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Panelists: LINDA FISHMAN†
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Summary: The Bush administration and Congress are working on several major health care policy issues, including a patients' bill of rights, managed care reform, prescription drugs for seniors, and Medicare reform. Panelists present the positions being staked out by the political parties, the likelihood of passage of any of the proposed legislation, and the potential impacts on the health care market of the various proposals.

MS. JAN CARSTENS: I'm Jan Carstens. I'm with Milliman USA and I'm also vice chair of the Health Practice Council of the American Academy of Actuaries (the Academy). I want to introduce a couple other people on the panel.

Cori Uccello is a Fellow of the Society of Actuaries and a member of the Academy. Cori joined the Academy earlier this year as its Senior Health Fellow to the actuarial profession's chief policy liaison on health care issues. Prior to joining the Academy, she was a senior research associate at the Urban Institute, a Washington, D.C.-based think tank where she focused on health insurance and retirement policy issues. Cori is going to be talking about insurance coverage expansions, Medicare drugs, and reform from a legislative perspective.

Our second panelist is Linda Fishman. Linda is Senior Policy Advisor at the Center for Medicare and Medicaid Services (CMS) where she is responsible for overseeing its policy direction. Prior to her arrival at CMS, she was with the Ways and Means Health Subcommittee for two years, where she was key staff for the Benefit Improvement & Protection Act (BIPA) of 2000 and the Balanced Budget Refinement Act (BBRA) of 1999. Linda is going to talk about Medicare reform from a regulatory perspective.

Note: The chart(s) referred to in the text can be found at the end of the manuscript.

Our third panelist is Rod Turner. Rod is a Fellow of the Society of Actuaries and a member of the Academy. He's vice president, director of government and industry affairs for American Republic Insurance Company. He's been active in effecting change in state and federal health care issues. He's been involved in analysis of reform proposals and development of alternatives. He has testified at state and federal hearings on health care reform and has discussed the effects of proposed legislation with legislators. Rod is going to talk about the patients' bill of rights.

Although it is true that priorities in DC have changed a little since September 11, (health care is not necessarily the top issue on the congressional agenda) the Academy is moving forward with various health care activities. They are activities associated with defined contribution (DC) plans, various Medicare + Choice and Medicare supplement products, health insurance rate filings, health organization risk-based capital, and genetic testing. There are numerous task forces of the Academy that are currently working on a multitude of issues. Rest assured that even though Washington may have focused attention elsewhere, the Academy is moving forward.

MS. CORI E. UCCELLO: I'm going to talk about insurance coverage expansions, as well as proposals to reform Medicare and prescription drug coverage benefits. Anything I say is just my opinion, and it does not reflect any official policy or view of the Academy.

In terms of insurance coverage expansion, the focus in Washington has changed dramatically since September 11. Since September 11, there has been much more focus on expanding health insurance coverage to displaced workers. I'm going to focus the majority of my discussion on insurance expansion proposals, things that were being discussed prior to September 11, in particular the debate about whether the best way to expand health insurance coverage to the uninsured was through tax credits or through Medicaid expansions. I think these issues will come back to the forefront at some point , and I think it's still important to think about these issues.

The options for providing assistance to displaced workers aren't an entirely new issue. They come up every few years. President Clinton had some proposals a few years ago to expand health insurance coverage to workers between jobs. One current proposal is to provide funds directly to states that can then use the funds to subsidize coverage for unemployed workers. These can be either new funds or unspent funds. There is also a proposal out there to provide temporary penalty-free withdrawal from retirement plan savings, so people wouldn't have to pay the 10 percent penalty if they withdraw money from their IRA or 401(k). They could take the money out and use it to purchase insurance coverage. There are also several options to increase COBRA coverage. One would provide subsidies for displaced workers to use towards their COBRA coverage. Another would expand the COBRA time limits from 18 months to either 24 months or 36 months. For those who aren't eligible for COBRA, there are options to expand Medicaid eligibility to that group.

Before we talk further about options for expanding health insurance coverage, let's look at who the uninsured are. Chart 1 reflects the non-elderly uninsured population. About two-thirds of the uninsured are in the working-age population between ages 19 and 54. Almost everyone 55 and older has Medicare coverage. About two-thirds of the uninsured are either poor, that is, they have incomes below the federal poverty level, or they are near poor in that they have income levels below two times the federal poverty level. Just as a frame of reference, for an individual, the poverty line is $9,000, and for a family of four, the poverty line is $18,000. As far as work status, nearly all of the uninsured are either work part-time or full-time, or they are in a household with a worker, either a part-time or a full-time worker. Only 20 percent of the uninsured are in households with no workers at all. So the uninsured are primarily poor workers and their families.

Options for expanding health insurance coverage include either expanding public insurance or expanding private insurance. In terms of expanding public insurance coverage, you can increase Medicaid and Children's Health Insurance Program (CHIP) eligibility for those currently eligible, but not participating in a program. It's estimated that about two-thirds of uninsured children are actually already eligible, but not participating in Medicaid or CHIP coverage. So increasing participation among those already eligible will go a long way to reducing the number of uninsured children. Another option is to expand Medicaid or CHIP eligibility to people who are currently not eligible for it. In particular, there are some options out there that would extend Medicaid eligibility to low-income adults, either parents of enrolled children or to adults, regardless of whether they have children or not. As far as expanding private insurance coverage, most of the options these days deal with extending tax credits to individuals to purchase part of an insurance coverage.

With respect to public expansion proposals, Medicaid expansions and the like, actuaries can help answer questions related to how public expansions will affect the private market. Will there be a crowding out of private coverage? Will people who already have employer coverage or an individual policy drop their coverage to take up Medicaid if they become eligible for Medicaid? What will happen to the private market as a result? These are all issues that actuaries can help answer.

In terms of the tax credit proposal, one of the most important issues we need to think about is what can a tax credit be used for. Is it available only in the individual market, or can it also be used for a worker's share of an employer-sponsored insurance plan? This is a very important question and has ramifications on what employers' insurance offering decisions are. If their workers become eligible for a tax credit that can be used only for an individual policy, will employers start dropping coverage if they have a lot of people who become eligible for that tax credit? If they do, what effects will that have on both the group and the non-group markets? In addition to whether these tax credits are available for use in the employer market, there are some options that would allow people to combine the tax credit with the CHIP lines so that families can go out and purchase a family policy in a private market.

Another question that relates to how many people would actually use this tax credit to purchase insurance concerns whether the tax credit is advanceable, whether you can get it ahead of time to use to purchase your policy or whether you have to wait until the end of the year. There's also the question, if the tax credit is based on your income level, what happens if your income level changes? How will that tax credit be reconciled? In other words, if your income goes up and you would no longer be eligible for a credit, do you have to pay some of that money back? Another issue is how much the credit is and who is eligible for it? Also, what are the income eligibility thresholds?

Let's look at a sampling of the types of tax credit proposals that are out there. Most would give about a $1,000 tax credit for individuals and about a $2,000 to $3,000 credit for families to purchase private insurance coverage. All these proposals would allow individuals in families to use the tax credit to purchase insurance in the individual market, but not all of them would allow them to be used in the employer market. The President's plan cannot be used for employer coverage; it can only be used in the individual market. Senator Jim Jeffords (I-VT) and some of his colleagues would allow lower tax credit amounts to be used for employer-sponsored coverage in order to prevent employers from dropping coverage. If you allow workers to use the tax credit for the employer coverage, this will provide incentives to the employer to keep coverage rather than drop it. If employers started dropping coverage, this would likely increase the number of uninsureds. Representative Armey (R-TX) proposes to limit employer dropping another way. He would actually penalize employers who drop coverage, by retroactively taking away some of the tax credit for employer coverage. He's using a stick approach rather than a carrot approach.

In terms of other insurance expansion proposals, there are proposals that would provide Medicare buy-in options for early retirees who don't have access to other sources of insurance coverage. There are also COBRA expansion proposals that would allow an early retiree to keep the COBRA coverage until age 65 when he or she became eligible for Medicare coverage. There are also some medical savings account proposals, as well as President Bush's proposal to expand community health centers. There are also proposals to provide a tax credit not to the individuals but to employers who offer subsidized coverage.

In terms of the tax credit proposals, actuaries can be of assistance here as well. A big question is whether a tax credit can provide enough money. Will people be able to use that tax credit to find an affordable policy in the individual market? Actuaries can also help with the question of whether employers will drop coverage in response to having their employees eligible for tax credits outside the employer market.

Prior to September 11, Medicare reform was getting a lot more attention than even the uninsured proposals. Since that date, however, everybody would agree that Medicare reform is not really going anywhere any time soon.

The big question regarding Medicare reform is whether to provide a prescription drug benefit, either by itself or in conjunction with more comprehensive Medicare reform. A lot of Democrats in particular were really for just adding the prescription drug benefit alone and then trying to address the Medicare financing problems separately, while the Republicans were more likely to favor providing prescription drug coverage in conjunction with more comprehensive Medicare reform.

As for the options for more structural Medicare reform, one idea is to simply modernize the current fee-for-service system either through selective purchasing, price negotiation, or price management. Another option is to modernize the Medicare + Choice plan. Yet another is to implement a premium support-type system. Medicare enrollees would be offered an array of plans, and the premium for their plans would be the difference between the cost of that particular plan and the government subsidy. Their premium would depend on which plan they take.

As I focus on prescription drug coverage, it's important to look at all Medicare enrollees who already have prescription drug coverage and those who do not (Chart 2). About three-quarters of Medicare enrollees do have some type of prescription drug coverage, either through an employer-sponsored plan, a Medicare + Choice plan, Medicaid, or an individually purchased plan. However, slightly more than one-quarter of Medicare enrollees have no prescription drug coverage at all. This understates the problem because even for those with coverage, not all their prescription drug expenditures are paid for by those plans. About 45 percent of all prescription drug expenditures for Medicare enrollees are paid for out of pocket, while only 55 percent are paid for through either public or private coverage (Chart 3). So there's a large portion of expenditures that are paid for by the Medicare enrollees themselves, regardless of whether they have prescription drug coverage or not.

Of the plans that are out there that would provide prescription drug coverage either with or without more comprehensive Medicare reform, the first is Senator Graham's (D-FL) plan. This plan is backed by a lot of Democrats. It would add a prescription drug benefit through a new voluntary Part D program. Cost sharing would decrease as your expenditure increased, and Part D premiums would be subsidized for low-income seniors. In effect, this is adding a prescription drug benefit to the already existing Medicare system.

There's also a Senate bipartisan plan, which has the support of Democrats, Republicans, and Senator Jeffords, the independent. It would allow people to either stay in the traditional fee-for-service plan, and receive a prescription drug benefit, or choose a modernized fee-for-service plan where Medicare Parts A and B would be combined. They would also implement an improved Medicare +Choice plan that would offer drug coverage.

President Bush has proposed in the short term to allow Medicare enrollees to get discount cards, which they could use to get discounts on their prescription drugs.

They would have to pay a $25 one-time enrollment fee. They could select a plan that they liked and then they would receive discounts of about 15 to 25 percent off of retail prescription drug prices. The legality of this plan is in question and right now it looks like it is on hold, although things have been changing a little more rapidly on that front than on some of the others.

In the long term, President Bush would like to see a prescription drug benefit available to all Medicare enrollees, and he wants more comprehensive Medicare reform. He has put forth a list of things that he wants to see included in a new Medicare plan. He wants all seniors to have the option of prescription drug coverage as a part of Medicare. He wants to see better coverage for preventive care, and he wants people to have more options. He also wants to strengthen the long-term financial security of the Medicare system, update the program, and insure high-quality care for seniors. The House Commerce Ways and Means Committee was trying to work with the President's guidelines to create the Medicare reform plan that was supposed to come out in September. It's not out yet, but part of it was going to be combining Parts A and B of Medicare.

There are questions I think actuaries can help answer here. Under a voluntary prescription drug program, how many people will actually participate? How will that vary depending on the pricing? What would happen if we combined Parts A and B? What effects would those different cost-sharing requirements have on utilization? At the Academy we are trying to work to try to answer some of these questions.

MS. LINDA FISHMAN: I'm going to give you a brief flavor of what's going on at the Centers for Medicare and Medicaid Services. I've been there for about four months. Had I known what it was like to work at CMS, I would have worked a lot harder while I was on Capitol Hill helping to write the laws, because implementation is everything. I've often said that everyone who works on Capitol Hill in a legislative capacity ought to spend at least six months at CMS because there might be a new appreciation for what the agency does.

Large-scale Medicare reform is pretty much dead for 2001. The events of September 11 have really turned the focus of the Congress away from health issues, but not in terms of Medicare reform in particular.

CMS reform continues to go on in the absence of any legislation to give a drug benefit or move to some kind of modernized structure in the Medicare program. We are going ahead with revamping the agency, trying to make it more efficient, and we're trying to improve coverage, increase flexibility for Medicaid, and stabilize the Medicare + Choice program. We have 4,600 employees and we work with 30,000 people in the states in Medicare and with CHIP. We have 21,000 private contractors who process and pay our claims, as well as 9,000 state and peer review organizations that we use to measure quality throughout those Medicare and Medicaid programs. Just the challenge of maintaining the day-to-day operations of these programs is astonishing, and, at the same time, we're trying to introduce

large internal changes to make the program more efficient. On top of all that, there have been over 700 legislative provisions since 1996 that have affected the Medicare and Medicaid programs. We are still in the process of implementing those changes, most notably the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which I'll address later. There were also a number of provisions from the Balanced Budget Act of 1997, which set up all kinds of prospective payment systems that we're still trying to create rules for.

We're also involved in the drug discount card program. We were taken to court by the retail pharmacies, and we walked into court with basically two criticisms. One is that we had characterized the program as an element in statute related to beneficiary education, and the court said that this was not an appropriate or proper framework under which to build the discount card program. In addition, we hadn't gone through normal processes of rulemaking, so the court struck us down on both counts. I can't really talk about it in great detail, but we are moving ahead on both fronts to remedy this situation.

The drug card program is a short-term solution. One should not think that the President intends to replace the need for a comprehensive drug benefit in the Medicare program with this discount card program. The discount card was an idea generated by the Office of Strategic Planning during the Clinton Administration. The last administration had shown no interest in it, and it was resurrected shortly after Tom Scully and Tommy Thompson came on board. We're in a holding pattern right now, but there still is a great deal of interest in taking this first step.

In terms of Medicare + Choice, we're trying to stabilize the program. Medicare + Choice is the foundation on which long term Medicare reform is going to be built, and unfortunately right now, it doesn't look too promising. If you look for the silver lining in the clouds, you could say that the number of health plans pulling out this year was not nearly as bad as what we might have thought, and they were not as bad as the year before. We are taking administrative actions, but much of the emphasis has been on the payment rates. The payment rates are congressionally mandated, and it's questionable what's going to happen this year legislatively in this arena.

Finally, let's talk about HIPAA implementation. We at the agency are concerned that many players in the industry are not ready to implement the series of rules. Tom Scully has taken it upon himself to talk about HIPAA first, every time he testifies in front of Congress. He's trying to elevate it to the level of Y2K in terms of the interest and immediacy that we need to have.

The secretary and Tom Kane talked in the spring of 2001 about setting up a culture of responsiveness as a basic framework for Medicare or CMS reform. They were mind-boggled by the layers of complexity, the layers of bureaucracy in both programs, and the inflexibility in both programs. As a result, they started on a march to make us a better business provider with providers, beneficiaries, and

stakeholders. First of all, they changed the name. They also reorganized the agency along our lines of business, and now we are structured into three sections. One is the Center for Medicare Management, which is the traditional fee-for-service component of the program. We also have the Center for Beneficiary Choices, which has the Medicare + Choice program and other kinds of nontraditional Medicare plans that are going to be established. The beneficiary issues, education, coverage, and appeal issues are all in the Center for Beneficiary Choices. Then finally we have the Center for Medicaid and State Operations (CMSO), which is the Medicaid portion of the program, the CHIP program, and survey and verification of various providers. We're also building a better internal management structure. Ruben King Shaw is the deputy administrator for operations. He is implementing an internal audit program. The other thing the secretary pointed out in testimony is the fact that the agency didn't have a unified accounting system. We have 64, I think, different systems. We're now on a program to implement the Healthcare Integrated General Ledger System (HIGLS), which is a single unified system for all our payment systems.

The thing I learned, which is also very frustrating to many of the new people who come on board, is that it takes us five months to make any changes in any system. This is very hard to explain to the political appointees who come on board and to the legislators on Capitol Hill who say, "What do you mean it takes you five months to do something?" We're trying to compress that time, but we face issues such as the fact that we're using antiquated systems and the fact that provider education and beneficiary education requires us to take a lot of time. Maybe we aren't so nimble, but we're actually trying to make a better go of it. The secretary also assigned key contact people to work with each state and each governor's office, who are all senior staff up in Baltimore and Washington. Actually, one of the things that we spend a lot of time on is answering letters, which I know sounds unbelievable, but it has been known to take five months to answer a letter because we have cumbersome clearance processes. The secretary has mandated that all letters to the secretary should be answered within 14 days. While that doesn't sound so difficult, in the Department of Health and Human Services, it is staggering. I was very surprised when I came on board to find out that we have a whole communications division that does nothing but track the paper in the agency and throughout the department. It's quite incredible how difficult it is to get things done, but we're marching forward and we're trying to make those things better and to be more responsive.

We're also working hard on provider outreach. This has been a big priority. We've set up nine provider outreach groups. They're called Open Door Forums, and they're meetings in which any provider group or any individual can come in and air their concerns. I'm in charge of the end stage renal disease group. We're having an open meeting in Baltimore in early November, and we expect hundreds of people to air their grievances and their compliments. We have open-door listening sessions across the nation. Tom Scully has traveled all over the country listening to various provider groups. We have in-house experts looking at ways to simplify the way we're doing things. For example, I don't know if you know what EMTALA is, but it's

emergency medical treatment in health care facilities. Providers had thought it was cumbersome and needlessly extended beyond the boundaries of the statute. We're looking at ways to simplify it. We're using some questionnaires and patient assessment instruments. We stepped up our contact with providers in terms of our contractors. We get 24 million calls a year to our contractors from providers, physicians, and others, and we're trying to standardize how we answer the questions. We have a Web site on which we post questions and answers about various policies. It gets 100,000 hits a month. So we're kind of taking things over and re-examining how we do things.

Reduction of the regulatory and paperwork burden is a major thrust in the agency on a number of fronts. The secretary has named his own regulatory reform group and is about to start looking into every nook and cranny in the Department of Health and Human Services to find ways to simplify regulations.

We are in the testing phases of producing a compendium, which would be issued quarterly and would contain all the rules that we're going to publish in the coming quarter, as well as all the rules and program memoranda so that you would have a single place to go to look to see where Medicare and Medicaid produced rules and notices. We're looking at electronic rulemaking to make that go a little bit easier. We're trying to have rules come out on a more predicable schedule. For example, Administrator Scully has said he wants to publish all regulations one day a month and right now that's the fourth Friday of every month. We're trying to be on a more predictable schedule. Tom makes the joke that you won't have to hire a lawyer for $500 an hour to look through the *Federal Register* every day. To the extent we can, we're going to try and hold to it.

We are embarking on contractor reform. The Senate Finance Committee is working on its own version of a regulatory reform bill, and contractor reform is embedded in it. I would say those reforms have the best chance of being enacted, .We have 49 private contractors who pay and process our claims. We're interested in turning that into a more competitive process. The laws currently in place are more restrictive in terms of how CMS has to deal with its contractors than any other kind of federal law.

We want to simplify it down to fewer players. We've also taken steps administratively to do some things that we can do that we don't need legislation for. For example, we moved the ACR date to September from July. We're not making any mid-year contract changes any more, and we are doing things like compiling all our policy letters into one big manual and issuing them at the same time. All of our guidances will be in one place now, and we're working with the industry to review those chapters to make our relationships with Medicare + Choice plans more predictable. We're simplifying the quality requirements as well. We're allowing private sector and Medicaid quality projects to also count as Medicare + Choice quality projects.

We have three different types of employer group waivers, and we are allowing plans to offer their plans only to employer groups. The idea is to create a more seamless transition between the under-65 people and the Medicare population so that you don't have to go shop for new health insurance or a new managed care plan when you go into Medicare. They can swap additional benefits of equal value. This is not on the core-required benefit of Medicare, but on the extra benefits. For example, you might want to get rid of a vision benefit in order to do a better benefit. As long as they're of equal value, that would be okay. Actuarial equivalence, again, would only apply to extra benefits. For example, you could raise the co-pay if you wanted to provide a higher level of benefit. These are all things that can be done administratively, and they have been received with a lot of enthusiasm.

In terms of better communication with beneficiaries, there is a $30 million ad campaign that has just started. Leslie Nielsen is the Medicare guy, and there are some print ads that have been in the *Wall Street Journal*. We also have ads done in Spanish, but they are different because they are not humorous. They advertise the fact that seniors really love Medicare, but they don't know very much about the choices they have or their benefits. They're told to call the 1-800-Medicare number. Since October 1, 2001, that number has been operating 24 hours a day, 7 days a week. After the first commercial, they got an additional 15,000 calls on a Saturday, so people have been noticing the ads. The campaign is called Helping You Help Yourself, so that the beneficiary is informed, can make choices, is aware of the choices, and can get help.

We're also looking at Web-based decision tools. We already have a lot of these on our Web site, including one that compares dialysis facilities in your neighborhood. We have something called the Personal Health Plan Finder. That is going to help the seniors choose the health plan in their area, and we'll be adding some measurement issues to improve the site. Tom Scully believes that seniors need to have a lot more information about quality. In the coming weeks, there will be an initiative from the secretary and Tom on establishing quality measures for providers and making them available to the public.

HIPAA is the last thing I want to address. HIPAA contains within it something that requires the adoption of standards for the format of health care transactions; medical code sets and standard identifiers for health plans, providers, individuals, and employers. There's a whole range of privacy and security requirements that have to apply to health data. The projection was that this was going to save the industry about $30 billion over the next 10 years after it's implemented. The problem is that the readiness of the various players in the implementation is really questionable right now. The transaction and code sets are scheduled to go into effect on October 16, 2002. The privacy rule is scheduled to go into effect in April 2003. On Capitol Hill there is a great deal of interest in delaying implementing the privacy rules. The Bush administration does not have a formal position, and we are not weighing in on it. We are prepared to administer the privacy rules as the law requires, but the states are very nervous about them. They say they're not ready. A

lot of people, however, don't want to delay the privacy rules and how that will work out is still unclear.

There are a lot of significant issues that concern CMS. For example, what is our role? We are currently writing a lot of the regulations and developing the systems that will have to be in place to issue numbers to providers and health plans, but we really don't have any resources to do it. We asked for $44 million, and we got substantially less than that. I just don't know how we're going to do it. There's $7 million to help the states, which is seen as woefully inadequate. It remains to be seen how we're going to trade off, for example, this implementation of the information system for our agency via the HIPAA rules.

Another amazing issue is that we don't know who is supposed to enforce HIPAA. Right now, the Office of Civil Rights has the enforcement responsibility for the privacy rules. It has not yet been decided who is going to do it for all the other items and who's going to do compliance. On Capitol Hill, CMS was not the favorite choice, but when we try to get all these functions moved somewhere else, everyone says, "Of course you're going to do it." Again we have no resources. The other thing is we're a covered entity under the law, so there's somewhat of a conflict of interest in terms of the enforcement mechanism versus who's going to do this. These are all being discussed at the departmental level.

Finally, there is the strategy for how to do the regulations. Do we put them out in little dribbles or do we clump them all together and put them out all at once? We're still trying to decide how to do it. My general sense is that there's an interest in putting them out as they're ready. I think that's what the industry wants. They want to know what's going to be expected of them before they have to do it. So we shall see.

MR. RODERICK E. TURNER: I am reviewing the two competing patient's bills of rights: Senate bill 1052 and House bill 2563. One was passed in the Senate, and one was passed in the House. Because there are differences between the two bills, they have to go to a conference committee. Perhaps some day the conference committee will meet and what will come out of it will be a hybrid of one of these two bills. I had thought something would have happened by now (October 2001), but following the events of September 11, it is on hold. However, I've heard that Senator Kennedy (D-MA) is still behind the scenes working with the White House to try to move this forward. Whether that will happen or not, we don't know.

Let's talk about liability issues in Senate bill 1052 and House bill 2563.

The main thing about federal liability is that they're trying to decide who can and who cannot sue health plans. This all arose from ERISA-sponsored plans that were protected from liability. The Senate bill would amend ERISA to allow health plans to be sued not only for medical, but also for non-medical reviewable decisions. The bill would exclude self-insured plans, as ERISA does, but it turns around and includes

fiduciary issuers, agents, employers, or designated decision-makers. So you may get excluded in one category and brought right back in another.

On the House side, it's a little bit different. Their bill would impose liability for denying or delaying claims, which is more what you would expect. It does exclude claims or services that are already provided. In other words, if you've been to the doctor and treatment is completed, you are excluded from the liability section.

As for state liability, both bills allow a cause of action against any person under medical review. They set up rules for who can be sued, who cannot be sued, whether it can be done in state court or federal court, or whether it's done in state court using federal laws.

When can they sue is another issue. The Senate bill allows them to sue after everything has been done and after they've gone through all their grievance procedures. The House bill says it can happen prior to a grievance procedure being completed. Both have a provision where if a person can show that irreparable harm will happen to him or her if something doesn't happen right away, he or she can get that into court, which I think all of us would agree is a good thing. The most common situation would be that in which somebody is suffering from a very serious health condition.

Damages is another issue that you hear about all the time. Both bills have caps. The Senate bill has no cap on damages. The House bill has no cap on economic damages, but it caps non-economic damages. Both provide for punitive damages awards, but they're arguing over numbers.

As for the scope of the bills, they will apply to any type of health carrier, whether you're providing individual insurance, group insurance, small group insurance, self-funded insurance, or ERISA plans. They're trying to drag everything in. There is a fee-for-service exclusion from some of the access requirements in the Senate bill, which means if you have a pure indemnity program, you will be excluded from some of the access requirements. I'm not sure that that exclusion is really worth much at this point because if you have that type of program, you're not going to be doing those things anyway.

The Senate bill would apply to all the federal programs out there. The House bill would apply to a federal program only if the President issues an executive order to that effect.

As for utilization review, both bills would define utilization review in broad terms. They set up federal standards for conducting utilization review. They also limit the frequency of utilization reviews, so that there would be more rules on when and where you can do utilization review in your program.

All of the things I've discussed here will affect your pricing. If you have greater

liability exposure, you're going to have to take that into consideration. If you have different ways that you can do utilization review, it will affect not only the types of programs that are going to be offered to people, but also the pricing that we have to do as actuaries.

The bills get very specific in how and when you can do internal and external appeals. They lay out a lot of definition about the time frames in which appeals have to be done. They define a medically reviewable decision. One controversial provision in the Senate bill is what's called the "not bound by" language. Both bills would set up a review panel, which would review your company's decision. But the Senate bill provides that the panel can reverse the decision of the company and require you to do it differently. It can actually modify the coverage or denial, which means that it can require you to apply these other procedures to this person, who may or may not be in your contracts. In other words, they can actually cause extra-contractual benefits to be provided to the person based upon their decision. On the House side, it's very similar except that it does not have the "not bound by" language in it, which means that the review panel can only uphold or reverse a denial.

The bills list the procedures for appeals, certification, qualification, and review. They have extensive language as to what you have to do under an appeal procedure.

Neither bill allows gag clauses. In certain situations, it has been claimed that HMO providers were told not to recommend certain providers, practices, or protocols that were out of network. In other words, they couldn't recommend people to go to some other provider or to get some other type of treatment outside of their network. Both of these bills disallow gag clauses and say that providers should be able to tell patients about any type of treatment from any type of doctor, any type of provider that's available, whether or not it's directly covered under their programs or not.

The bills also lay out access-to-provider rules. These are more for plans that limit access to providers. The bills also regulate the rules about having to have a gatekeeper.

Both bills define situations in which care must be provided when a provider terminates your network. It may set up a federal level of coverage or access to handle these situations. If you already have something in your state that defines this, you may now get a federal rule that comes in over it. It may be considered a floor; it may not be considered a floor. It may cause things to change. It's one of those issues that's going to have to be worked out over time, whether the state or the federal laws really apply here. Some people question whether we need a federal law since most states have bills like this right now. So this is an issue you're going to have to watch out for, for any kind of contradiction in your processing.

On the subject of drugs and formularies, how do you determine what drugs are in

your formulary? The bills require provider participation in developing a formulary, which means you have to have a drug provider in your panel to help you determine what drugs should or should not be in your formulary. It means that as companies, if you don't have this already, you're going to have to either go out and hire somebody to do it or work with a PBM that has hired someone to develop this panel. You're going to have to know who the panel is. They're going to have to qualify to do these things. Both bills here are pretty much the same on this point.

The Senate bill has no provision for association health plans (AHPs), but the House bill does. Basically, it allows for the federal government or the secretary of labor to set up a federal certification to multiple employer health plans, removing it from the state certification process. Certainly some of the states are a little concerned because they have traditionally had laws to rule these association health plans. They must be sponsored by a trade association that was established for non-insurance purposes.

The AHPs can be self-funded. They can exempt themselves from state-mandated benefits. The theory is that the AHP should be able to come in with a lower cost because of the lack of state regulation, a lack of the mandated benefits, and the preemption from state form filing. There's some concern because of a potentially unlevel playing field. If your plan has to compete with one of these, and you have to provide all the state-mandated benefits, it's going to be difficult to keep a price that's on a level playing field with the AHPs. If it passes, it's certainly going to force all of us to take a look at the plans and how we approach things, particularly whether or not we must get into this type of a program if we're going to compete. We already have medical savings accounts (MSAs) out there, but they're really limited to the small employer and the self-employed. The House bill would open MSAs up to everyone: individuals, large employers, and the self funded. Right now, it's a temporary program, but the bill would make them permanent. Companies are a little bit reluctant to get into a program if they don't know whether it's going to be permanent or not, so this would help us as insurance companies by giving us some certainty. The bill would change things like the maximum contribution to the MSA—it would be increased to equal the deductible amount that you have each year. It will allow both the employer and the employee to contribute to the MSA in the same year. Right now that cannot be done. It lowers deductibles. It opens up some PPO options. It would allow you to offer it under a cafeteria plan. These changes would make an MSA program more attractive to companies and to many people.

MR. JOE TORNEY: I think you're aware of this, but I just want to re-emphasize the critical nature of fixing the Medicare + Choice plans. I know fewer plans have dropped out this year, but I think it's hitting a very critical point. Moving forward, I'm not sure how much longer that program can last the way it is. My quick question is, do you see the APR deadline being September for next year?

MS. FISHMAN: I believe personally that it will be. We're trying to get legislative change. The situation on the Hill right now is basically that if there's not bipartisan

agreement on something, you're probably not going to get it, but the administration has asked for it and we're working on it. With respect to your point about Medicare + Choice plans, I was on the Hill last year when the policy for the smaller cities and rural areas was formulated, and I know that it's hard for plans in areas with the minimum update to make it. The problem is that something else is too costly because that's where all the people are. To be a predictable business partner, one would need to lay out the strategy of payment increases for three to five years. It's going to be too costly. There's nothing we can do.

FROM THE FLOOR: Right. It's got to be difficult to have Medicare + Choice be the foundation of the future.

MS. FISHMAN: I understand. There have been comments on the Hill that if Republicans want to give Medicare + Choice money, there's going to have to be a dollar-for-dollar match in other areas, and it quickly blows up into a big giveaway bill that I don't think anyone wants to do this year.

FROM THE FLOOR: Many people believe that Medicare + Choice is basically a flawed program and that it really needs to be totally redesigned if you want to bring in the private market place in its entirety. Can you comment on whether or not that's the attitude on the Hill?

MS. FISHMAN: I know that my boss, Tom Scully, has often said the system's broken; it needs to be redesigned. When I was on the Hill the past two years, we recognized that what they were trying to do in 1997 was difficult, plus it's the notion of reducing variations and increasing spending at a time when we took out $115 billion. We would be interested in looking at proposals to redesign it. Congress supposedly wants to go to a competitive model, but it's hard to introduce the element of competition because at some level one has to ask the question, do any provider groups really want to compete with each other? We have to provide the right incentives and the right model to actually get to that point. So far, I haven't really seen a comprehensive redesign plan, and certainly it's not a legislative priority this year.

MR. GRAHAM COX: I look at this from the employer perspective as opposed to the insurer perspective, and it seems like there are a lot of factors right now that are encouraging employers to get out of the health care market entirely. The expansion of medical spending accounts, the introduction of liability under the patients' bill of rights, and the cost increases of 15 percent or so on health care bills are all encouraging employers to get out of the health care market. What would the reaction be from a government standpoint? How do you anticipate employers will respond?

MS. UCCELLO: On the question of how employers will respond, I think that there are two groups of people. About 70 percent of the people who have insurance have it through the workplace, so I'm not sure that the people want to try to stop

employers from offering coverage. You can see from some of the proposals to provide tax credits that some of them have incentives so that employers will keep offering their coverage. I think there's a big fear that if employers stop offering coverage, even with these other opportunities to purchase insurance coverage, that you'll actually see an increase in the number of uninsured rather than a decrease. On the other hand, there are some people who think everything should be done in the individual markets and that it would be okay if we got rid of the employers and let people have choice. They like the idea that they would not be tied to what their employers say that they should have. There are some rules on the right and the left that will either help sustain the employer market or help bring it down. There's more than one answer to that question. I would actually be interested in hearing from benefit consultants on what goes into an employer's decision-making process on whether to offer coverage and whether some of these incentives to keep employers offering coverage will work.

FROM THE FLOOR: I have a question about the prescription drug coverage for Medicare enrollees. We're in the individual Medicare supplement market, and most coverages in the 1980s provided at least some options with respect to prescription drugs. They tended to work fairly well. With the implementation of the standardized plans and the open enrollment requirements, more companies either chose not to provide the prescription drug plans under the open enrollment requirements or got hurt by doing so. There are very few companies that offer the prescription drug plan because of the open enrollment requirements. Is there any discussion about exempting the prescription drug plan from the open enrollment? That's probably contrary to politicians trying to increase coverage, but I think it would be a way to actually increase the individual Medicare supplement coverage of prescription drugs.

MS. FISHMAN: Last year Representative Bill Thomas (R-CA) passed a drug bill on the floor of the House. I'm trying to remember if that was an element of the bill. I know that at least he used to talk about having to buy a lot of things in those policies that you might not want and that maybe drugs-only would be a good idea, for example.

MR. TURNER: That's an interesting concept because it could be done similar to the individual marketplace where in many states we have high-risk pools for people who can't qualify. That could be something where I know you could work with the drug companies who have offered in some instances to help fund some very catastrophic programs. It could be an underwritten drug program and then for those people who can't qualify, they could go through some kind of a special program that is set up with a special funding mechanism. There are a lot of people who receive Medicare benefits or Medigap-type benefits that supplement drug benefits and medical benefits through their employers or through the federal government, and nobody wants to lose that funding source. This might be an easy way to get to it, just say here's the special program.

MS. UCCELLO: Remember these are items from last year. The federal government,

if they have to pick up some of those people, wants the private markets and all of its variety involved.

MS. CARSTENS: It does seem to me that there's going to be less money available for anything related to health care. The monies are going elsewhere at this period of time. I'm wondering if there's been discussion regarding where the money is going to come from or if we're just kind of coasting for the next couple of months.

MS. FISHMAN: I haven't followed the appropriations bills that closely, but a colleague of mine said they're shoveling money out the door for things like bioterrorism and public health. We're looking at doing everything our budget-neutral way. We've had discussions in White House—small policy meetings about where to get the money from for next year. It's conceivable we could get back to the old deficit role where we actually have to pay for everything we do.

Chart 1

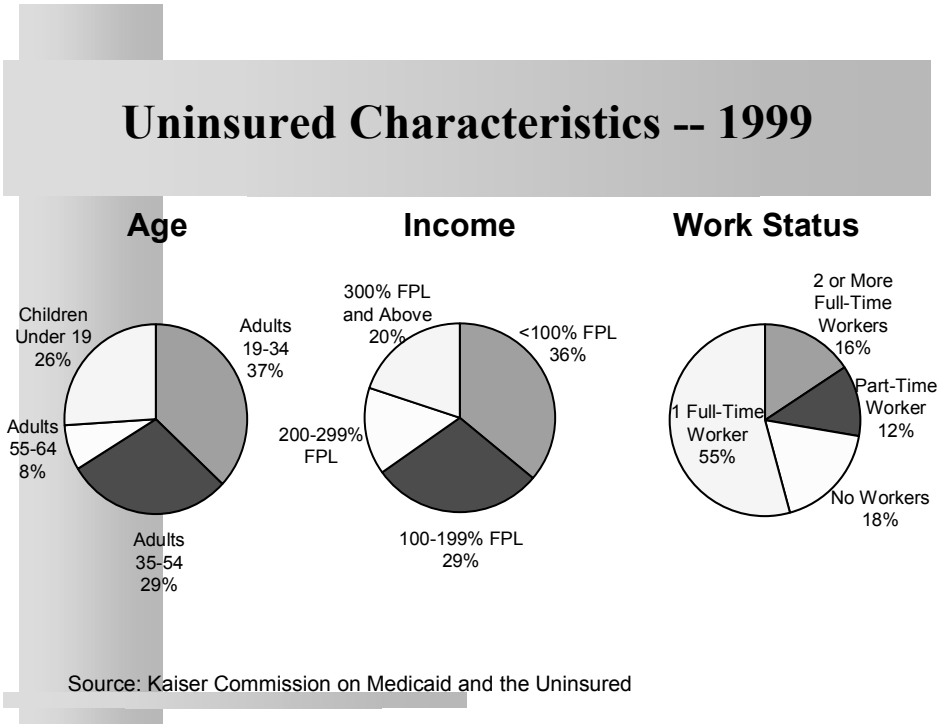


Chart 2

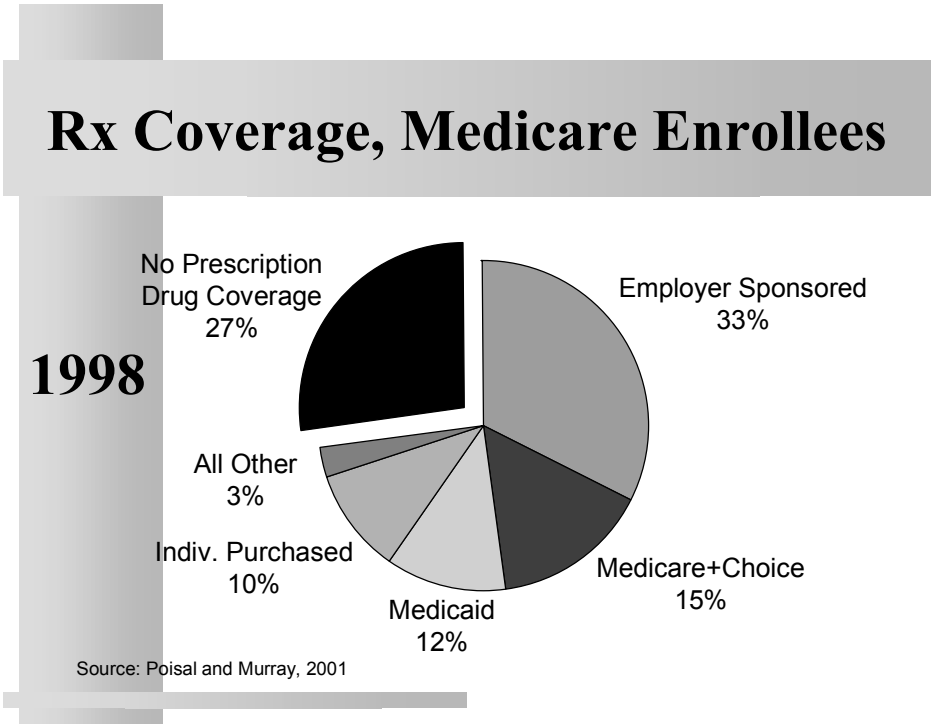
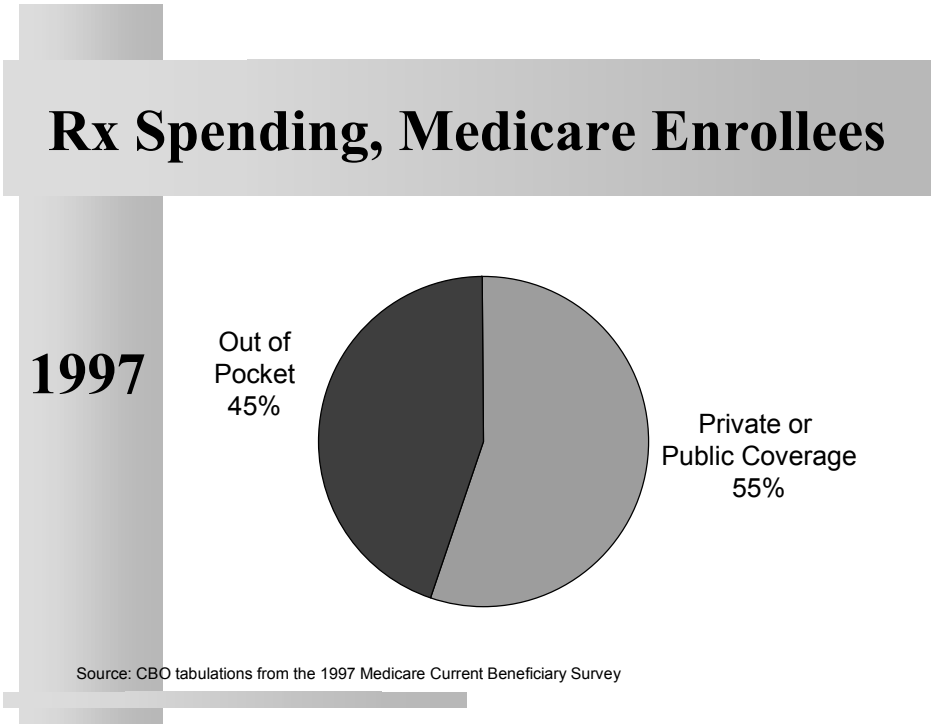


Chart 3


Rx Spending, Medicare Enrollees
1997
Out of Pocket 45%
Private or Public Coverage 55%
Source: CBO tabulations from the 1997 Medicare Current Beneficiary Survey