a problem

Mr. Schobel: The American Academy of Actuaries has looked at the actuarial assumptions quite a lot. In fact we had a session on Capitol Hill, talking about assumptions back in January 2000. I was one of the speakers at that session. The Academy itself does not take a position on any assumption in particular; it doesn't say this one's right, and this one's wrong, this one should be higher, this one should be lower. It isn't really in a position to do that. However, we have looked at the process by which the trustees come up with their assumptions, and we think that the process is very sound.

Every few years, technical panels of actuaries and economists from outside the government get appointed, and they look at the assumptions and they make recommendations. Ordinarily the trustees are very responsive to those recommendations. They don't like the cost estimates for the programs to jump around wildly, and so they don't necessarily adopt all the recommendations instantaneously. But if you look at the trend over time, you'll see the trustees are always moving sort of inexorably in the direction of the last technical panel. Of course, by the time they get there, there's been another panel, and then they start moving in the direction of that panel's recommendations.

The Chief Actuary of HCFA has to certify the reasonableness of the assumptions, and really the Academy has no reason to believe there is some sort of conspiracy to come up with assumptions that would make the problem look worse than it really is. There are people who have suggested such a conspiracy; we don't see it. I was in the Government for nine years myself. If there was a conspiracy, nobody told me about it.

The one assumption that the outside observers have focused on the most is the growth in the GDP, which is assumed to be much slower over the next 75 years than it has been over the last 30 years. If the past rate of growth were assumed to continue, the problems in funding for Social Security would entirely disappear, and the problem for Medicare would be reduced down to something very manageable in size. However, there are very good reasons for assuming lower growth in the future than we've had in the past. The fundamental reason is that the economy cannot grow faster on a long-term basis than the compound growth rate of the work force, which is closely related to population and worker productivity.

The trustees assume productivity will remain constant at a historical level of about 1% per year. They assume no change in productivity. But the population grows much more slowly in the future, and the work force grows even more slowly, because one of the reasons the work force grew so quickly in the post-World War II era is things like the entry of large numbers of married women into the labor force. That can only happen once. Once married women are in the labor force, they are already there, you can't have them enter again and get that accelerated growth rate as a result.

So the bottom line is that we have no reason to believe that there is anything wrong with the assumptions, and we think, in fact, there is a lot of justification for assuming lower economic growth in the future. Therefore, we think the problem is real and not something that has been manufactured in the government.

Ms. Darlene H. Davis: Regarding the Task Force recommendation that the Medicare expand into some managed care: I take this to mean that the Task Force supports the notion that managed care does, in fact, save money for the Medicare program. I'm wondering if that support is given in the monograph.

Mr. Ripps: Actually, that is a great question, as a lead-in to our next presentation, which is going to deal with this whole notion of managed care and competition. We've heard from Dwight that the political realities are such that the Congress won't act unless there is a perceived crisis. What we've heard from Bruce that there is a crisis, and the actuarial profession is saying "act now." Beyond that, one of the crucial areas in which action could be taken is to increase the use of competition, which is the subject about which John Bertko will talk.

Mr. Bertko: First of all, I want to acknowledge the work that went into this competition monograph and the assistance of the Academy staff. I'm going to be treating a small chunk of it today, which hopefully addresses the question that Darlene asked.

Let me just start by saying that there have been a lot of proposals, in the last two years. The Bi-partisan Commission produced the Premium Support Model, sometimes known as Breaux-Frist, in early 1999. In July 1999, the Clinton Administration also put out a proposal. There has also been a competitive pricing demonstration that was set forth in the Balanced Budget Act of 1997(BBA), that has been kind of toiling forward. Because of the Balanced Budget Refinement Act of 1999 (BBRA), which erased funding for the demonstrations in Kansas City and Phoenix, it may not exist anymore.

Let's just say there's a whole bunch of things going on, and people have looked at it. What we are trying to wrap up in the monograph are some of our collective thoughts about what that process is like.

What are some of the common elements here? The first element there is what some people call the reference premium, which I believe, is used in the monograph. The key thing in any kind of market system is, what is somebody willing to pay for it? How do you determine that price? In the large employer market, the large employer sometimes set prices, sometimes manipulates prices, manipulate contributions to it; they may have lots of goals in mind. In a public policy forum, we want to do those according to some rules that continue to be fair and perceived as equitable. That becomes exceedingly important for its success.

There are other key elements to consider. What do seniors pay? As part the competitive pricing demonstration, some of our area advisory committees said watch out for disruption. The people involved today are our parents. I've got two

88-year-old in-laws. When they have a problem, they call me up and say, what in the world is going on? They don't have a clue on all of this. We need to understand that. Seniors may retain all the savings, if the plan's bid is less than the reference premium. Secondly, they pay all of the excess if a particular plan, which may or may not include traditional Medicare, is above the reference premium.

How does that fit with the current Part B premium? This is where Carol, Bruce, and I all kind of interlock. Bruce, to some extent, didn't quite say this, but maybe Part B premium needs to go up to assist with financing. Well, if competitive pricing comes in, maybe I'm going to raise what is effectively Part B Prime, for instance, something that goes along with it.

So this comes to the next point, where does traditional Medicare fit? The Breaux-Frist plan has said just let it be one of the bidders. The Democratic plan said no, no, just let it sit alone out there. The competitive pricing demonstration did not have authority to bring in traditional Medicare. As a bidder, it was really a stand-alone, in the demonstration, off to the side.

What did we actually look at here? I'm going to be a little bit broader for a couple of moments here. First, what I am going to devote nearly all of my comments to competition in the health plan model. But there are several different levels here. Suppose I put competition into the provider level? Suppose Medicare acted like a buyer in many of the ways that health plans, or (as in Minneapolis) the private sector, do today, in terms of selecting the provider groups, physician groups, and hospital systems?

Then we looked at several specific proposals separately; vouchers, and running of Medicare PPO, which is to some extent connected with the provider level competition. Let me acknowledge here that we were well aware that the Medicare+Choice legislation in the BBA created these things called Medicare PPOs and for the most part, those really don't exist today.

We also talked about technical and operational issues are just gigantic in all of these. Every time you go down a path, something else happens. Everything is connected to everything else along these lines.

We looked at the possible effects in a competitive system. Suppose that in California, where I live, that you have 50% occupancy, and you sent all of the seniors in Oakland, California, to one or two hospital systems. The other one goes out of business. It has lost 40% of its revenue and probably most of its fixed-cost base. Do we want to do that? Do we want to put physicians basically out of business in this certain area?

I think what's going on in just home health care, with the rate changes in the BBA, have shown some of these effects. What are the unintended consequences? I certainly would point to BBA as being the key thing that had many more consequences than Congress, and probably a lot of other people, expected at the time of its enactment.

Last, to address one of the questions that is likely to come up, did we say much, if anything, about cost estimates? We backed down from that one. But, CBO said a few things, and the Clinton Administration said a few things, about cost estimates for these kinds of competition among health plans. They said that the amount of savings predicted in the short run would be relatively small. Having a part of the competitive pricing demonstration and hearing the hallway conversation, I will tell you that small is all relative. In the failed Denver experiment, the bids actually came in. Gossip was that they may have had savings somewhere in the 1–5% range. Bruce will tell you that 2% would mean quite a difference over a 25-year time span, and maybe that answer is part of what Darlene's question is. Is there a potential out there for some savings? Does this come into play and possibly work? The best answer right now is maybe.

I wanted to talk a little bit about provider competition. I think that I'm probably joined by most of the actuaries that have worked in managed care, who agree that if we can have true provider competition, relatively unfettered by regulations, the potential for savings there is really gigantic. Let's take just a favorite topic here: academic medical centers. Hey, we train too many doctors today, at least in my experience; many of them have been relatively inefficient. Suppose we stopped paying for them the way we do today, because this whole mechanism changes. Well, half of the hospitals in Boston would close. Do we want that? Do we want to stand up to that? But we would have some savings, and potentially we would have really great savings with fairly great consequences as well.

These savings here all depend on Congress's ability to make very tough decisions about contracting with only certain providers, and perhaps requiring seniors to pay much more than their current Part B premiums to choose a health plan which might include traditional Medicare.

If health plan competition were to move forward, we would recommend that traditional Medicare be included as a bidder. It's out there. Many of us that work in the private sector know that one particular option does not have to compete. It really reduces the reason for the other bidders to bid low.

It would be important to use a bidding manager with competitive bidding experience and sufficient resources. Let me make one statement right now. As much as some of us have perhaps criticized HCFA, it has done a remarkable job with the resources it has, and it has been my observation that, over the last few years, it has had a ton of work dropped on it, with virtually no more funding. So let's not criticize people unfairly here.

How would we implement this? Do we do it all at once and go cold turkey? Do we have different competitive pricing demonstrations of some sort?

One of the things that we came up with as part of our lessons learned, at the end of our competitive pricing advisory committee meeting, was that learning about competitive bidding ought to be an investment. To make it work, we may need to

put some money in, as opposed to just trying to gather savings today. We've got to learn to walk before we run.

Next, do we need to think about grandfathering older seniors into this continuation of traditional Medicare? I would say almost everybody aged 60–65, particularly those working for large employers, know what managed care is about. However, we need to think about grandfathering older seniors into a continuation of traditional Medicare. My 88-year-old in-laws, who are part of a Medicare+Choice plan, do not have a clue of how the funding mechanism works. To drop something on them would mean that I would need to spend probably every day for the next two years to explain to them how to do this.

If you were to move forward to pilot a competitive payment model of some sort, where might be a good place to start that's not subject to "not in my backyard?" Maybe it's prescription drugs.

Mr. Bachman: John, we heard earlier there's almost no administrative expense in the current program of fee-for-service, less than 2%. As you move into the competitive bidding, the marketing and administrative expenses would be much higher, maybe 10–15%. Where does the savings come to offset those dollars going into the private sector that were going into fee-for-service benefits? Secondly, would there be something you ought to be doing for the fee-for-service benefit to gain that segment there without having to go all the way to managed care?

Mr. Bertko: Let me try to answer the first part. Formerly from a consultant perspective, now from a health plan perspective, and from being in what I call the independent planet of California, I think there is still room for efficiency, certainly on the inpatient side. I think there is a huge amount of room for reducing the cottage industry of traditional practices with incredible variations in practice. I think there are upcoming technologies. Can we through technology, through data gathering, make things a lot more efficient? I'll put that under the managed-care umbrella. Some Medicare+Choice plans may get there, some may not. Maybe there is a new organization type to get there. Maybe PHOs get there in one aspect or another.

For traditional fee-for-service, the second part of your question, here's an anecdote. I had some quiet discussions with HCFA on incorporating management programs, in particular, managing congestive heart failure patients. We had a cardiologist from a fee-for-service group in New York on the HCFA panel, who asked a very direct question: When is this going to happen in fee-for-service?

I can't see it happening. Cardiac surgeons are trained to do surgery on patients. Why would you stop getting paid for that, and turn a patient over to someone who will give him or her drug therapy and then take away your income? At this point, it's hard for me to imagine how. Could a new model emerge from HCFA? Are there some traditional Medicare fee-for-service that would use some of these? Are quality improvement initiations underway?

I think the answer to those questions is all yes. I kind of know the direction that Carol's company is going. I can only see it as this fog out there in traditional fee-for-service Medicare.

Mr. Ripps: I would just like to add a little bit to that. This notion of HCFA's administrative costs being 2%, and the private sector being 10–15%, is sort of comparing apples and oranges in a way. There are some things that fee-for-service programs could do that involve spending money on administrative costs but would have a great return in terms of the reduction of overall costs. For example, there may be tighter controls on fraud and upcoding and all sorts of things that private sector companies do as a matter of course, because they are on the risk. They end up spending more money in administrative costs and claims settlement processes, but arguably, end up spending less in total, because there is hopefully a greater reduction in the amounts spent on fees for care than the increase in administrative expenses.

Mr. Schobel: Just to be fair, of course, we have to recognize that one of the reasons that the government's administrative costs are so low is that the government gets a certain amount of its administration done by its employers, who have no choice. A lot of record keeping and the collection of taxes and so forth are done by the employers, and so the government doesn't have to spend money doing those things. So it is a little bit of an apples and oranges comparison. But one can hardly doubt that even if you included all of the costs that are done by the employers, it would still be very, very efficient.

Ms. Carol J. McCall: Two things I would like to add. With respect to administrative costs, when I look at Medicare+Choice plans, one of the biggest portions of the cost is, in fact, member acquisition. I think that in a competitive type of model that worked across the board, there would be opportunities to rationalize the whole process of member acquisition. To take a Medicare+Choice overhead, and lay that across an entire reform basis is probably inappropriate.

Secondly, my company, Allscripts, provides hand-held prescribing devices for doctors. The doctors like the prescribing device, because it saves them time. The health plans like it because it saves them money. In an analysis that I just completed, using what I believe to be reasonable assumptions, not assuming that doctors have to use it all the time, or that all of the health plans' doctors need to use it, I believe that a health plan can save between 2–3% of their entire pharmacy spending by having doctors use this hand-held prescribing device. That's assuming that only 40% of the doctors use it. If more use it, you can save even more money by using it.

So those are the types of techniques I believe that we can put in place. But it takes the right type of incentive, and it really is a managed care approach. But I think they are available.

Mr. Ripps: Darlene, could you repose your question so we can address it? I share your views, and if you could repose it, perhaps we could address it more completely.

Ms. Davis: My question is, is your recommendation based on the assumption that the Medicare+Choice program, as it is now, will save money, based on the projected payment rates to Medicare+Choice plans, without modification?

Mr. Ripps: Let me try and answer your question directly; I think the answer is no. You've asked, does our assessment of the potential for competitive programs rest largely on the current Medicare+Choice program and what it appears to be doing, with respect to reimbursement from the Medicare+Choice plan? The answer is no, that's not really what our conclusion is based on.

Ms. Davis: The question wasn't relative to competitive plans. The Medicare+Choice program, as it stands now, is not a competitive-bid program; it operates under a formula for payment to HMOs and to possibly any other organization that want to participate. The problem is that those payments are projected to increase at a much slower rate than fee-for-service costs, and there is much contention about that. I am wondering how that figures into the task force recommendation.

Mr. Ripps: I would throw out an answer, and you the other panelists can correct me if I'm wrong. We really didn't look so much at that directly in viewing the potential for competition. Is that fair?

Mr. Bertko: That's right.

Mr. Ripps: With that, perhaps the next thing we should talk about is the hottest topic in Washington today, which is prescription drugs.

Ms. McCall: Saving the best for last; the hottest topic, that is. What I would like to do is give an outline and then an overview of the prescription drug monograph that the American Academy of Actuaries Medicare Reform Task Force has put together.

The purpose of the monograph is three-fold. There was a large discussion about how much we should put in the monograph with respect to how prescription coverage works. We decided that it was very important to lay in a great deal of background and education about what the current pharmacy delivery system, and some of the impacts thereof on insurance coverage.

I've had a unique opportunity. Prior to working for Allscripts, I worked for Humana as vice president of pharmacy management for about two and a half years. That's a non-traditional role for actuaries. But it took me into the ins and outs of every aspect of pharmacy coverage, and I must tell you that there is so much that happens in there, and so many of those details are important to figuring out where trends are going and how in fact you can control drug costs.

We felt that it was important to share some of how prescription coverage actually works in the monograph in order to give everyone else a better feel for what is happening there. So that is one of the main purposes of the monograph.

The second is to talk about pharmacy benefit design—the specific features of how it is designed, and how it will affect the costs of any pharmacy program. What I will touch on in a little bit more detail later is a specific design of a pharmacy benefit, because of the unique aspects of pharmacy coverage; it can dramatically impact the adverse selection elements of a Medicare program.

The third major purpose is to consider providing drug coverage under Medicare, and some unique Medicare-specific issues that should be considered when designing the program.

Let's talk briefly about how seniors receive drug coverage today. It comes from a variety of sources: employer-sponsored health plans, Medicare+Choice plans, Medicare Supplement, Medicaid, Tri-Care, the VA and some other government programs, both federal and state, pharmacy assistance programs, and discount programs such as through AARP. For the discount program, think of it like a Sams Club card. It gives access to some of the discounts that can be available through some of the retail networks.

If we look at the source of the coverage and the percentage of seniors that are covered by the various sources, about one-third of seniors are covered. Approximately one-third have no coverage. The remaining third are covered through a variety of mechanisms—Medicaid, Managed Care, individual Medicare Supplements, and others. I would point out, there was a comment made that Medicare+Choice does, in fact, provide coverage and yet according to the Actuarial Research Corporation, a little bit under 10% are covered through Medicare+Choice, so expanding that, given the constraints of quick expansion, is not really an option if universal coverage is the goal.

Let's go through an overview of what some of the key design issues are for our Medicare program, and I will talk about each one of these in more detail in turn. The first is a "single payer," which is really not in fact a payer, but more of an intermediary. I'll talk about that soon, but one of the design considerations is a single payer versus a competitive model.

Also, you need to consider whether or not to use some of the private sector options as fiscal intermediaries. For example, if you wanted to use pharmacy benefit managers (PBMs) and some of their techniques, they have a whole host of techniques that they use to help manage drug costs for their clients, which are insurance companies and health plans. Also, Medicare+Choice plans themselves, have their own internal PBMs and do this for themselves.

Next we'll talk about cost-sharing mechanisms, and specifically the type of benefit design is a key issue for Medicare. We'll talk about formularies and rebates, drug utilization management techniques, and mechanisms that PBMs use. Network

access is a very, very important topic. Adverse selection issues are absolutely critical issues. We'll talk about that, and then the importance of coordinating with the existing coverage.

There are in fact, a number of mechanisms through which coverage is received today, and how to coordinate any universal program that comes in, even if it's voluntary, is of the utmost importance.

Before we get into each of those, I'd like to discuss two more key design issues that are important. First, prescription drug coverage will, in fact, impose a large financial strain on the Medicare program. Because of that, it is important to look at overall reform of Medicare before adding this new benefit. This strikes to the heart of what we were talking about earlier. Irrespective of whether or not the HI fund or the entire Medicare program gets into trouble in 2025, 2020, or 2030, none of those things take into account the fact that a pharmacy program would add a much larger financial burden onto that. So it's very important, when looking at the design issues, to take these into account, and keep them top of mind as we consider each and every aspect.

I want to talk a little bit about single-payer versus competitive models. I'll define what these are. For single-payer, what it means is really similar to the current Medicare fee-for-service. There would be regions, and there would be a single payer per region. Payers would, in fact, compete to win an entire region. In that sense, it is still a competitive model, and some of the issues that John has talked about in competitive bidding come into play in the pharmacy program as well.

But then there is the pure-competitive model, which is similar to Medicare+Choice. There would be multiple intermediaries or payers per region, and payers will compete at two levels. First, they would compete to being able to be a competitor within a region at the next level, which is then to compete to win the beneficiary.

One thing I would add here is that there are different proposals out there, that in addition to talking about whether it is a single payer, or a competitive PBM type of model, they also talk about whether the intermediaries would be at risk for some or all of the pharmacy costs. I will tell you that competitive models make that more likely, although we'll talk about why pharmacy risk is a little bit different from other types of risk.

Let's compare these models just a little bit. At a real high level, the model that you would prefer actually depends very much on the goals of the pharmacy program. Both the single-payer and the competitive model are capable of providing broad access to coverage. Most if not all of PBMs have the capability, if not current capacity, to reach nation-wide. If you think about how many pharmacies there are in the United States, there's about 50,000, and most PBMs currently have contracts or could get contracts with most of those pharmacies.

Consider the quality of care. Both approaches have the opportunity to enhance the quality of care because of some of the drug-interaction information that is available from PBMs.

In terms of consistency for beneficiaries, a single-payer model, where everyone would attain the same benefits and the same exact coverage, by definition, provides greater consistency for beneficiaries; on the flip side, a competitive model would allow for more choice. In a competitive model, when you have one PBM competing with another, you have the opportunity for them to compete on the basis of some of the different cost containment mechanisms that they use. So, for example, when you talk about formularies, if one PBM decides to use a formulary, and the other does not, that provides choice for beneficiaries; it's not consistent coverage, but it gives them a mechanism, and a way to trade off—maybe a lower cost and therefore a lower premium, but in return, the trade for the beneficiary is a formulary you now have to deal with.

Those types of things are going to be more acceptable politically, and more viable under a competitive type of approach. Because you then allow PBMs to then use those mechanisms, you have a greater opportunity for cost containment in a competitive type of model.

The single-payer model is obviously easier to administer. A lot of the things that John had talked about for the competitive monograph in respect to reference premiums, how you get it set up, how you allow people to compete against one another—all of those rules would come into play in setting up a competitive model. You still have to have some of those elements in a single payer model, because you still have to pick which PBM wins. But the level of complexity is nowhere near as great.

As John alluded to, a competitive model is, in fact, more compatible with other approaches for other reforms. So if we wish to go to more of a competitive approach overall for Medicare, a competitive type of pharmacy benefit approach is in fact more compatible with that. We could also take the opportunity to learn from putting in a competitive approach for pharmacy, and we can then expand that to overall Medicare+Choice plans.

In addition to some of those higher-level comparisons, let me talk a little bit more about a single-payer model.

First, a single-payer model does lessen the problems in adverse selection between payers. One of the things that can happen, as you have more than one PBM out there, is you will also have the opportunity for different morbidity groups to land at different PBMs. A single-payer model may also restrict the ability to have a competitive model at a later time. If we start with the single PBM approach, and then want to migrate into a competitive model, that would be pretty tough, because the early winners for a given region would have a leg-up on anybody else that might want to come in later on.

It gives an advantage, also, to larger, or national, PBMs because they would in fact have the ability to take over an entire region. Let me give you an example. There are smaller PBMs. My example was relatively small nationwide, with about 1.4% national market share. However, in the state of Wisconsin, it had a 37% market share of the PBM market. They can do, for example, a great job in Wisconsin, because they have a tremendous relationship there already. But they may not have the same relationships nationwide. So if you require a single bidder and a single winner for a fairly large region, you would lose the opportunity to take advantage of some of those smaller PBMs.

A single-payer model may reduce savings available from using drug-management techniques. Again, if you have one PBM in a region, because the beneficiary doesn't have any choice, he or she can't choose whether he or she wants a formulary or mandatory generic substitution. Some of those types of techniques are not going to be acceptable in a single PBM approach. Because of that, they may not be as viable in those types of models. The savings from those types of programs would go away. They would not be there.

There would be fewer incentives in a single-payer model for payers to compete based on customer service. Once they have won a region, they are in fact in, and they are in for the entire duration of the region. If you have a competitive model with an annual open enrollment, then, if some of the beneficiaries don't like the service that they are in fact receiving, they have an opportunity to go to another PBM that is competing in that region. Also, contracts end. I have had the great pleasure of trying to convert from one PBM to another PBM in Humana, which was, according to a press release, the largest single turn of pharmacy business in U.S. history. Let me tell you, any single change for Medicare single-payer would probably dwarf the size that Humana went through. It went very, very well, but it was also very, very hard; and if they are not done well, you can actually create access-to-care issues for the beneficiaries. So that becomes very hard when you go from all one to another, and needs to be considered.

A competitive model does allow more flexibility of program design. Again, in some of the drug utilization management techniques, the knowledge gained from this program, in putting in a competitive model, would work in competitive bidding used in overall Medicare.

In a competitive model, you are better able to deal with some of the formulary issues. The competitive model allows your mother or grandmother, for example, who may be under a particular therapy for, let's say, high cholesterol, to choose a PBM based on what drugs are on what formulary, and not necessarily have to switch therapy. If formularies were used in a single-PBM approach, it basically says you need to use my drugs, and that's really that's all you have access to, unless you get a medical exception. It is, however, more difficult to communicate plan specifics to beneficiaries in a competitive model. Again, if you are allowing PBMs to vary things, then you have to find a good way to explain that to seniors so they can understand it.

Another core issue concerns cost-sharing features. What cost-sharing is going to be required? Copayments, coinsurance, deductibles, and benefit caps, are all the basic flavors of how to design benefits, which I'm sure you're all familiar with. All of those come into play here. The issue, we talked about earlier, the Breaux-Frist model has an actuarial value model, whereas the Democratic proposal essentially has a defined benefit. In a pure actuarial value approach, there are lots of opportunities for anti-selection. I know that if we had a contest here today, and I said, "Design a benefit that has $20 of actuarial value, and you can do anything you like," that you would in fact be able to come up with front-loaded, or back-loaded, or middle-loaded benefits, all of which would have different incentives to the beneficiaries who are buying them, based on whether or not they thought they were going to have care tomorrow versus a year from now, and the extent to how expensive they thought that was going to be. So there still are opportunities for anti-selection in a pure actuarial-value approach.

Also in respect to cost-sharing features, there's a question of whether to allow intermediaries to enhance benefits at their own cost. So if you have a base-level approach, can a PBM, or a health plan, for example, offer an enhanced benefit, as long as they are paying for the value of the enhancement?

We'll talk a little bit about formularies and rebates. There are things to consider. Would a national formulary be required? PBMs all have different formularies, and what if you had a single PBM approach, or national formularies, which are the same across all regions required, or can you have different drugs available to people, simply because of the region they live in? Think about John's mother-in-law living out in California; would she in fact have access to the same drugs as my mother living in Wisconsin? They have different PBMs. Would you force these PBMs to make the same decision about a set of drugs? How much political pressure would be applied by the drug companies to have their drug as the drug of choice across the nation?

Also, do you use formularies that are open, closed, or incentive? Incentive formularies tend to use three-tier approaches, those types of things where you're allowed access to the drugs but there is a different cost share. Closed formularies deny coverage unless there are medical exceptions. Open formularies are essentially invisible. You're allowed access to all drugs without permission, but there may be techniques to try to get you to switch, after the fact.

Would medical exceptions be allowed, and how would they be determined? How would the pharmacy and therapeutics committees function and be monitored in different health funds of PBM? How would rebates be handled? Rebates are an extremely important component of reducing health care costs, and can get to be a rather significant portion of total health care spending. I've seen them as high as 5–10% of drug spending, and how those monies flow back from manufacturers and back to beneficiaries, either directly or indirectly, is extremely important.

We talked a little bit about drug utilization management techniques. The questions are, what sort of mechanisms can be used? Can they be used in the single-payer

approach, and would they be required by all health plans or PBMs, as a basis on which to compete with each other? Those are all important things in deciding whether or not they can compete with each other, and the basis they can compete.

You need to determine what the network size and access requirements are; also, will performance-based networks be permitted? However, if pharmacies cannot be excluded, and it's an "any willing pharmacy" type of model, it makes performance-based networks that much harder to put together. There's no incentive for pharmacies to want to be in a performance-based network.

Can mail order be used? Is it a mandatory feature, or is it an optional feature? The monograph talks a little bit more in detail about why these are important and whether or not money can be saved by using them.

To me, adverse selection is absolutely critical. Is the program voluntary or is it mandatory?

What are the benefit levels? I want to stop here and talk about this. The level of pharmacy claim costs for seniors is much more predictable than for other types of health care coverage. If you think about the utilization and the cost-per-unit aspect, to create an insurable mechanism, there are two things that you would like. One is that you would like it to be relatively infrequent. The second is that you would like it to be fairly high cost, so it's not very predictable. You have neither of those with respect to pharmacy. Each unit cost, each prescription is relatively inexpensive; and it also is something that happens very, very frequently. It's one of the most, if not the most, frequently used part of the medical insurance dollar.

When seniors look at the benefits, they know what their outlay is, they know what they've been spending, they know how many pills there are, and they know how many prescriptions they take every month. They know what their payout is today, and if in fact it is $700 or $800 per year and is predictable, it is very easy for them to compare that cost to the cost of a new drug program. Those that say, "this is a good buy for me," will go in. Others will say, "you know what, I can do better on my own, because I'm going to end up paying $1200 to get my $800 coverage;" they'll be able to do that calculation in an approximate way, and they will decline the opportunity to participate.

Benefit design is extremely important here, about how you incent the various populations to come in.

Another question in terms of adverse selection: do beneficiaries receive subsidies, and will risk adjustment or reinsurance be used?

John Bertko and I took the opportunity to analyze some data from a health plan, and we broke the seniors out into quintiles. We said we've got 20% of the membership in each bucket, in terms of membership, not cost. We asked, for each of those quintiles, what is their relative cost, relative to the average?

There were a couple of things we found. Number one, rather than the 80/20 rule of thumb that everybody throws around for health care, pharmacy follows what is more of a 50/20 rule. Rather than 20% of the people taking 80% of the cost, in pharmacy 20% of the people only take 50% of the cost. What does that mean? It means that the other costs are in fact pushed back over the other parts of the distribution. So everybody is in fact utilizing it to a greater extent.

The second point is, that if you get equal enrollments in each quintile, you don't have any adverse selection or change in your distribution because of participation. However, to take a rather extreme example, suppose the healthiest two quintiles drop out. The average cost for the remaining participants becomes 57% higher. That's an important thing to keep in mind. So, if in fact, you have adverse selection in those populations, again, remember the calculation that these people are going to perform on the back of the envelope. It is very likely that with a certain type of benefit design, perhaps back-loaded benefit design, where the healthier seniors don't think they are going to get the bang for their buck, they will not enroll.

If you think about the healthiest 20%, they only take 2% of the drug costs spent. It is very likely that we would not, in fact, get 100% participation in that bucket. The consequences are that we need to look very carefully at how we design and create risk adjustment mechanisms, and how we in fact pass those costs back, either through reinsurance pools or back to the intermediaries or the payers.