RECORD, Volume 26, No. 3*

Chicago Annual Meeting
October 15-18, 2000

Session 3PD
Medicare Supplement Update

Track: Health

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Summary: Is Medicare Supplement a dying product? Or is it thriving in the world of Medicare+Choice? Panelists discuss recent enrollment and cost trends and competitive dynamics with Medicare+Choice capitated plans. Expected future trends are also discussed.

Mr. Michael S. Abroe: What I'd like to do first is to introduce our panelists. Mark Bartorelli is vice president and chief actuary for United HealthCare Insurance Company. He joined United about four months ago. Prior to that, he was principal and chief actuary for the Apex Management Group, a health-care actuarial consulting firm. He will talk about Medicare Supplement update by discussing some aspects of Medigap reform from an insurance company perspective.

Sally Burner is a special assistant to the chief actuary of the Health Care Financing Administration (HCFA). She is a career federal employee, having been with HCFA since 1980 and prior to that, with the Social Security Administration. Her major area of responsibility is the modeling of the impacts of proposals to reform Medicare. Today she will talk about one of the hot Medicare issues, the coverage of outpatient prescription drugs. Rich Coyle is an actuary also with HCFA, and Rick's focus at HCFA is on private health insurance issues, including Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Medicare Supplement. Prior to joining HCFA, Rich spent nine years in the financial reporting area of the AEGON's Special Markets Group. He will be talking about Medicare trends and especially some of the issues involving the recently implemented hospital outpatient payment system.

We had planned on another speaker, David Kerr, who would have presented some excerpts on claims trends from a recent Academy report that was released several months ago. You can get the report on the Academy Web site. I think it's the report on claims trends and the date of the report is June 8, 2000. There will be

some reference to the information in that report that will be interspersed within the presentations, especially what Rich is doing.

I would strongly urge that anybody who is interested in the trends go to the Academy Web site and download a copy of the report. The reason I'm harping on it is I was the chairperson of the working group who put the report together.

Mr. Mark F. Bartorelli: Once again, Medicare reform is subject of a great debate. For some of you, it probably seems like we have never stopped debating. There are many reasons for discussing Medicare reform. Chief among them is the lack of affordable drug coverage. Another key reason is the high cost of a Medigap plan with medical cost trends averaging in excess of 10% over the last several years. Interestingly, medical cost trends for Medigap plans have averaged about 10% since 1982. Thus, despite all the changes that have been made to the Medicare program, we still have not been able to tame Medicare cost trends. Yet another reason for reform is that some people say the rating structure and loss ratio mechanism are broken and need to be fixed.

Today we are going to investigate these and other reasons for Medicare Supplement reform. I think it is important to understand that in the context of Medigap reform, reforming Medicare+Choice (M+C) and the Medicare program itself are also part of the process.

Before getting into some of the reform issues, I will provide some background information in three areas. First, I will go over very quickly the types of medical benefits that are covered under Medigap plans. Second, I will compare Medicare Supplement plans to M+C plans, because again, it's not just Medigap reform we're talking about today, it's M+C reform as well. Third, I will give a market update. I want people to know that there is a reason to be bullish about Medigap and M+C. Given the population figures, with the number of Medicare members going from 40-80 million, there is great opportunity to reform these programs for the good of the senior population.

The session description asks two questions. Is Medicare Supplement dying? Or is it thriving in a world of M+C? Given that another 1 million members are going to be disenrolled from Medicare Risk HMO programs by the end of 2000; many Medicare Risk HMOs, though staying in the market, are closing their doors to new members; and that many are either raising their premiums, or cutting benefits, or both, the weight is now shifting toward Medigap.

As an aside, we should consider a name change for the next session. Rather than call it the "Medicare Supplement Update," let's call it the "M+C Update" instead, and change the questions accordingly. Despite this, both markets are viable and we should be bullish about both.

I think history is very important, so I have developed an abbreviated Medigap Supplement history for you. There is a very interesting trend. We can call this a Medigap lifecycle rather than death cycle. Some people might want to call this trend the Medicare Supplement Regulator's 10-Year Maximum Patience Threshold.

In 1981 Baucus was a defining moment for Medigap. The Baucus legislation delineated some minimum benefit requirements for Medicare plans, but did not do a lot beyond that. Companies still had a lot of flexibility with respect to plan design, rating, and marketing.

Ten years later, in 1991, we had standardization of Medigap plans. Standardization corrected some of the problems created over the previous 10 years, including churning, block-closings, and duplicate coverage.

Looking back at standardization, I think most of us will agree that standardization really stopped at the plan designs. There's still a lot of work that needs to be done. I guess that is why many of you are here.

When I talk about current standardized plans, I'm really going to be focusing on plans A-J and what I know about them. I will not be covering the types of standardized plans that are offered in Massachusetts, Minnesota, and Wisconsin.

I'll explain a high-level plan summary of the benefits covered under Plans A-J. All plans cover the basic benefits, which include Part A coinsurance and 365 days of inpatient coverage after Medicare's benefits are exhausted, Part B coinsurance, and three pints of blood each year.

Most plans cover foreign travel and the Part A deductible. Some plans cover the Part B deductible, at-home recovery, and preventive benefits. Prescription drug benefits are covered under Plans H-J. Plan J covers $3,000 a year in prescription drug costs, while Plans H and I each cover $1,250.

When addressing the topic of Medigap and M+C reform, it is helpful to compare both programs on many levels. The first level I look at is end-stage renal disease (ESRD). Right now, someone with ESRD is screened out on the front-end from M+C plans. Interestingly, if someone later develops ESRD, Medicare will actually make a risk-adjusted payment to the M+C plan. On the Medigap side, those with ESRD can enroll in a Medigap plan during the six-month open enrollment period. That's an important difference.

On the rating structure side, the premiums members pay to M+C programs are community rated. The per-capita payment that goes from HCFA to the M+C plan is demographically adjusted to reflect such factors as age, gender, institutional status, and working status. In contrast, most Medigap carriers were community rated at the time the Baucus changes were enacted. By 1992 (standardization), most carriers had changed to entry-age rating. Since standardization, most carriers have switched to attained-age rating where permitted under state law.

The movement from entry-age rating to attained-age rating underscores one of the problems some carriers are having with the current loss ratio mechanism. It is my understanding that many entry-age rated carriers could not meet the durational loss ratio requirements, so they switched to attained-age rating.

In terms of benefit designs, the M+C plans have federal minimum benefit standards. The minimum benefit standards really still afford a lot of plan design flexibility to M+C programs. In contrast, Medigap plan designs are fixed by state law and, thus, cannot be changed.

Another key difference between M+C and Medigap plans is termination. M+C plans are allowed to terminate members with notice. On the other hand, Medicare Supplement plans are guaranteed renewable; thus, while carriers can basically close the book of business, they cannot terminate any members. Moreover, if a Medigap carrier decided to stop writing, they would be prohibited from writing new business for five years.

In terms of availability, M+C plan availability depends on the presence of viable provider network and on whether the setting is urban or rural. Most networks are concentrated in urban areas. In contrast, the availability of Medigap is not hampered by network availability or area. Access to Medigap coverage is virtually nationwide.

With respect to growth, starting in the early 1990s, M+C programs experienced meteoric growth until around 1998. In 1998 growth slowed down due to the Medicare HMO disenrollment activity and other factors that we have been reading about. In terms of the future, M+C plans appear to be heading into a phase that can be characterized as level to decreasing. In contrast, Medigap plans are moving from a decreasing growth phase to a decreasing to level growth phase. Whether these trends continue, only time will tell. One of the big unknown variables is what the federal government does in response to the current membership-contraction in the M+C program.

Let me give some information that gives a good reason to be bullish about Medigap and M+C. About 30% of the seniors are in Medicare Supplement plans and 19% are in M+C plans. On a combined basis, that's almost 50%. There are 10% of seniors on Medicare only and 10% on Medicaid. About 31% of seniors are currently covered under employer medical plans. As you know, the enactment of FAS 106 in the early 1990s resulted in a lot of changes with respect to the retiree medical programs offered by employers. Many employer retiree medical programs were either eliminated or modified to reduce the retiree financial obligation. Another factor is that people are increasingly working for small businesses that typically do not cover post-retirement medical coverage.

A potential impact of both these is that the 31% figure (i.e., the employer's share of the retiree medical market) is going to decrease, possibly rapidly, over the next ten years. We should expect to see relatively more seniors seeking coverage under Medigap and M+C programs in the future.

Previously, I discussed Medicare Risk HMO disenrollments. From 1995-98, the enrollment in the Medicare risk plans doubled by 3 million to about 6 million.

Since 1998 enrollment levels have been relatively flat. This may be due to the disenrollment activity of the last three years. By the end of 2000, almost 2 million

members will have been disenrolled. I believe there's a good chance that the number of members at the end of 2001 will actually dip below the membership as of the end of 1998. Even though this might not look good in the short term for M+C, there still are about 6 million people enrolled in Medicare Risk HMOs. Thus, this market is still viable.

I want to spend the rest of my presentation talking about areas and opportunities for change. As I discussed with Mike earlier, the Medigap reform debate is really just beginning. All of us have a lot to learn on this topic. It is important to note that a lot of committees and work groups that have been formed to begin working on the issues. In fact, if you are an interested party and are not on one of these groups, you are in the minority.

The first opportunity for reform is benefit design. Benefit design is like the fuzzy math that George W. Bush discussed recently. Even though we have 10 standardized plan options, in reality, we only have five.

To explain why 10 equals 5, you need some background on Medigap benefit costs. Let's consider at-home recovery, preventive care and balanced billing. These benefits were intended to produce meaningful differences among the standardized plans, not only in terms of the level of benefits themselves but also in terms of the cost. Now we have learned otherwise.

With respect to preventive benefits, now that Medicare covers a significant proportion the cost, this benefit adds very little value and cost to a Medigap plan. With respect to the at-home recovery benefit, Medicare covers substantially all the at-home health care, which leaves very little left to be covered by the at-home recovery benefit ($40 a visit, up to 40 visits per year, and up to seven visits a week). From a cost standpoint, this benefit is also relatively insignificant.

Shortly after standardization, significant limits were placed on Part B access charges (a.k.a., balance billing). Balance billing charges were limited to 15% of Medicare fees. Moreover, non-participation physicians receive 95% of Medicare's allowable fees as their Medicare payment. Coupling this with the fact that the vast majority of all physicians are participating in Medicare has resulted in this benefit being a relatively small factor in the pricing.

The conclusion of this background is that you can add all three benefits—preventive, at-home recovery, and balance billing—to all plans without significantly affecting the total plan cost. With that as background, I would like you to focus on the plan groupings. You have Plan A, which is the cheapest plan. It is the limited benefits Medigap plan and stands alone. Plan J, being the $3,000 drug plan, is the most comprehensive and expensive plan and stands alone as well. I group Plans H and I together, because they cover $1,250 a year in prescription drugs, and differ only with respect to at-home recovery and balance billing.

Plans C, F, and G differ with respect to balance billing and the Part B deductible. Plans C and F cover the Part B deductible. Plan G does not. Plan G covers 80% of the balance billing charges, Plan F covers 100% of balance billing charges, and Plan

C does not cover balance billing. By adding the Part B deductible to Plan G, you can then combine Plan G with Plans C and F.

Plans B, D, and E differ with respect to the at-home recovery, preventive, and skilled nursing benefits. Since at-home recovery and skilled nursing costs are relatively insignificant, it is easy to see why I group Plans B, D, and E. As an afterthought, you could also add Plan G to this group. You really have places to put Plan G. That's how I arrived at the five plan groupings.

Another benefit design issue is options for lowering premiums. Cost is a major issue. Some people have proposed eliminating the "marginal" benefits as a way either to lower the cost of a Medigap plan or to partially pay for a prescription drug component. We just discussed three marginal benefits; at-home recovery, preventive, and access Part B charges and we now know that these won't provide much relief.

Some people have proposed the elimination of the Part B deductible benefit as a way to lower cost. The rationale given is that this benefit is dollar trading. One word of caution for everyone is that seniors like it. Like us, seniors do not like to fill out claim forms and they like the convenience of having the first $100 of benefits covered.

Another area on the cost reduction side is the Medicare Select Plan. There are some opportunities to cut costs of a Medigap plan using Medicare Select as a vehicle. Currently, Medicare Select is a Part A deductible discount plan only. In order to reduce costs further under Medicare Select, the scope of services eligible for discounts needs to be expanded. As an example, Part B services should be eligible for discounting under Medicare Select.

Even if we were permitted to discount more services under Medicare Select, expanding Medicare Select will depend on the availability of networks and on the willingness of providers to accept discounted payments. That's no easy task.

Plans C and F are the most popular plans. It is noteworthy that both of these plans cover the Part B deductible, so, again, we should be careful about recommending the elimination of that benefit.

I would like to make three more points. First, compared to all carriers, a larger proportion of our members are in prescription drug plans H-J than for all carriers combined. The primary reason why we write proportionately more drug plans than the industry as a whole is that we offer all three drug plans in nearly all states, whereas most other carriers do not offer drug coverage. Moreover, those carriers that do offer a drug plan generally offer either Plan H or Plan I.
Second, we offer all 10 plans in most states, compared to other carriers that generally offer only 4 or 5 plans.

Third, after nearly eight years of standardization, our pre-standardized block is almost the same size as our standardized block. It appears as though many seniors have decided to keep what they had rather than switch into a standardized

plan. Because so many seniors kept what they had, it appears that standardized plans were not as appealing to the seniors as expected.

People like to see numbers. Table 1 shows a percentage breakdown of benefit payments as a percentage of total claims. This is done by major benefit category. I made the statement before that the preventive at-home recovery, and Part B Access Charges benefits aren't worth a lot in terms of cost. Based on the figures in this table, these benefits comprise less than 1% of the total benefits cost under all standardized plans. Again, for those who are looking to trade or eliminate benefits and use the savings to create a drug plan, it is not going to work.

TABLE 1
BENEFITS AS A PERCENTAGE OF TOTAL CLAIMS

	Plan A	**Plans B-G**	**Plans H-J**
Part A & B coinsurance	100%	77%	52%
Part A & B deductible	-	17	10
Skilled Nursing	-	5	2
Prescription Drugs	-	--	35
Total Above	100%	99%	99%
All other benefits	0%	1%	1%

We can also use this table to estimate the level of medical cost savings that is achievable under a Medicare Select plan. As an example, refer to the Part A and Part B coinsurance. Part B coinsurance is a majority of that cost. Recall that the Part B coinsurance benefit is 20% of Medicare's resource based relative value fee schedule. If you were to negotiate a 95% payment with providers in your network (I guess that would be easier said than done), you would achieve a 15% reduction in the total non-drug cost under most Medigap plans. The actual savings would depend on the actual benefits package. Moreover, by coupling this with a Part A hospital deductible discount, you could then produce substantial savings through a Medicare Select plan. Alternatively, the savings could be used to fund a prescription drug benefit. These are just a few ideas to think about. To do this would require a federal law change.

Our standardized plan claim trends for all benefits and states combined for the period 1995-99 have increased. For most years, claim trends exceeded 10% with the drug plan trends running higher than the non-drug plan trends. Since these figures are for all states combined, they won't necessarily correspond to our experience in any given state. One of the key points to consider as part of the Medigap reform debate is the impact on medical costs of adding new benefits. Adding prescription drugs is likely to increase trends compared to non-drug plans.
From the Floor: Is aging factored into your trend figures?

Mr. Bartorelli: The change in average age is factored into the medical cost trends. Based on our data, the year-to-year change has remained relatively constant. One other point is that the average age of the drug plan holder is lower than that of the non-drug plan holders.

The next opportunity for Medigap reform is clarifying the benefit definitions. Again, we heard George W. Bush's statements about fuzzy math. The outpatient prospective payment system (PPS) system is a great example of fuzzy math. Since outpatient hospital services are covered under Part B, the average person would expect Medigap plans to cover 20% of the cost. In reality, Medigap plans pick up close to 50% of the cost. With the new prospective payment system for outpatient hospital services, effective in August 2000, this is supposed to change. However, the transition period, as I understand it, is measured in decades.

On the inpatient side, there is a difference of opinion as to what benefit payments should be made after Medicare benefits are exhausted. As we discussed before, Medigap plans stand in Medicare's place for 365 days after the lifetime reserve days are exhausted. That would be after day 151. Based on our experience, providers and carriers have a difference of opinion as to what the definition of Medicare allowable is. It would be helpful to have this clarified.

Another opportunity for Medigap reform is access. Right now there's a six-month open enrollment period during which Medicare enrollees can purchase a Medigap plan without medical evidence. From a senior's perspective, is six months long enough? Seniors have a lot of life/lifestyle changes to consider at retirement, so limiting the time to enroll in a prescription drug plan without medical evidence to six months seems to be too short. Moreover, since most carriers also medically underwrite the non-drug plans, changing to a more appropriate plan is becoming less of an option for seniors. One idea is to consider a 12- or 13-month open enrollment period.

Another area for reform relates to the consistency of treatment of the disabled Medicare population across all programs. Right now, seniors generally subsidize disabled Medicare enrollees under Medigap. The relative cost of Medicare disabled enrollees are 1.5 to 3.0 times that of the Medicare aged enrollees. As I stated before, this is an area where Medigap and M+C plans are treated unequally.

Even though standardization created uniform plan designs, we still have non-standardized rating practices that can be very confusing to seniors. There are a number of states with rating restrictions/requirements. The question is whether there should be uniform rating standards. Any changes will have to be weighed against the impact on existing insured members.
As I said before, the cost of prescription drug coverage is one of the main drivers of Medigap reform. Since Sally Burner will be going into this subject in a lot of detail, I will not make any further comments on prescription drug coverage.

To quickly summarize my thoughts, Medicare Select has a lot of promise as a vehicle for lowering the cost of a Medigap plan. One of the keys to success is passage of Federal legislation to extend discounts to all services, not just the Part A hospital deductible.

Mr. Richard F. Coyle: My presentation will be from the perspective of the Medicare program. It's going to involve two topics. The first topic is recent claim

trends for program and beneficiary spending and the second is an overview of the recently enacted outpatient hospital PPS.

The claim trends reflect per-beneficiary spending for the entire fee-for-service population. That is, they include all aged, disabled, and ESRD beneficiaries who are not enrolled in a M+C Plan. The data include payments for Medicare-covered services only. For instance, excluded from the experience is beneficiary spending for physician balanced billing, and inpatient hospital spending beyond the lifetime reserve days. Of course, prescription drug coverage is excluded.

As background to the trends, Table 2 presents per-beneficiary expenditures incurred in 1999, broken down by major service category. Program expenditures reflect Medicare's payments from the program's trust funds. Beneficiary expenditures reflect the individual's liability for deductibles and coinsurance. The first three service categories correspond to Medicare's Hospital Insurance program, or Part A. They are hospital inpatient, skilled nursing facility (SNF), and combined home health and hospice care. The last three categories, physician, hospital outpatient department, and other services are covered under Medicare's Supplementary Medical Insurance program, or Part B. As you can see, about $5,500 or 83% of the total expenditures were incurred by the program with the remaining 17% being the responsibility of the beneficiary.

TABLE 2
PER-BENEFICIARY EXPENDITURES—1999

	Program	**Beneficiary**
Hospital Inpatient	$2,672	$224
Skilled Nursing Facility	366	82
HHA/Hospice	358	0
Physician	1,126	379
Hosp. OPD	294	295
Other Services*	678	152
	$5,494	$1,132

* Includes DME, ASC, ambulance, laboratory and renal dialysis

Inpatient hospital services accounted for 50% of the program expenditures, and over 60% of the program spending was for Part B services in total. In contrast, beneficiary spending was dominated by Part B services, which made up over 70% of the individuals' expenditures. Of particular note are the hospital outpatient services, which represented only 5% of the program spending, but over 25% of the beneficiaries' expenditures. These relative differences in spending by category have played a key role in recent Medicare trends.

Specifically, the Balanced Budget Act of 1997 (BBA) had a larger fiscal impact on hospital spending than on non-hospital outlays. The BBA was enacted in August 1997, with many of the provisions taking effect in October 1997 or January 1998. Consistent with these dates, the trends that I will provide are grouped into two time periods: 1995-97 and 1998-99, which roughly correspond to pre-BBA and post-BBA timeframes.

Let's start with program trends for Part A services. The trends reflect the average annual growth in spending for each time period. Lower trend for recent hospital inpatient expenditures reflects lower payment updates, as well as a declining case-mix. The BBA specified the PPS updates for 1998 to be 0%, and for 1999 the market basket minus 1.9% resulted in a 0.5% update. Additionally, for the first time since PPS was implemented, there was a declining case-mix in 1998 and another decline is projected for 1999.

The SNF, which was in excess of 20%, was significantly impacted by the SNF PPS, which was enacted in July 1998. Initial PPS per-diem rates were based on 1995 costs, which were projected through 1998 using the market basket minus 1%. This update methodology resulted in PPS payment rates that were significantly lower than would be realized under the prior cost-based system. Home health expenditures were also growing in excess of 10% prior to the BBA. The BBA required implementation of a PPS, which took effect on October 1, 2000. Additionally, an interim payment system (IPS) was implemented in October 1997. The IPS introduced limits on costs per-visit and added agency specific limits on average costs per-beneficiary. These limits, in conjunction with HIPAA fraud and abuse initiatives, contributed to a 50% reduction in home health expenditures from 1997-99.

The beneficiary trends for Part A services revealed a similar, but less dramatic pattern, as those for program expenditures. The drop in the hospital inpatient trend was primarily the result of lower increases in the inpatient hospital deductible. The deductible increases averaged 3% during the earlier period, while the post-BBA updates averaged only 0.5%. The pre-BBA SNF trend was a product of the 10% utilization trend combined with the 3% trend in the per-diem coinsurance. Since the BBA, the utilization trend has dropped to around 1%, which is coupled with a 0.5% growth in per-diem coinsurance.

We'll now move to program trends for Part B services. The physician trend has been consistent over the five-year period, despite the switch to a single conversion factor in 1998 and the implementation of the sustainable growth rate (SGR) mechanism in 1999. The hospital outpatient trend experienced a significant drop due to the elimination of the formula-driven overpayment mechanism in October 1997. A large portion of the other services trend decrease can be explained by the $1,500 per-beneficiary outpatient therapy caps, effective January 1999 but subsequently removed for 2000 and 2001. Please note that these caps do not apply to therapy services provided by hospitals outpatient departments. The other services trend was also suppressed by limits placed on durable medical equipment (DME) and oxygen payment updates beginning in 1998.

With the exception of outpatient hospital services, the beneficiary trend for Part A services was comparable to the corresponding program trend. Coinsurance for hospital outpatient continued to be based on charges that contributed to the high ongoing trend. However, as will be discussed, implementation of the outpatient hospital PPS should lead to lower future cost-sharing trend.

In aggregate, the pre-BBA trends were similar for program and beneficiary expenditures. In contrast, the post-BBA program trends were considerably lower than the corresponding beneficiary trends. However, this relationship is not expected to continue into 2000 and 2001 due to relatively low trend expected for beneficiary SNF and hospital outpatient services. Also, the program's home health spending is expected to increase. The Academy report is a useful tool in trying to understand this trend differential.

I will now switch gears and talk about the new hospital outpatient PPS. The authority and framework for the PPS were established by the BBA and further clarified by the Balanced Budget Requirement Act of 1999 (BBRA). Final PPS rules were published in April 2000 and the system took effect in August 2000. The PPS replaces a system that was primarily based on hospital costs for Medicare's payments and hospital charges for beneficiary coinsurance. In comparison, the PPS is essentially a fee schedule. The PPS covers facility services and applies only to hospital outpatient departments with a separate fee schedule in effect for ambulatory surgical centers. The system also excludes hospital outpatient services currently paid under other fee schedules, such as DME, clinical lab, and ESRD dialysis.

Under the PPS, provider reimbursement is based upon an ambulatory payment classification (APC) system. Services are typically bundled and are assigned to APC groups based on resource and clinical characteristics. With a few exceptions, the median cost of the most expensive service in an APC group cannot be more than double that of the least expensive. An exception to the clinical requirement is found in the generic new technology groups, which are strictly based on cost. Within three years of their introduction, new technology services will be moved to an existing APC group or will be accommodated through the creation of a new group. Procedures are mapped to the APC groups using current procedural terminology codes, resulting in 451 APC groups. Generally covered under an APC group are bundled services including an operating or treatment room, recovery room, anesthesia, drugs, and other miscellaneous services and supplies. Exceptions to the general rule are blood and blood products, casts, splints, and many high-cost drugs in which payment is provided under non-bundled ancillary APC groups.

The National APC rates are a product of the group's weight and an overall conversion factor. As required by the BBA, the relative weights for each group are based on the 1996 median payments. The 1996 payments were adjusted to remove the excess program spending resulting from the formula-driven overpayments. The weights were developed relative to a mid-level clinic visit, one of the most frequently performed services.

In accordance with the BBA, the initial conversion factor was set at a level that left hospitals revenue neutral for 1999. The BBA also specified the calendar year 2000 conversion factor update to be the market basket minus 1%. Sixty percent of the payment rate is wage adjusted, using the inpatient wage index. The APC rate and corresponding coinsurance are discounted by 50% for multiple surgical procedures,

except for the most expensive one; and procedures that are begun but aborted before anesthesia is administered.

Beneficiary coinsurance is based upon values that are referred to in the regulation as National Unadjusted Coinsurance Amounts (NUCA). The NUCAs were calculated for each APC using 1996 median charges projected to 1999 and multiplied times 20%. The NUCAs are frozen at the 1999 level, which will result in a gradual decline in the beneficiary share of hospital reimbursement.

The determination of beneficiary coinsurance is based on a ratio, which I will refer to as the coinsurance percentage. The coinsurance percentage is determined to be the greater of the NUCA, divided by the APC rate or 20%. Currently, only five of the 262 non-technology, bundle groups are at the 20% coinsurance level.

The beneficiary coinsurance is calculated as the coinsurance percentage times the localized APC rate, net of any Part B deductible. As you can see, the geographic adjustment applies to the beneficiary coinsurance as well as the program payments. Coinsurance is required for each APC group and it's limited to the inpatient deductible on a per-APC basis. Currently, 17 of the groups have a NUCA in excess of the inpatient deductible.

The coinsurance percentage is set at 20 for new technology APC groups. Hospitals have the option to reduce the coinsurance down to 20% on an individual APC basis. However, the reduction must apply to all their Medicare patients, thus limiting the ability of Medicare Select carriers to contract for outpatient hospital services.

Following is a simplified example of the PPS payment calculation in which the Part B deductible has been satisfied. The coinsurance percent in this example is 40. The APC payment rate is $1,000. The NUCA is $400 with a 1.1 wage index. The localized APC pay rate {1000*[0.4+(0.6)(1.1)]} is $1,060. The localized NUCA {400*[0.4+(0.6)(1.1)]} is $424. The benefit cost sharing is $424 and the Medicare payment would be $636. More involved and realistic examples can be found in the regulation text and in the April 2000 issue of the *Health Section News*.

We assume that, as of August 1, 2000, the PPS implementation date, there was a decrease in aggregate per-service coinsurance. The decrease is primarily the result of using the 1996 median versus mean charges in the development of the NUCA. Using the 1996 mix of services, this aggregate reduction is estimated to be 13% for the last 5 months of 2000. However, this figure does not reflect any offset to the savings, due increased intensity or volume of services. Also, because the coinsurance percent is greater than 20 for the majority of services, future cost sharing trend should be lower than the historical trend.

There are three categories of additional program payments, all of which do not require beneficiary coinsurance. Outlier payments occur when a calculated bill is more than 2.5 times the APC rate. The payment is equal to 75% of this difference. The payments are budget neutral; meaning that conversion factor was reduced to reflect the projected impact of the outlier payments.

Transitional pass-through payments are additional payments above and beyond the APC rate, which are made for innovative medical devices and drugs. For the drugs, the payment equals 95% of the average wholesale price minus the implicit APC rate for the drug. For devices the payment equals the hospital cost minus the implicit APC rate. The payments are budget neutral and will be limited to the first two or three years of the PPS.

Transitional corridor payments are made to hospitals that experience a decline in revenue due to the outpatient PPS. The payments are not budget neutral. That is, they result in additional revenues to the hospitals. Payments will be made through 2003.

Each year HCFA is required to review and/or update several components of the PPS system. In consultation with outside experts, HCFA will review and adjust accordingly the APC grouping and relative payment weights. The calendar year wage index will be updated to match the inpatient wage index for the corresponding fiscal year. Also, the BBA specified the annual conversion factor updates to be the change in the market basket minus 1% through 2002 and the full market basket thereafter. Finally, although the authority exists, there is no volume control mechanism in place.

There are sources of additional information that I have referred to. Of particular note is the HCFA Web site, where you can get a copy of the final regulation, PPS questions and answers, and other useful information.

Ms. Sally T. Burner: I'm going to talk about something a little bit different. It certainly has an impact on future markets. It is coverage of prescription drugs for seniors. It's one of the hottest political issues and if it's not of interest because of its potential impact on the Medigap market, it should be of interest to you personally as your parents, or maybe your grandparents, become eligible for Medicare.

Under current law, Medicare does cover some drugs. It covers drugs for beneficiaries who are inpatients of hospitals or skilled nursing facilities, as part of their treatment and these payments are made directly to the facility. It covers drugs and biologicals that cannot be self-administered, that is, drugs that are administered by injection. However, drugs that are generally self-administered, such as insulin, are not covered. The payments for these are made to the physician. Medicare also covers immunosuppressive drugs during the 36 months following a discharge from a hospital for a Medicare covered transplant, oral cancer drugs, hemophilia clotting factors and immunizations. It covers pneumococcal pneumonia vaccines, Hepatitis B, and influenza virus vaccine.

There is some coverage under current law Medigap. The Medicare drugs in outpatient settings are covered under the Part B program. Insofar as Medigap is picking up the coinsurance for Part B services, it's covering some of these drug costs. Also, as Mark pointed out, there are also Medigap Plans H, I, and J that cover drugs.

I'd like to look at current coverage. Prescription drug coverage only data for Medicare beneficiaries in 1996 shows that one-third of the people got coverage through an employer plan. Another 11% purchased a Medigap policy, 10% got coverage through a risk HMO, and 12% through Medicaid and about one-third of the population had no drug coverage at all. This data is available from the Medicare Current Beneficiaries Survey, which is conducted by the HCFA. It's an annual survey and data is available for 1991-97. It surveys individuals and collects information on beneficiaries use of all medical services, not just those that are reimbursed by Medicare. It is a good source of information on current drug coverage for Medicare beneficiaries.

The picture that we had in 1996 has changed slightly for several reasons including risk HMOs dropping some of the drug coverage. As drugs are the fastest growing component of national health expenditures, it's getting to be a bigger and bigger burden on our seniors to pay for the drug coverage. This has led to a lot of different suggestions for reform.

I do want to point out, I'm only going to be talking about the drug part of the proposals, but all of these are in the context of broader Medicare reform. Everybody thinks Medicare needs to be modernized. The Medicare benefit package needs to be restructured, as well as to use some of the private sector tools such as competition to gain more efficiencies in the system. Even though these proposals address broader Medicare reform, I'm going to focus only on the drug piece.

There are four bills that have gotten the most attention recently. I'm going to discuss and contrast them. The first one is the Medicare Modernization Act (S. 2342). This is the Clinton Administration's bill that was introduced by Senator Moynihan. The next one is the Medicare Rx 2000 Act (H.R. 4680), which is Representative Thomas's Bill. It was actually the only one that's gone anywhere. It was passed by the House, but that's as far as it got. The Medicare Prescription Drug and Modernization Act (S. 2807) is a bipartisan proposal. It was introduced by Democrat Senator Breaux and Republican Senator Frist. The last one is the Medicare Outpatient Drug Act of 2000 (S. 2758), which is a Democratic alternative to the administration's bill.

In the time since being asked to present this information, Senator Roth has introduced another bill that has a slightly different way of approaching the problem of providing drug coverage.

There are also the two presidential candidates. Vice President Al Gore basically has the same plan as the administration's plan. George W. Bush has a two-phase plan, which I'll go over in a little bit. But there is no legislative language for this, so it's just what I've been able to glean from his Web site and sound bytes and that kind of thing.

The four plans I will discuss are the administration plan, house plan, bipartisan plan, and Democratic alternative. In general, the first and the last will be very similar, if not identical. The two Democratic plans have a lot of the same features,

as do the House Republican and bipartisan plans. They are also very similar, but there are differences and I'll just point out where the differences are significant.

The first significant difference is the general approach. The Democrats want to make it a Medicare benefit, which means it would be just like home health or SNF or any other benefit. It would be subject to different rules. It would be Medicare Part D. The House Republican and the bipartisan plans want to use a private sector approach. They want insurance companies to offer stand-alone drug policies or do it through a M+C plan.

Eligibility is basically the same as for an M+C plan. Participation in all these is voluntary. No one has dared to discuss making it any kind of a mandatory benefit. But because of the amount of subsidies that are given to it, we feel that, depending on which plan and the amount of the subsidy, most if not all seniors will take the option.

In order to try to combat some adverse selection, there's a one-time only enrollment on first becoming eligible for Medicare. Now there are a few exceptions to that. For instance, under the administration plan, if you have coverage through a retiree plan, and your employer drops it, you then will have one additional opportunity to enroll. But it's very limited, in order to keep the selection issue as limited as possible.

There are two approaches. If it becomes part of the Medicare program, it will be administered by the hated HCFA. I understand we're hated even more than the IRS and that's really bad. In order to get around HCFA, the other plans create two separate agencies. The House Republican plan has a Medicare Benefits Administration and the bipartisan has a competitive Medicare agency. They're not called HCFA, but they're still, in effect, regulating agencies. Not only would prescription drugs reside there, but they would also take M+C plans out of HCFA and put them under the control of these two agencies and HCFA would be left basically with the traditional fee-for-service program.

The benefit package under the two Democratic plans has a standard package defined in statute. The other two allow some more flexibility. You can have plans with the same actuarial value and in those two plans; you can also offer some additional coverage. Now, what the plans look like. In the Clinton Administration's plan, there's no deductible. In all of the other plans there's a $250 deductible starting in 2003. Co-insurance: there's 50% up to an annual benefit limit. That's similar in the first three plans. There is a little bit of a difference in the Democratic alternative.

There's a benefit limit in the first three. Under the Clinton Administration plan it's $2,000 in 2002, which increases in $1,000 increments until it reaches $5,000 by 2008. The other two have $2,100 benefit limit in 2003. All the plans have a catastrophic cap. The administration's plan has a $4,000 out-of-pocket maximum as does the other Democratic plan but they get there in slightly different ways. The two other plans have a $6,000 out-of-pocket maximum, which is still a lot of money.

The deductible, the benefit limit, and the caps are indexed by different things. They are indexed by CPI, growth in per-capita Medicare drug spending, and in total Medicare drug expenditures. If they weren't indexed, because prescription drugs are projected to grow so much faster than overall inflation, it would become a much richer program very fast. In all the plans, they have addressed this by indexing a deductible, benefit limit, and caps by some index, which varies but it's attempting to keep the benefits at a level percentage of coverage.

The Clinton Administration bill is called a doughnut design, at least that's what those of us who are working on the estimates named it. We think it is a very strange concept. There's both a benefit limit and the catastrophic cap. In the initial plan, there wasn't a catastrophic coverage. It was subsequently added in another one of the 7,000 iterations of it. For the first $2,000 of expenses, the government pays 50%, the beneficiary pays 50%, so they have $1,000 each expended. Between there and the catastrophic cap which is up to $5,220 for 2003, it's been indexed so it's no longer $5,000, the beneficiary pays the full amount. They pay another $3,220. Once they hit the cap, they pay nothing. The government pays the full amount after that. You have coverage, no coverage, coverage. Sort of looks like a doughnut, with a hole in the middle.

Again, there's a slight difference in what would be covered. Basically, FDA approved outpatient drugs and biologicals. The Democratic plans also would cover insulin and smoking cessation drugs. They all allow the use of a formulary, but to varying degrees. How strict they are and what enforcement they're allowed to use is fairly broad. The administration uses a formulary, but it can be overwritten when medically necessary, which has been scored as the same as having no formulary at all. The other plans would allow it to be stricter, like is done in employer plans. They all allow formularies but at different levels of meanness, the correct word escapes me, but that's sort of the concept and depending on that, it would be how much savings would be attributed to that particular feature.

The only other thing I would say is that in the hole where there is no coverage, beneficiaries still get access to negotiated prices. Even if they're between the benefit limit and the catastrophic cap, they still have access to any discounts that are negotiated under their plan.

Beneficiary premiums. Under the administration plan, beneficiaries pay 50% of the program costs for the basic benefit and the catastrophic coverage is fully financed by the federal government. This is similar to the other Democratic plan. In the two private plans, the plans set the premiums. They then negotiate with whatever agency they are under. There is a 25% subsidy under the bipartisan plan, but it's included in taxable income, so there is sort of an income related premium component to that one, as there is in the Democratic alternative. The premiums are estimated for the administration plan to be $25 increasing to $50 a month when fully phased in. The Congressional Budget Office has estimated premiums in the range of $35-40 a month for the House Bill, and they have not actually done estimates of the other two.

Federal government reinsurance. There's none under the two Democratic plans, but under the two alternatives, there are reinsurance subsidies. For the House Bill, it's sort of a step function. Overall, the target is for the government to pay 35% of plans' overall cost. Under the other one, the government will subsidize 80% of the costs above the $6,000 catastrophic limit. Here's another fundamental difference. Under the two Democratic proposals, there's a premium subsidy, and under the other two, it's reinsurance for an insurance plan. There's a different concept. Hopefully the reinsurance subsidy to the plans gets passed on as lower premiums to the beneficiaries. But there doesn't seem to be wording that guarantees that.

All the plans have low-income subsidies. Basically, for beneficiaries with incomes below 135% of poverty, they will pay no premiums or co-insurance. For beneficiaries between a 135-150% of poverty, the premiums are reduced or actually, the premium subsidy is decreased on a sliding scale. By the time you get to 150% of poverty, you will be responsible for the whole premium. There's a little bit of difference in the House plan. In that plan, only 95% of cost sharing is subsidized. They felt that it was important to still have some up-front cost to try to hold down utilization. Most of the financing is through full federal funding. Even though a lot of this is done through the Medicaid program, the match rate is in fact a full federal match.

You wondered when I was going to get Medigap, right? Under the administration plan and the other Democratic plan, M+C plans are required to offer equivalent coverage to what is offered under fee-for-service Medicare. They will also, for the first time, be actually reimbursed. The capitation rate will include a payment for providing the drug coverage. In the past, if they provided drug coverage, it was done through the accelerated cost recovery system. Now they will actually have payments as part of their capitation to pay for the drug coverage, which means they can now, I guess, offer hearing aids and I don't know what else.

Under the House and the Senate proposals, plans can qualify to offer standard or actuarially equivalent coverage and receive reinsurance subsidies.

Employer-sponsored retiree coverage, this is a little bit different. The administration was hoping to avoid wholesale dropping by employers of their retiree drug coverage. Also, they didn't want to give them the same subsidy as beneficiaries receive, because of the tax treatment of health benefits, so they came out with a scheme to give them 67% of what would be the normal subsidy. If you're an employer and you maintain your coverage for each of your retirees, the government will give you 67% of the premium and you are fully responsible for those retirees' drug coverage. They do not have Medicare coverage. They still have retiree coverage.

Recently, Hewitt did a survey of its plans, which are primarily large plans, but basically the findings from that survey was that employers will likely drop their retiree coverage and wrap around Medicare. The employer subsidy isn't strong enough for them to keep their coverage. Under the other proposals, a retiree plan is treated like any other plan. If it qualifies as an acceptable plan it will receive the reinsurance subsidy.

Medigap. Under the administration plan and basically under the other Democratic plan it doesn't eliminate Plan H, I, and J. They need to be revised to make their drug benefit complement rather than duplicate Medicare coverage. Also under the administration plan, they would like the NAIC to develop a new Plan K, which will require the beneficiary to pay nominal co-payments and all or a portion of the Part B deductible. At one point they were trying to eliminate coverage of the deductible in any Medigap plan because they think it's very important to have some payment up front to deter utilization. This is what they came up with. Anybody who offered any Medigap plan would have to offer Plan K. It wouldn't be an optional offering. It would be a mandatory offering.

Now I'm going to talk about a different approach. It is Senator Roth's plan, which is called the Medicare Temporary Drug Assistance Act. It's pretty well known that no major drug legislation is going to pass in 2000. It will be amazing if it passes in 2001 because there are many areas of disagreement such as, is it private or public, who administers it, what the benefit looks like, what the catastrophic cap is, that kind of thing. But Senator Roth felt very strongly that we needed to do something at least as a stopgap measure to offer some sort of protection to low income beneficiaries. His plan is basically a grant to states to establish a program, separate from Medicaid, and to provide assistance to local income beneficiaries to obtain coverage for prescription drugs. At the state option, they can offer catastrophic coverage to all beneficiaries.

I'm going to go back just a minute, to George W. Bush's plan. He has sort of a mix of this idea and the bipartisan plan. His plan is called Immediate Helping Hand. It's $48 billion over four years to states, to provide full coverage for those below 135% of poverty. For informational purposes, that's $11,300 for an individual and $15,200 for a couple. If we're talking $6,000 or better in drug expenses, we're talking an awful lot of a seniors' income going to prescription drugs.

It also would provide some coverage for those between 135-175% of poverty and would provide catastrophic coverage for all seniors for their costs in excess of $6,000. There may be a problem with this in that it would require state legislators to do something. In some states the legislatures only meet every other year, so how quickly this could be implemented may be as slow as passing a federal law and implementing it, but it seems to be an idea that is catching on.

This phase is limited to four years. For phase 2, there's no detailed legislative language but the general plan appears to be very similar to the bipartisan plan.

Mr. Arthur L. Wilmes: With states leading the way now, rolling out some programs for prescription drug coverages, what do you see as happening to those programs if the federal programs basically take over?

Ms. Burner: My understanding that there's not going to be a maintenance of effort. They will be able to qualify for the full federal amount, even if they currently have a plan. They can make it richer. They can use the money to expand the poverty level up to 150% or 175% but they will not be penalized for currently having a program.

From the Floor: I understood that there was one other initiative and I don't know where it stands now, which was a bill to allow reimportation of U.S. drugs from foreign countries. Do you know where that stands and what that might do to drug pricing in the U.S.?

Ms. Burner: I really don't know because it affects the market but it isn't part of what I've actually looked at. I don't think it's been passed. Has it? Somebody attached something to it or tried to kill it.

From the Floor: It's been struck, but I think the characterization was veto proof.

Mr. Dale C. Griffin: Mr. Coyle, I wonder if you could comment on the impact of the outpatient prospective payment systems on our Medicare plans? There are a couple of pieces and there's some confusion on the relationship between them and that is, the effect on the services that are effected by the new payment system and then how much of our outpatient cost is effected? For example, in your example there's about 30% is of the cost of to the beneficiary as included in hospital outpatient department and then the aggregate effect was 12-13%, but in our company there's some confusion before the things really hit, as to what percentage of that 30% will be affected by the new system.

Mr. Coyle: I believe that there are two questions here. The first question is, "what proportion of the outpatient hospital expenditures will be affected by the PPS?" The second is "what impact will the PPS have on the affected expenditures?"

Referring back to Table 2, we see that in 1999 the per-beneficiary hospital outpatient expenditures were $295. Of this figure, over 95% will be subject to the new PPS.

Secondly, as referred to earlier, the aggregate coinsurance for covered services is estimated to decrease by 13% for the last 5 months of 2000 due to the PPS implementation. Unfortunately, this is not a figure that I can support with confidence for two reasons. First, it is based on 1996 services and does not reflect new technologies and shifting service patterns since that time. Also, the figure does not reflect any potential changes in the coding, volume or intensity of services resulting from the introduction of the PPS.

It's also worth noting that there is a table contained in the Academy report that illustrates the projected state-by-state impact of the PPS on beneficiary coinsurance. The projected impacts are quite variable with some states projected to realize decreases in excess of 20% and others are projected to have increases over 20%. However, the impacts are based on aggregate costs and charges trend from 1996 to 2000, whereas the local trend might be significantly different that the national trend. Mike, are you aware of any actuaries that are looking at this impact using data more recent than 1996?

Mr. Abroe: The only thing that I'm aware of is that some of the hospitals in Vermont have retained some consultants to help them understand the cost implications and I haven't participated in that. This is second-hand knowledge, but

my understanding is that they tended to support the numbers that were in the report. Vermont happened to be a state that had expected to be something over 40% increase in cost on hospital outpatient, which is why the big hullabaloo in Vermont, that everyone is looking at it. But the hospital supported research that supports the cost increase.

Mr. Robert G. Lynch: I'm a little bit dismayed looking at these plans. People are designing them and they seem to have a fairly slow learning curve. You mentioned that there is a drug plan available for Medicare Supplement in every state. Well, there is one plan listed in Wisconsin by Harvest Life, but I surveyed 20 insurance agents in Wisconsin and couldn't find one that was even aware it was being sold. I don't think they've been marketing it.

Wisconsin is one of those states that has the waiver and there the prescription drug is sold voluntary, as an independent writer, which is being proposed. The prescription drug plan is $250 deductible with 50% of the next $6,000, which is similar to what is being proposed and insurance companies have all refused to carry it. Insurance companies have not refused because they couldn't collect enough premium to cover the drugs. If you sold any insurance plan, you would find that selling Medicare Supplement and trying to sell that prescription drug rider would result in adverse selection that was so bad, that the claim costs and all the other medical costs were 50% higher. You would drive yourself out of business very quickly, which, from the structure of these plans that are being discussed, looks almost identical to what has failed spectacularly in Wisconsin in the last 10 years. When are the people in Washington going to learn?

Mr. Burner: They won't. I do know there's been a lot of discussion on whether anybody would actually offer these plans and the general opinion is that no, nobody's come forward to say that they would. That's why this is sort of a work in progress. There is the original bipartisan plan. Breaux and Frist later modified their plan significantly to allow for a fee-for-service Medicare plan and have it be the fallback as well.

Mr. Bartorelli: I just want to say that my presentation was about all the plans in all states except for Wisconsin, Minnesota, and Massachusetts. I didn't want to single out any individual state and perhaps alienate some people about one of the programs that do exist in those states, but I do appreciate the comments that we just heard.