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Session 5PD
Medicare Reform

Track: Health

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Summary: Comprehensive Medicare reform has been an ongoing issue in Congress and the White House. Financing and solvency concerns, changes in eligibility and benefits, and the addition of a prescription drug benefit have all been part of the public discussion. Attendees gain a better understanding of the key issues in the Medicare reform debate and the direction of future change.

MR. MICHAEL JAMES THOMPSON: The issues confronting Medicare are huge. They are complex. They hit us in a lot of different ways. They affect our industry, our country, and our parents. I think is a very important and timely topic. Realistically we haven't seen the end of Medicare reform. There's a lot of that's going to be happening. What we've tried to do in terms of this panel discussion is to give you multiple angles on the impact of Medicare. What's being considered in Washington? What are the implications for health plans? What are the implications for employers?

With that background let me start by introducing the panel. To my left is Cori Uccello, who is a fellow in the Society. She is also the senior health fellow for the American Academy of Actuaries, which makes her the chief policy liaison on health care issues, and she does congressional briefings to staffers and prepares testimony on Medicare drug reform and other health policy issues. Prior to her position with the Academy, Cori was a senior health research associate at the Urban Institute, which is a Washington, D.C., think tank, where she focused on health and

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

retirement issues. She's authored a number of publications on health policy, health care reform, coverage of pre-Medicare adults, workers without employment insurance, and other types of activities. Cori's going to give us an overview of what actually is happening in Washington, and she is so close to it that she is aware of things that have changed even in the last week.

Kevin Rease will be the second speaker. Kevin is an ASA, a member of the Academy. He is a consultant in Atlanta with Reden & Anders, with 18 years of experience. He has extensive experience in pricing, provider contracting arrangements, Medicare + Choice design, adjusted community rating (ACR) preparation, and risk adjustment. He was previously with an independent health care consulting firm that specialized in the areas of actuarial services, managed care education and operational management. He's been a consulting actuary for Kaiser Permanente and also served as an actuary for a number of the Blue Cross and Blue Shield plans. He was a member of the American Academy of Actuaries' Task Force on Expanding Choices for Medicare Beneficiaries, and he's currently a member of the Terrorism Extreme Events Work Group. He has over 18 years of experience in the health care industry, with the last 10 specifically in managed care. Kevin is going to focus on the impact of Medicare reform on health plans and particularly the Medicare + Choice-type program.

My name is Mike Thompson and I will follow Kevin. I will focus on the employer's perspective as it relates to Medicare + Choice. I am a fellow of the Society, and a member of the Academy. I am also a member of the Health Practices Committee, the Federal Health Care Committee, and the Medicare Committee of the Academy and have testified before the Senate Finance Committee on improving Medicare choices. My primary role is to advise health care purchasers, major employers, on things like consumer-directed health care, disease management, defined contribution retiree health, process excellence, and vendor management strategies. My clients include companies like American Standard, Honeywell, the Mellon College Retirement Project, and the National Consortium for Health Care Process Excellence.

REFORM: WASHINGTON UPDATE

MS. CORI UCCELLO: I'm going to talk about Medicare reform from the viewpoint of Capitol Hill, and this is the third time in the past year I'm giving this talk at an SOA meeting. I'm going to set the stage, talk about Medicare's financing problems and how the benefit package is out of date. Then I'll go over what's happened in the past year and try to give a little perspective on how the debate has evolved over time. Then I'll talk about what's going on now and talk about some of the specific legislation that's out there. Although I am going to talk about specific legislation, I do need to give my usual disclaimer that the Academy does not take positions on specific legislation. My comments today reflect my own thoughts and do not represent any official statements on behalf of the Academy. Every time you go to Washington you'll hear that same kind of talk from everybody who speaks.

Medicare is suffering from some financial problems. According to the best-estimate assumptions of the 2002 Medicare Trustees' Report, Medicare expenditures will begin to exceed non-interest income in the year 2016, and the Medicare trust fund will become insolvent in the year 2030. If action were taken today, restoring solvency over the next 75-year period would require either a 38 percent cut in Part A benefits or a 60 percent increase in Medicare payroll taxes or some combination of the two. Delaying action would result in even more onerous remedies required.

There are three general approaches for dealing with Medicare's financing problems. The first is to modernize the current fee-for-service system, and that could be done either through selective purchasing, negotiated pricing, case management or other utilization management techniques. Another option is to modernize the Medicare + Choice system, and this would usually entail competitive premium pricing. The third approach is more of a radical structural change to the current system, and that would be to implement a Federal Employees Health Benefits Program (FEHBP) type of premium support system. This was touted in the 1999 National Bipartisan Commission on Medicare Reform. They couldn't actually recommend this because they needed a supermajority to agree to this, and they couldn't get that, but they did quasi-recommend that. In this type of system, beneficiary premiums would be based on plan cost. Beneficiaries could choose from an array of plans. If they chose plans that cost more, they would have to pay higher premiums. If they chose lower-cost plans, they might not have to pay any premiums at all. So those are the financing problems and how to deal with them.

Now we'll talk about the benefit package and how it's somewhat out of date relative to when it was implemented back in the 1960s. The first and most significant problem with the program is that, generally, Medicare does not cover outpatient drugs, and more than one-third of enrollees do not have prescription drug coverage. Looking more closely at where beneficiaries do get their coverage, they can get it from a variety of sources, including an employer-sponsored retiree health plan, a Medicare+ Choice plan, a Medigap plan, or a Medicaid plan, or some other type of plan. Nevertheless, about 38 percent of Medicare beneficiaries have no prescription drug coverage at a given point in time, and this number is likely to increase in the future as retiree health plans are dropped, as Medicare + Choice plans leave the market, and so on, and even those people who do have coverage, the generosity of that coverage is likely to decrease in the future as co-pays and other cost-sharing increases for prescription drug coverage.

Looking at how much prescription drugs cost, the Congressional Budget Office (CBO) estimates that prescription drug spending by the Medicare population will total $87 billion this year and will more than triple to $278 billion by the year 2012. Total spending over a 10-year period, from 2002 to 2011, is estimated to be $1.6 trillion. Jumping ahead a moment, it's important to keep in mind this $1.6 trillion when we look at how much Congress is actually going to spend to fund a benefit. They're talking about spending between $350 and $500 billion over the next 10 years. That's not even one-third of the estimated total spending on prescription

drugs. The increase in drug spending is not due solely to the increasing number of Medicare beneficiaries. On a per-enrollee basis, spending on prescription drugs will grow nearly twice as fast as Medicare spending. Another reasons for spending is that each individual senior has higher utilization, gets more prescription drugs. Also, the price of the drugs is going up, and new and more costly drugs are being introduced.

The other weakness of the Medicare benefit package is that there's no limit on beneficiary liability. Medicare does not cap out-of-pocket payments. Medicare does have deductibles and co-pays, and on one hand, these can create barriers to access to care, especially for those with low incomes. On the other hand, people with supplemental coverage, a retiree health plan or a Medigap plan, that covers those deductibles and co-pays, don't have any incentive to seek cost-efficient care because they don't actually see them. So, there are problems with the co-pay and deductibles whether they are filled in by other insurance or not. Current Medicare reform proposals attempt to address Medicare's financing problems and/or the weaknesses of the current benefit package.

What's been going on over the past year or so? In the spring of 2001, the first time I spoke on this, the key issue was whether to add prescription drug coverage alone or in conjunction with more comprehensive reform, and, if it was more comprehensive reform, whether to take the route of the modernization of the current fee-for-service and Medicare + Choice plans or whether to implement a more structural premium support-based system. At that time, the Republicans favored more comprehensive reform, and the Democrats favored adding prescription drugs only or just a modernization to the current system. Prior to this spring, the Republicans controlled both Houses of Congress, and any momentum at that time was for more comprehensive reform. Then, as we all know, in May, Senator Jeffords (VT) left the Republican Party, giving control to the Democrats, which changed things, and now you had interests diverging between the House and the Senate, and the outlook at that time was that agreement was very unlikely.

Then in fall of 2001, the key issue was whether to add prescription drug coverage only or in conjunction with more comprehensive reform. Parties were either introducing their bills or planning to do so. But as we all know, on September 11, priorities shifted. Medicare reform was no longer at the top of the agenda, and instead Congress was focusing on the stimulus package. In addition, the shrinking surplus meant that not as much money was available for adding prescription drug coverage anyway. In any case, there wasn't much agreement on what direction to take. There was very little likelihood of anything being passed last year, and, indeed, nothing really happened.

Here we are in spring 2002, and that issue of whether to add prescription drug coverage only or in conjunction with Medicare reform has shifted toward adding prescription drug coverage only, although some of the House Republicans are in

disagreement themselves on how far to go down the Medicare reform route, but the focus is on just the prescription drug aspect of Medicare reform.

Both the House and Senate budget resolutions include money for prescription drug coverage and Medicare reform. The Senate has allocated up to $500 billion for this, and the House has allocated up to $350 billion. Last week both of those bills were introduced, and I'll talk a little bit about what those bills include. As far as the plan design of the prescription drug component of the Senate Democrat bill is concerned, it would have a $25 monthly premium. There would be no deductible. There would be co-pays that depend on the drug. There would be a $10 co-pay for generic drugs and a $40 co-pay for brand name drugs. There would be an out-of-pocket maximum of $4,000, after which the government would pick up the entire tab. Low-income subsidies would be included. The premiums and the cost sharing would be free for people below 150 percent of the poverty line and a sliding scale down to zero subsidies for those with incomes of 175 percent of poverty. Just to give you an idea of what that means, 150 percent of the federal poverty line is about $17,000 for a couple.

The CBO just estimated that the monthly premium of the House plan would be about $34. The deductible would be $250, and the cost sharing would increase along with drug spending. Beneficiaries would be responsible for 20 percent of their costs, up to $1,000, and then 50 percent of cost between $1,000 and $2,000. They would be responsible for all of their drug spending until they reached an out-of-pocket maximum, which is $3,800. To reiterate, the beneficiaries would be responsible for all of their drug spending between $2,000 and this out-of-pocket max, and you'll hear this referred to as the hole in the donut. It's the gap in coverage for that plan.

In terms of coverage provision and risk-bearing under the Senate plan, pharmacy benefit managers (PBMs) and/or other entities would be established in various regions to manage the benefit, and the risk would be shared between Medicare and the PBMs. Under the House plan, they rely on private insurers to provide a drug-only benefit, and the risk would be shared between insurers and Medicare.

That's the basic structure of the prescription drug benefit. The House plan does have some other features. Compared to current law, the plan would increase payments to physicians, hospitals and other Medicare providers. It would also increase payments to Medicare + Choice plans and would delay the onset of the lock-in until 2003. This provision was actually enacted as part of the bioterrorism legislation a couple weeks ago. It would also extend the plan reporting deadline for Medicare + Choice plans.

There are also some options being forwarded on reducing prescription drug prices. One proposal would allow reimportation of drugs from Canada. Similar legislation was passed a few years ago under the Clinton administration, but it was not enacted into law. The fear was that the Food and Drug Administration could not

guarantee the safety of the drugs that were reimported. So this legislation limits the reimportation to Canada with the thought that they're probably more safe from Canada, but I believe that that would be vetoed if it was passed. Another proposal would ease generic drug market entry. Another would limit the tax deductions drug makers can take for marketing cost. And yet another would allow states to extend drug discounts that they receive under their Medicaid program to non-Medicaid beneficiaries. Last year President Bush introduced the drug discount card. The courts said that he couldn't do that just by government fiat, and so the House Republican plan was going to include the drug discount card as part of its proposal. I haven't seen any actual legislation, so I'm not sure if it's included.

What's the bottom line? At this point, even policymakers agree that there is little likelihood that anything's going to be passed this year. I think both the House and the Senate, Republicans and the Democrats, differ quite a bit on how much to spend on the prescription drug proposal component and how to structure the benefit. However, I think the give-back portions of the House bill, that is, the increasing payments to providers, the hospital, physicians, and so on, may have a better chance of passage.

While I'm here I just want to put in a little plug for the Academy. Over the past several months Holly Kwiatkowski, the Academy's health policy analyst for federal issues, and I have been getting a lot of calls from Hill staffers on both the Senate and the House side. We serve as a resource to them when they're trying to put together their bills. They were trying to run things by us on how things would work, looking at the risk-sharing components of it, the benefit design and things like that. And then, if we can't answer those questions ourselves, we try to find actuaries who are members of the Academy who can help us talk to the House and Senate staff to help them put together better legislation. So I wanted to say if anyone in the room feels that they can be helpful in this regard, we'd really love to get more volunteers who can help us with this, and afterward you can either see Holly or myself. We'd love to have you. We keep going to the same people, and I think they're going to start hanging up on me.

MEDICARE + CHOICE REFORM: THE MCO'S PERSPECTIVE

MR. KEVIN REASE: I'm going to discuss Medicare + Choice reform from the managed care organization's (MCO's) perspective. Some points that we want to keep in mind as we go through this discussion is what Medicare + Choice is, why post-Balanced Budget Act (BBA) reform is needed, what post-BBA initiatives have been considered already, and then, lastly, what proposed Medicare + Choice payment system reforms are currently being considered.

The Medicare program was established in 1965 as part of the Social Security Act, and it was intended to provide health care benefits for seniors, but then it was later amended to include disabled persons as well. The Centers for Medicare and Medicaid Services (CMS), as we know them now, is the entity that was established

to administer the program. Then under Section 1876 of the Social Security Act, a "Medicare Risk" managed care option was initiated. What payment methodology did Medicare Risk use? The method was based on a per-capita payment that was disseminated to each Medicare Risk program or plan, and it was based on 95 percent of the county-specific fee-for-service Medicare costs, and these payments were better known as the adjusted average per-capita cost (AAPCC).

At times, federal officials looked upon this program and felt as though too much money was being made by plans, but many of the plans will beg to differ in that they were receiving only 95 percent of the fee-for-service amount. On top of that, they would have to incorporate administrative costs as well. There was a bone of contention in this area. Were there problems with the Medicare Risk program? Obviously there were, because they created a new plan to counteract it.

Three major problems that were included as part of the payment methodology were inequities between the AAPCCs on a country-wide basis, and then also for particular counties that had a higher AAPCC, plans in those service areas could offer a richer benefit package, whereas plans in the lower AAPCC regions were at a disadvantage. Finally, the AAPCCs fluctuated so widely every year, that caused a problem as well.

In response to these problems with the AAPCC methodology, a new and improved program was established called Medicare + Choice. Under the BBA of 1997, as the health policy centerpiece of the BBA, the expanded private-managed Medicare option to Medicare beneficiaries was what we see today. Congress specified reasons for starting the Medicare + Choice program, such as, "To allow beneficiaries access to a wide array of private health plan choices and to enable the Medicare program to utilize innovations that have helped the private market contain cost," and, of course, the almighty dollar, they thought they could save $116 billion between 1998 and 2002, and we've come to find out that that has not happened.

Chart 1 illustrates the reasons why Medicare beneficiaries join managed care plans. Take a look at the dark blue wedge. It talks about better benefits. This is saying that Medicare beneficiaries, when they choose their managed Medicare plan, 25 percent will choose based on better benefits, but, going a step further, if you look at the green wedge, we see that 40 percent will choose a plan based on cost, which isn't too surprising when you understand that 60 percent of all Medicare beneficiaries have incomes of $20,000 or less, and that's close to poverty level. Cost is really a primary driver for Medicare beneficiaries.

Keys to a successful Medicare + Choice organization include effective provider contracting, reasonable administrative expenses, efficient medical management, critical mass of membership, a competitive benefit design and adequate CMS revenue. These six keys must be in proper balance. If one of these is out of balance, then there's a problem. We'll focus most of our attention on reforms that are related to revenue or the CMS payment.

Let's take a look at the overview of the Medicare + Choice payment formula which most of us are already familiar with. Under the BBA of 1997, payments to Medicare + Choice plans were the greatest of three possible payment rates by county: 1) A minimum floor rate; 2) a minimum annual percentage increase over the previous year's rate that's been set at two percent; and 3) a blended rate that reflects a mix of the local and national rate, with the caveat that tier three is subject to a budget neutrality adjustment that is able to take a total of Medicare + Choice spending, and it must equal what HCFA would have paid to plans if only the local rates had been used.

Why was post-BBA reform needed? Primarily what we're seeing is that as a result of Medicare + Choice plans reducing their service areas or reducing benefits or increasing member cost-sharing, we had a number of plans that entirely left the program. This, in turn, caused Medicare beneficiaries to enroll at a slower rate, and, in fact, quite a few beneficiaries left their programs, and it wasn't their fault because plans weren't there. We also had very few plans come back into the program. That's a problem as well. Chart 2 illustrates the decline of Medicare + Choice contracts over about a three-year period. You'll notice is that there is an increasing decrease in the years as the plans are leaving. If you look at year 1999, we have a net of 36 plans leaving. In 2000, we have a net of 43 plans leaving. And then in 2001, we have a net of 88 plans leaving. Over a three-year period, over 160 plans left the program. That's a significant statistic. Chart 3 illustrates what has happened to enrollment over this period of time. There was a peak in 1999 of 6.3 million beneficiaries under the program. That decreased to 5.6 and then an estimated 5.0 million this year.

Plans have been experiencing payment inequities between urban payment areas and rural payment areas. Primarily the biggest problem with this whole program is that Medicare + Choice payment increases are not keeping pace with Medicare + Choice plan medical expense trends, as I'm sure a number of you are very familiar with.

Let's take a look at our first example in Table 1. If you'll notice here, we're looking at two counties in Florida. We have Dade County, which includes Miami, and we have Alachua County, which includes Gainesville. Taking a look at the 1997 payment rate, we compare the two, and we see that there is a $300 per-member-per-month difference between Dade and Alachua. Five years later we look at the difference in the payment rates, and it's over a $320 difference. By the way, this is just reflective of the aged population. Over five years we have a 12 percent increase. Then on the medical expense side, and we use an aggressive assumption of five percent annually, you see quite a bit of difference here. We see what the problem is, and why many plans are dropping out. It just doesn't make financial sense.

Table 1

Example #1

Florida County	1997 Payment Rate	2002 Payment Rate	5-Year Increase	Medical Expense*
Dade	$748.23	$834.20	12%	28%
Alachua	$448.77	$512.99	14%	28%

* Assuming an annual medical expense trend of 5%

Under the Balanced Budget Reform Act of 1999 (BBRA) and the Benefits Improvement Protection Act of 2000 (BIPA), we had seen that increased payments were implemented primarily in rural counties or the low-payment areas, and this was an attempt to stimulate growth in the particular small counties, but, unfortunately, the attempt at stimulating that growth did not happen. Our next example in Table 2 bears that out. We're looking at three counties in New Mexico—Bernalillo, Los Alamos, and Santa Fe. Looking at their 2000 payment rate, we had $430, $423, and $403, and then in 2001—this was as a result of BIPA—their payment rates went up substantially. This was a result of the bump-up in the floor payment that was implemented in March of 2001, and we see it had a significant effect on some of these smaller counties: 20 percent in Bernalillo, 10 percent in Los Alamos, and 15 percent in Santa Fe.

Table 2

Example #2

New Mexico County	2000 Payment Rate	2001* Payment Rate	Increase
Bernalillo	$430.44	$525.00	20%
Los Alamos	$423.74	$475.00	10%
Santa Fe	$403.79	$475.00	15%

* Post-BIPA

What those payments would have been without BIPA, the payment in Bernalillo County would have only been about $439, which is a very, very big difference. Los Alamos was $432, and Santa Fe would have only been $415. So, that helped those counties very much. Just to reiterate the point that the reforms that were in place under BIPA and BBRA addressed those small counties, but, unfortunately, most of the Medicare + Choice beneficiaries are in urban counties, as this bears out. Forty percent of all Medicare + Choice enrollees are in these five areas: southern California, northern California, southern Florida, Philadelphia and New York City. These all make up about two million members, and there are five million total beneficiaries in the plan.

Another area of concern that we've seen is that many plans have been having difficulties in their provider contracting area when they go to contract on a yearly basis. I know we personally at Reden & Anders have noticed that with some of our Medicare + Choice plan clients that providers seem to be less willing to go into risk arrangements, even though they've had risk arrangements in the past. We've also seen providers pressuring plans not to lower their schedules. The results are being reflected because we see decreasing physician reimbursements and also the development of the prospective payment system.

What are some of the initiatives? I'll discuss briefly some of the sections of BBRA and BIPA that pertain to payment reform. We've got enrollment rules and then the phase-in of risk adjustment. Risk adjustment is another area that plans are baffled by sometimes. With the current risk adjustment methodology, the principal

inpatient diagnostic cost group (PIP-DCG), many plans feel that it's inconsistent with the idea of managed care and that the idea of managed care is to be as efficient as possible, to have lower hospital admissions if necessary, and also lower cost by lowering the number of days, but under this program, plans get rewarded for hospital admissions, which, from a plan's perspective, doesn't make a lot of sense.

The next area is bonus payments to smaller counties, user fees for Medicare + Choice organizations, and then again BIPA where the increase in the floor payments went up, and then this was just for the year 2000. There was also a 3 percent minimum increase for 2001, instead of 2 percent. Table 3 shows the beginning of the plan in 1998 through 2002 and how many plans had the floor payment, the blended payment or the minimum increase, and we notice that over the first couple of years about 35 percent of plans got the floor, and 65 percent or so got the minimum increase, and none got the blend. We see one anomaly in 2000 where 63 percent of the plans got the blended payment, and that was because that blend is tied to an increase in the national growth rate, which happened to be a little higher than normal. But ever since BIPA, we see that approximately 70 percent of plans are getting the floor payment, and 30 percent are getting the minimum increase. Chart 4 bears out that a percentage of Medicare + Choice enrollees by payment type—72 percent of enrollees are attached to plans that received the minimum update in March of 2001.

Table 3

Percent of Counties Receiving Floor, Blend, or Minimum Increase, 1998-2002

Year	Floor	Blend	Minimum Increase	Floor Payment
1998	33.8	00.0	66.2	$367
1999	39.7	00.0	60.3	$380
2000	29.1	63.1	7.8	$402
2001	30.7	00.0	69.3	$415
2001 (Post-BIPA)	69.7 81%/low 19%/high	00.0	30.3	$475/low $525/high
2002	80.0	00.0	20.0	$500/low $553/high

Source: HCFA, Public Policy Institute, AARP

What proposed reforms are on the horizon? We have the Medicare + Choice Equity and Access Act (S. 1317/H.R. 2836), the Medicare + Choice Stabilization and Improvement Act (H.R. 2980), and the Medicare + Choice Improvement and Stabilization Act (H.R. 2584). Last, but not least, we have the 2003 Bush administration budget proposal. Of these three legislative proposals, they all include a provision for a fourth tier of payment. In the first bill, the Equity and Access Act, had bipartisan support, and it addresses a fourth tier by offering 100 percent of the local fee-for-service rate, which would be very helpful for a lot of the plans in the larger urban areas. It also re-weights the Medicare + Choice blend using a Medicare + Choice enrollment. And then, of course, it eliminates a budget neutrality constraint.

The Stabilization and Improvement Act, which also had bipartisan support, added a fourth tier, but the difference is that it limits just the graduate medical education (GME) carveout. Lastly, the Improvement and Stabilization Act adds the fourth tier again, a 100 percent fee-for-service, and this eliminates the budget neutrality constraint. Under the Bush administrative budget proposal, they want to infuse $3.7 billion into the Medicare + Choice program.

To reiterate, the reasons for reform is that plans are reducing service area benefits or they're plain just leaving the marketplace. This results in a decrease in the enrollment, and this is mainly because of enrollees being displaced by plan withdrawal. Past reforms barely scratched the surface of the problem and in current proposed legislation will only act as a bandage. Our conclusion here is that significant funding is necessary to stabilize this program, particularly in the urban areas where we see most of the enrollment. Unfortunately, though, the current political environment seems to be unreceptive to providing additional funding for the Medicare + Choice program.

It is estimated that in the year 2030, Medicare beneficiaries will about double. What does that mean to a Medicare + Choice program? It would mean about 10 or 11 million enrollees, so this payment issue needs to be addressed quickly and decisively.

MEDICARE REFORM: AN EMPLOYER PERSPECTIVE

MR. THOMPSON: The situation with Medicare is very disconcerting on all fronts, and not the least of which from an employer perspective. I'm going to talk from an employer perspective, and, beyond that, I hope to challenge the way we're thinking about the problem and bring it into the context of how employers are starting to think fundamentally about the root causes of the problems in health care today, beyond the fact that we have an aging population. Clearly the population is aging at a rapid pace: The population over 65 is going to double by 2030, but the population over 85 is going to grow that much more exponentially.

If you're talking about an employer perspective, they're seeing the same issues as Medicare only with even greater urgency. As you know, Medicare pays a very significant percentage of the hospital and medical expenses for people over age 65, but they don't pick up the drug expense. When employers pick up the bill, they're picking up a disproportionate amount of the highest trending element in health care, which is the prescription drug component. Many people are estimating the trend in drugs at somewhere between 15 and 25 percent. The idea of walking away from retiree health is a complex issue with employers and clearly some employers have, in fact, already done that.

Some employers are looking at the issue of: if we don't provide retiree health, will that discourage people from retiring? If that discourages people from retiring, then I have them as actives, and if I have them as actives, I'm picking up the full bill as they enter their later years. It's a complex issue from that standpoint. Chart 5 illustrates the difference between pre-65 and post-65. You see that the mix of expenditures pre-65 is much more typical of your active population where inpatient and medical expenses and outpatient are significant, and drugs are more like 21 percent of the bill. But post-65, drugs are over half the bill for major employers. When we talk about Medicare reform and Medicare sweeping in and potentially picking up a piece of the drugs, that's a huge impact on employers.

Making it even more complex for employers is the fact that they have been accounting for retiree medical using assumptions that seemed reasonable two to three years ago but that don't seem so reasonable anymore.

Recent trends in Financial Accounting Standard (FAS) 106 calculations reflect assumptions that start at nine percent to 10 percent and then grade down to something like five percent pretty quickly, e.g. in four to five years, and yet if you look at recent trends, that doesn't seem realistic, particularly when half the bill is prescription drugs. We all know the impact of technology and other things going impacting drug trend. The concerns are exacerbated by both SEC concerns and, frankly, the Enron situation if in fact we have liabilities on the balance sheet that aren't necessarily reflective of the true liability. While some employers have limited their liabilities through retiree medical "caps," they are getting increasing pressures on that cap as the higher retiree cost-sharing starts to emerge. That is going to increase pressures for cost reductions, plan cutbacks and plan elimination, but also for cost management strategies like disease management. Some are looking at strategies to redefine their obligation, to get out of the unlimited liability business and move to more of a defined contribution approach to retiree health. That doesn't solve the problem, mind you, but that's what they're doing.

If you step back and you look at the issue from a Medicare reform standpoint, the problem is that we basically have three alternatives. That is, if the employers weren't in the picture, we'd have three alternatives. We have traditional Medicare, and under the traditional Medicare approach, there are major gaps in coverage. The costs are huge for people that have to pick up that level of cost-sharing, and the

lack of prescription drug coverage, a major part of the expense for people over age 65, is a significant concern. Beyond that, the fact that we've split the drugs from everything else has created a very dysfunctional environment.

Major employers, particularly major employers that have large populations of early retirees, pre-65 retirees, are investing heavily to better manage those expenses through programs such as disease management. However, employers cut those programs off at age 65. Those are the people that more times than not actually benefit from some of these programs. However, employers are not going to invest in them because they are not financially responsible for the hospital and medical expenses—the portions of the expenses that they would save by investing in disease management. They're trying to manage just the prescription drug, which is very siloed in its effect.

Then you add into that the Medicare + Choice, which I think was viewed as "the promised land." Conceptually under Medicare + Choice, we put it all together to manage the whole thing together through the private sector. However, for many major employers the instability in that market has left it with no credibility. While employers took major reductions in their FAS 106 liabilities when they started utilizing these plans, as health plans started to pull out of Medicare + Choice programs or raised the premiums for those programs, employers had to jack up their FAS 106 liabilities again. So it's not viewed as *the* solution anymore because it just doesn't have the credibility that it did before. There is also concern about risk segmentation, although, quite honestly, that's more of a concern from HCFA's perspective than it has been from the employer's because the cost had been so low.

Considering private Medicare supplements, there are a lot of concerns around them. One is that they fill in 100 percent of the gaps, so effectively we have no cost-sharing left in a plan. Who would design a medical plan without cost-sharing? Furthermore, we mandated that that's the way they'd be. So we only have a fixed number of plans, and we mandated they fill in the gaps. Beyond that, they all cover prescription drugs inadequately. There are some plans that provide prescription drugs, but those plans are typically capped, and while the primary purpose of insurance is protect against catastrophic expenses, we do everything but that.

So we have a very dysfunctional system when you look at how it exists in the absence of an employer-sponsored plan that supplements Medicare.

What needs to be re-looked at? Everything. Do we just add prescription drug coverage? We don't have the money to add prescription drugs without fixing it. We need to re-look at the benefit framework. We need to look at it from more of a consumer focus, consumer support perspective, disease management, financing, quality management, the whole thing. We have to re-look at it the way major purchasers are re-looking at their medical programs constantly. This system was designed in the early 1960s, and then we added this Medicare + Choice, hoping this would potentially save it, and clearly it hasn't done that.

What would the employer response be if there were Medicare drug coverage? The answer is no one knows, although there's so much financial pressure on the employer's balance sheet, and prescription drug trends have been just through the roof, that one would know that it's going to be much worse than this would ever indicate. In a survey that Hewitt did in 1999, 20 percent said they would eliminate drug coverage if there was Medicare reform, and 80 percent said they would retain it and supplement it in some way. Certainly any drug program that gets proposed by the federal government is not going to be super-comprehensive because we can't afford it. So even with Medicare reform, there is probably going to be a need to subsidize it or supplement it anyway.

According to a survey done by The Henry J. Kaiser Family Foundation, the Health Education and Research Trust (HRET) and The Commonwealth Fund, since 1999 there's been a dramatic reduction in coverage of retiree health. In spite of the problems in the system—that is, the gaps in coverage—when employers aren't in that system, the commitment of major employers has continued to reduce toward retiree medical coverage, and it's more dramatic for the Medicare eligible. Furthermore, 72 percent in 2001, pre-Enron, said that they're expecting further changes.

It seems to me there are certain things we can't change. We can't change the aging of the population. But a lot of things we can change. In health care, in general, we have very demanding consumers. We've got wasteful processes. We've got costly technology, some of which we may want, but for others, it's questionable whether the added value is consistent with the technology that's being added, and in some instances inadequate supply, be it nurse shortages or whatnot. The private sector heretofore has tried to deal with those cost pressures largely through discounts and managed care and care limitations, and the public sector has tried to deal with it through price controls and by focusing on financing, not on health care. The outcome, and this is really true on both sides, is poor quality.

The Midwest Business Group on Health did a study with the Juran Institute, and they determined that the cost of poor quality in health care, the cost of not doing it right, is $390 billion in the system. It's about a third of the cost, about $1,700 per employee, and of course that would be much higher if you were talking about actives. We've got very cumbersome rules. Physicians are not happy with the system. We've got dissatisfied consumers.

There's cost-shifting. Every time we squeeze on this Medicare bubble it just pops up on the other end. Employers are not interested in Medicare reform that simply shifts costs, because as they squeeze here they put pressures on other employer costs. If Medicare implements price controls on drugs, what's that going to do to the employers on their regular drug costs?

I think where it's heading or where it should be heading is toward greater convergence between employers and Medicare, focusing on two elements—

managing demand for services and improving quality and processes in the health care supply chain. On the demand side, we need increased consumer awareness of cost. There is no awareness of costs when there is a $10 co-pay or you have Medicare supplement plans that fill in the gaps.

Shared decision-making, decision support and targeted disease management strategies (focusing on the 20 percent that incur 80 percent of the cost) can start to incent and enable patients to make prudent choices. From an evidence-based medicine standpoint, we need to focus incentives and programmatic efforts to reduce variation in clinical practices. Nothing in Medicare does that today. It's an old 1960s fee-for-service system. From a supply chain management standpoint, there needs to be an effort to improve quality in the system, and it has to include Medicare. Medicare is 40 percent of the system. The focus should be on reducing variation and eliminating non-value waste in healthcare system processes.

We will need to collaborate across the system (private and public sector) to reduce the cost of poor quality, that $390 billion that was cited by the Midwest Business Group on Health, that's the only way in my mind that we're going to have a shot at dealing with the aging population as we move forward. So far I haven't heard a Medicare reform bill that comes anywhere near addressing root cause.

MR. DOUGLAS MCCANN: Under the House GOP plan, will the insurers bear the risk or will the insurers and Medicare share the risk?

MS. UCCELLO: I think it's shared. I'm not 100 percent certain on this.

MR. ROBERT HIMMELSTEIN: When they're discussing the changes to Medicare, especially prescription drugs, how much consideration are they giving to the Medigap plans, especially closed ones where people cannot move freely to even lower plans in a lot of states, and they probably have to go elsewhere and be re-underwritten?

MS. UCCELLO: I haven't seen the current plans that were just introduced last week, but I know in the past when they had a prescription drug component, they specifically addressed the Medigap plans. Some would phase them out. Other ones would let them stay. I think it really depends on the plans, and, not having seen the current plans, I can't really say.

MR. THOMAS AHMANN: Regarding Medicare reform, structural reform objectives, my question is, what is their objective? One of the features that I think is there is the desire to provide first-dollar coverage and to provide a great deal of coverage that's analogous to employer coverage. On the other hand, the need that may be there may be the true insurance angle. Does Congress appreciate the difference between first-dollar coverage and true insurance , and which one are they trying for?

MS. UCCELLO: I think that staffers in Congress do understand the difference. A lot of questions that we get pertain to the effect of cost-sharing on utilization and things like that. So, I think they do understand that, and they're trying to work out a balance between those two things.

MR. THOMPSON: Let me reinforce what you're saying. We're all familiar with the Rand study that showed that higher cost-sharing leads to lower utilization of services. A subsequent study came out that showed that not only does it lead to lower utilization of services that may be discretionary, but it also leads to lower utilization of services that shouldn't be discretionary, and, because of that, there is some concern that you don't want to make prescription drug coverage a catastrophic coverage, that if people take their drugs, they stay out of the hospital sometimes. So if you create cost-sharing that stops them from doing the right thing, then maybe you shoot yourself in the foot. We need to look at it holistically. I don't know if that's their thinking, but I think that has some rationality to it.

MS. UCCELLO: But I think that they recognize that some level of cost-sharing is needed, that it's not going to be necessarily first-dollar coverage.

MR. DAVID ADAMS: In the expansion of Medicare benefits, for example, the prescription drug benefits that are being at least discussed, would to some degree provide a windfall for those employers that have agreed to provide pharmacy benefits to their retired employees. When Congress enacted the catastrophic Part B provision back, I think, in the late 1980s, there was a feature called, innocently enough, maintenance of effort, which basically kept that windfall from happening, and it said that employers had to provide the same value in some way. In other words, it theoretically allowed the government to spread their dollars further because they weren't going to replace private coverage. Is there any talk of that, and what does your crystal ball say about that?

MS. UCCELLO: One of the House plans had a component in there that would subsidize employers who continued to offer their retirees health. I think it was a carrot rather than a stick. But that's all I know.

MR. THOMPSON: I would suspect they're just as concerned by the trend of employers to stop offering retiree coverage, but I don't know the answer to that. That's an interesting observation, though, from a parallel situation in the past.

MS. UCCELLO: Well, especially given that they're willing to spend only $350 to $500 billion when total spending is going to be $1.6 trillion. I think the hope is that these other supplemental plans will still be in the picture.

FROM THE FLOOR: I'm thinking back to my Blue Cross/Blue Shield of Florida days when the BBA was passed, and we actually had a chance to digest the cost implications, the revenue implications of it. When you saw that material, couldn't you pretty much have drawn the charts that you put up here now?

MR. REASE: Yes.

FROM THE FLOOR: Regarding your figure of $1.6 trillion being total spending, and the $350 billion that Congress is willing to spend, are they anticipating that the premiums paid by the beneficiaries are going to make up the difference? Are they basically just going to subsidize enough to get people into it?

MS. UCCELLO: I think that they believe there will be a very high participation rate in these plans. I think the CBO has estimated participation rates upwards of 90 percent to 95 percent, which would mean then that the cost-sharing and premiums would be paying for part of that difference between $1.6 trillion and $500 billion. I also think that these other supplemental plans may still be there to supplement some of the other costs, but I don't know this for a fact.

MR. THOMPSON: At one time they were looking at a defined contribution approach to Medicare, a premium-subsidy-type approach, kind of an expansion of Medicare + Choice but over time eliminating fee-for-service-type program.

MS. UCCELLO: The premium support. That's not being discussed as much these days. I think it may be in part due to the Democrats having control of the Senate, and they're really just pushing more for adding a prescription drug coverage component, and…

MR. THOMPSON: Expanding access.

MS. UCCELLO: Yes. That change has occurred just in the past year, although there are a lot of people who are still supporting that type of approach. It hasn't gone away completely.

MR. ADAMS: At the risk of stating the obvious, the comments of a minute ago suggest that there are political forces at work here. This is a political issue. It's not an actuarial issue. It's not an insurance issue. I'm not suggesting that the actuarial profession should attempt to take a particular position on this, but the political forces—some toward a federal approach to this, a government approach to this, others toward a private sector approach—can't agree on a solution, and that's true of quite a few things in our culture these days. But until one of those forces starts to gain ground at the expense of the other, I don't think we're going to see significant changes.

FROM THE FLOOR: As a follow-up to that and all these political issues, I have a question as to the Society or the Academy or Foundation's responsibility to the public to educate them. Maybe you can't take a position like the previous speaker said because there are a lot of different options, but I think as a consumer what I'm concerned about, and as a professional I'm concerned that we're shirking our responsibility in getting the facts out there. I feel like the politicians are kind of sucking the people in and saying, "Okay, we'll come up with $350 billion," but no

one's telling the public that somebody's going to have to come up with the rest, and it seems like the politicians always do that. They're leading the people in. They're getting them in their door, and then who's going to solve the problem? Well, we'll solve it later. We'll do it from general revenues or something like that. But doesn't the Academy have a responsibility to get this information out? You don't have to take a position as to the right answer, but don't you have a responsibility to communicate with the public and say, "If Congress gives you this much, there's no free lunch, folks." If they're going to give you all these prescription benefits, somebody's got to pay for it. And let's tell them now before we build another Social Security dilemma.

MS. UCCELLO: Rick Lawson, the executive director of the Academy, is here and hopefully will get me off the hook.

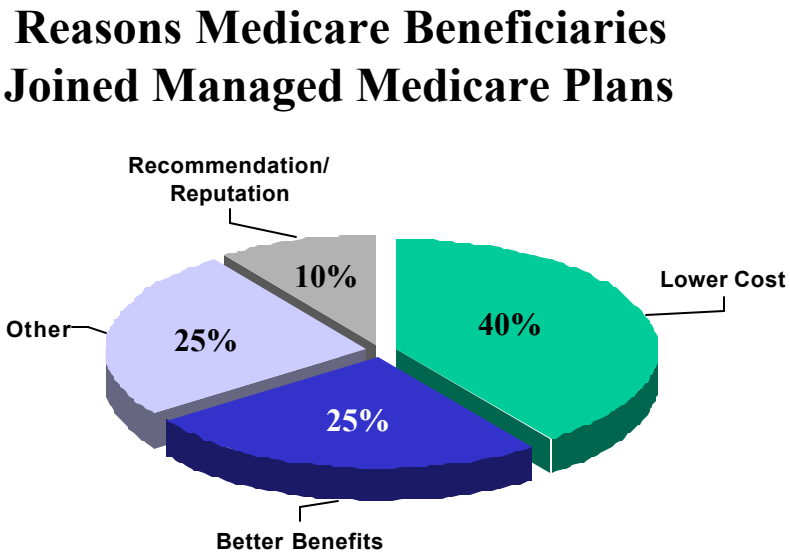
MR. RICHARD C. LAWSON: We just got a letter out to every member of Congress that goes over every monograph that we've put out. The letter also said don't do anything with prescription drugs until we have the financing fixed. So we did just send that letter to every member of Congress, and it links to every document that we have created in this area. Typically that is the audience that we gear it toward, and I hear your question about going out to the general public. Typically we send it out. We do make it available on our Web site for those who come and look. Some of you will remember back in 1999 we had a press conference on Social Security that got national attention, that drew very mixed reviews, shall we say, from our membership, but we do make it available. We do put out press releases when we put out our different monographs so the general public knows about them, but our primary audience is members of Congress, and we did just put something out last week.

MR. THOMPSON: The comment was made to add the American Association of Retired Persons (AARP) to our list.

MR. LAWSON: We actually meet with the AARP on quite a regular basis. We started a new external outreach program within the last couple of years. AARP was at the top of our list. We have had several different meetings with AARP on a number of different topics, including this one, and we meet with them on a fairly continuous, ongoing basis.

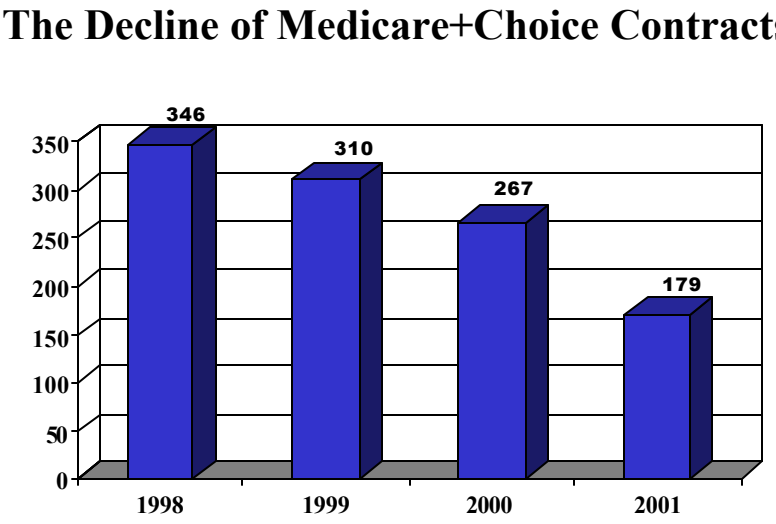
MR. THOMPSON: Just reinforcing what was just said here, we are in a profession that is central to one of the core issues facing America today, and if we don't take a leadership position, we're going to have a problem. That is, leadership at least in terms of an active involvement in the debate.

Chart 1



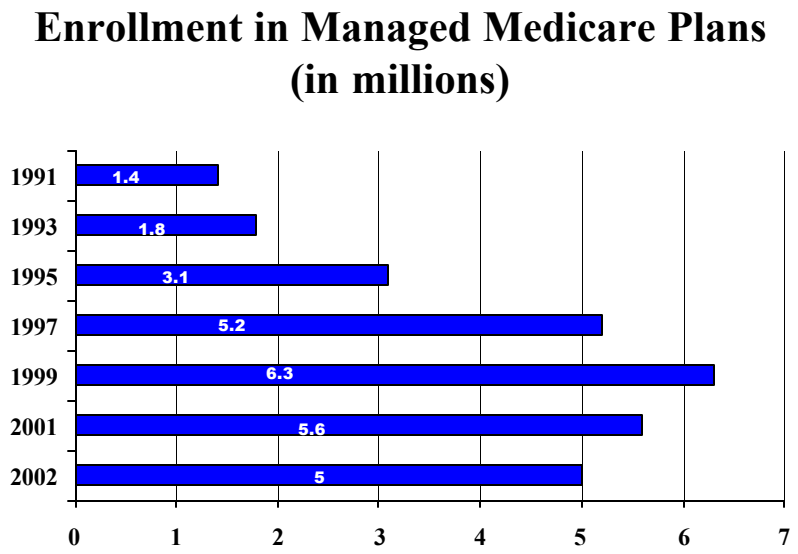
Source: MedPAC analysis of Medicare Current Beneficiary Survey data, June 1998

Chart 2



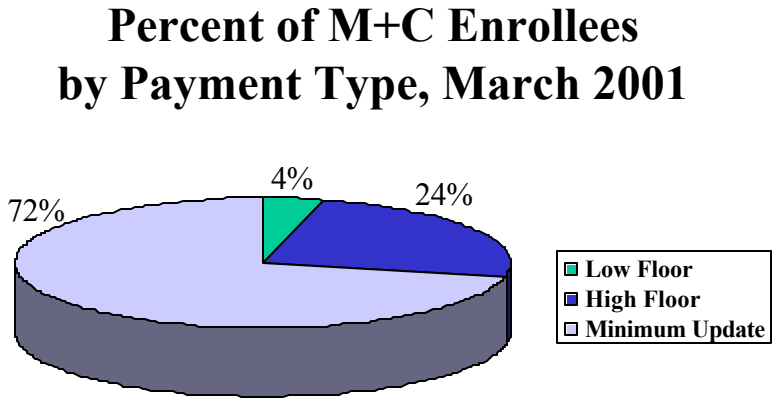
Source: HCFA/Office of the Actuary

Chart 3



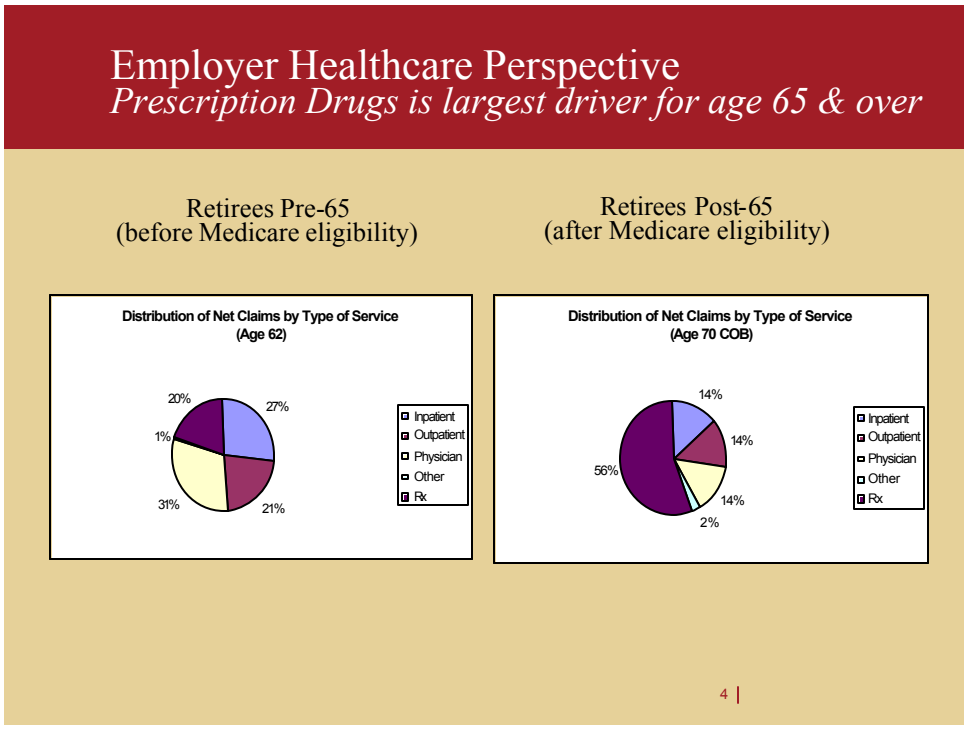
Source: Medicare Current Beneficiary Survey and 2002 data from CMS.

Chart 4



Source: Public Policy Institute analysis of HCFA Medicare Managed Care Market Penetration Reports, March 2001

Chart 5


Employer Healthcare Perspective
Prescription Drugs is largest driver for age 65 & over
Retirees Pre-65
(before Medicare eligibility)
Retirees Post-65
(after Medicare eligibility)
Distribution of Net Claims by Type of Service
(Age 62)
20%
27%
1%
31%
21%
Inpatient
Outpatient
Physician
Other
Rx
Distribution of Net Claims by Type of Service
(Age 70 COB)
14%
14%
56%
14%
2%
Inpatient
Outpatient
Physician
Other
Rx
4