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Session 66PD
Medicare Reform

Track: Health, Pension

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Summary: 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.

Panelists address the following:
- *The overall outlook of the Medicare program*
- *Current Medicare reform proposals*
- *Longer-term Medicare reform proposals*
- *Medicare prescription drug proposals*

Attendees gain a better understanding of the key issues in the Medicare reform debate and learn about the direction of future change.

MR. P. ANTHONY HAMMOND: When we first started planning this session we weren't really expecting or imagining that we would be sitting here discussing this topic at the very moment when the largest change in Medicare was being debated in Congress, and it's quite likely in the next week or two that we're going to have prescription drugs added to Medicare or at least a bill is expected to pass the Senate. At least one version of the House Bill has already passed, and they're expected to go into mark-up and conference probably within the month of July. So it's really pretty timely what we're talking about here, although things are changing daily. Let me just note that when we planned this session, we didn't expect what's

†Mr. Mays, not a member of the sponsoring organizations, is consultant with Actuarial Research Corporation, owned by Gordon Trapnell.

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

happening on the Hill right now. There are a lot of similarities in the drug plans that have been discussed over the last several years and what they are talking about now, but our discussion doesn't deal exactly with those proposals.

Let me introduce our panel of distinguished actuaries, who I think together represent at least a century in the health actuarial and health policy fields. Harry has been in the managed care and health insurance field for years. I think he helped start the HMO concept. He'll be talking about why Medicare needs more comprehensive reform to avoid adverse selection or, to put it another way, the actuarial case for changing Medicare to stand on its own.

Jim Mays is going to be talking about the range of Medicare prescription drug proposals that Congress has been considering over the past several years and his presentation is going to comment on the attributes of some of the current proposals and discuss some of the features intended to address adverse selection concerns. He's also going to be presenting some survey data that will show how prescription drug expenses might be able to be predicted for a Medicare population extrapolating from a near Medicare and a broader non-elderly population.

Bill London, an actuary from CMS, is going to discuss how Congress has added several new options to the Medicare Plus Choice program and attempt to increase managed care penetration. Two of those options are the private fee-for-service (PFFS) plans and the new preferred provider organization demonstration projects. His presentation intends to give you an idea of how a plan might implement some of those options.

MR. HARRY SUTTON: I'm going to talk about Medicare from a macro perspective, which means the long-term funding. It seems to me that Congress really doesn't want to face the problem with the federal budget, with Medicare, and the last two or three times I've talked about Medicare reform, we're trying to say "Just because there's a huge fund there for Part A doesn't mean Medicare isn't underfunded in an actuarial perspective." It's not insolvent, but it's going to draw down tremendous resources out of federal general tax revenue. The first projection was actually done before the last two tax reductions that the President got through. The effect on the overall federal budget after those is even more drastic than this looks.

Chart 1 is right out of the 2003 Medicare Trustee's Report. It shows how much federal general tax revenue is required to cover the parts of Medicare that are not paid for by direct contributions to Medicare. That would be the FICA tax, the tax on Social Security benefits for Part A and the 25 percent of the premium cost estimate for Part B. The expenditure of federal general tax revenues doubles in approximately 10 years, and this is really before the large majority of the baby-boomers retire. The draw of federal tax revenues just to keep Medicare afloat under current conditions is $1.1 trillion.

The first is merely to warn you about what's happening because of Medicare. These numbers are not adjusted for the tax cost of employee benefits, not involving an individual paying taxes on them because of the tax shelter for employee medical benefits. But what this shows is that the out-of-pocket cost is now only 14 percent. If you go back to 1965, it was 45 percent. Part of that is the extent of coverage and the other part is less out-of-pocket. HMOs have probably been part of the problem with that. When HMOs expanded in 1973, they originally had very little out-of-pocket cost to the enrollee.

In the next 10 or 15 years, the percentage paid for by public sources (i.e., federal and state) with a doubling of the Medicare population in the next 25 to 30 years, has got to increase to well over 50 percent. If the federal government is buying 60 percent of the health care and they can negotiate prices or pay whatever they want , what are the chances of the private marketplace surviving with the government trying to balance the federal budget by reducing their payments to providers, particularly hospitals? I happen to think that the Balanced Budget Act (BBA) in 1997, which froze hospital reimbursement for about three years initiated a major cost shift. The hospital reimbursement increase for next year is only about three percent and if their costs are really going up at 6.5 percent, as hospitals claim they are, it means we must be cost-shifting due to the federal government reducing their hospital payments. Hospitals are raising their charge patterns. If you read about Tenet Health Care in California, they buy a hospital and raise the rates 25 percent overnight. That increased their Medicare reimbursement, which maybe it shouldn't have, but it did.

The result of this is that it may not be a level playing field. There may have been a period of time in the last 15 years where the employers got the benefit of the controls and negotiated rates with the HMOs and the carriers and now it may well be going in the other direction. When I talked to my friends in the Health Services Department of the University of Minnesota, they still say the government at least pays what their real cost is. But I'm not sure; nobody has studied it in the last five years and there's obviously been a major shift since 1997. That's something to think about.

I was a member of the advisory panel to the 1990 Social Security Commission, which every five years or so looks at what the future of Medicare and Social Security are. Some of the things I'm going to talk about were suggested even then but totally ignored as suggestions.

In Chart 2, it looks as if we could not fund any other service in the United States with federal revenue.

We came up with the conclusion back in 1990 that we would only have five percent of federal revenue left for all the other services other than health and Social Security approaching 2065. At this point it looks like zero and that's without taking into account the last two tax reductions.

The trust funds for both Social Security and Medicare are what I call a paper tiger. Of course, the government people say, "It's money owed by the government and, of course, they'll pay it," but the question is, where are they going to get the money to pay it? I was thinking as I wrote this that for about four or five years during the 1990s, the FICA tax and the taxes on Social Security were not enough to cover the actual costs of Part A of Medicare. Instead of doing anything about it, the federal government decided to transfer a whole bunch of home care benefits out of Part A into Part B. Part B is only 25 percent funded by individual premiums. What they did is even help make the fiscal situation worse by doing that, by hiding it from the public.

You've probably seen tables that go out to about 10 or 25 years. A table was done by CBO some time ago, and it shows that in the year 2070 the total cost of Social Security, Medicare and Medicaid (i.e., the part paid for by the federal government which is about 60 percent of it) will be equal to approximately 20 percent of GDP. We talked about Canadian health care being at 9.1 percent or about 10 percent. The reason the Canadian cost is relatively low compared to our 14 or 15 percent of GDP for total health care expenditure is that their GDP grew between five and 10 percent a year for five years and therefore even though their health care costs went up the same as ours did, it didn't rise as a percentage of GDP until recently. Canada went into kind of a recession. We're in a recession so that now our GDP has gone up only one or two percent. In the U.S., GDP adjusted for cost factors, only went up about one percent a year for about 20 years. In Canadian dollars versus U.S. dollars, their costs went up exactly the same as ours did, but not as a percentage of GDP.

The ratio of federal tax revenues from all sources, to GDP has varied between 18 percent and 22 percent for the last 10 or 20 years. That 20 percent seems to be the guideline. If you're in Europe, you have 40 to 60 percent, and most people in the U.S. do not want the federal government taking more than 20 percent of their money. But if they don't fix funding for all these benefits some place, they will run out of money for anything other than these services in 70 years.

I wanted to talk briefly about employer-provided retiree medical benefits. I just attended a session that shows that right now if people were to start covering retirees, their cost estimate would be at the current inflation trend factor ranges between eight and 12 percent. Drugs range between 10 and 14 percent--this is current. Chart 3 shows the actual trends from a study by Hewitt and Kaiser at the end of 2002. Essentially, the inflation trend is 20 percent and nobody is using that as a gross estimate even currently. A speaker said, that was a pay-back because they overestimated the cost in 1992 when FAS-106 started to be implemented. The original liabilities were set up and overestimated and actually the trend factors dropped below the assumptions.

The long-term trend factors they're using for health care, total health care, are five to 6.5 percent forever into the future for their calculation of long-term liabilities for

FAS-106, which seems a little on the light side. For prescription drugs it was eight or nine percent. The conclusion of the speaker at the session was that now everybody intentionally, one way or another, is always underestimating the cost.

Retiree health coverage is shrinking. At one time 30 to 40 percent of our Medicare retirees had employee medical benefits continued by their employers. The numbers may be off, but 22 percent of large employers continue coverage. I would guess that the number of retirees covered now is somewhere between 20 and 30 percent. But the employers are passing part of the cost back to the employees more often. They're also cutting the benefits back. Some of them cut their drug coverage because that's estimated at 50 to 60 percent of the total cost of a Medicare supplement. Employers set up cap limits that they never thought they would hit and now they're hitting them early because the costs are so high. Part of the problem with the large employers is that they have unions in many cases, and they've negotiated things that they just could not estimate very far into the future and now they don't know what to do about it.

The unemployment rate is up and there are big layoffs. What about people who are laid off or who retire early? How do they get coverage up to Medicare? Essentially what we're seeing for the steel industry, for example, is that 50 steel companies filed for bankruptcy so they could get out of their retiree benefits which they guaranteed to their unions. They are selling their company lock, stock and barrel through the insolvency. They're even keeping the same active employees, which they've maybe shrunk down to 25 or 30 percent of what they used to be.

Bethlehem Steel has turned their pension plan over to the PBGC, but we're reaching a point where we're fighting for jobs. If the steel company wants to keep being a steel company, they can't support all the benefits that they promised to the union or other members, and they try to negotiate with the members so the members may negotiate lower wages and negotiate to give away their retiree benefits and in many cases the new company doesn't offer any of these benefits. Now we're at a point where we've got 10,000 employees and they want to work and the retirees say we want our benefits and we won't give them up. How do you get out of that bind? In other words, we've underfunded these benefits all along and now the people who are retired thought they have all these benefits, and maybe legally were guaranteed the benefits, how do we solve this problem?

For example, General Motors pays $5 billion a year for benefits for retirees only in the United States. They show 460,000 retirees, husband and wife in many cases, and 150,000 active employees in the U.S. The retiree health cost is a major problem.

There are many companies that have gone through this. Unisys was one that I was involved with because many of their operations were located in Minneapolis and their retirees wanted to hire me. The retirees hired an actuary who estimated the value of all future medical benefits and the company put up $400 to $500 million to

fund these. The only problem was six years later they ran out of money again and the employees sued again. I don't even know what happened. The employees were already starting to worry that the money wasn't enough. They wanted to hire me, but there were all kinds of actuaries and others with all the data. They may not have ever settled the case. They didn't want to go into bankruptcy.

AT&T has always had, in the last 20 years, many retirees. The majority may be under 60 or 65 because of the change in telephone structure. They don't need nearly as heavy a population to run that business as they used to, so they have retired a lot of people early. Certainly more than half the people that AT&T covers are retirees. Auto companies and rubber companies all have a large number of retirees, more than they have actives that they're insuring.

The question is: Can you really reduce active salaries in the future enough to cover the retiree liabilities? You're having a big fight between the active employees who want to make a living and raise their family and the retirees that feel they're owed these benefits. There's a tremendous battle there.

Generational equity is the major problem, as Guy King and others at HCFA/CMS have pointed out over the years. We're underfunding Medicare and the longer we wait, the worse it's gotten.

Chart 4 is from one of Guy King's memos. It originally came from HCFA and it shows, for example, if somebody retired today on Medicare the Part A benefits they're going to get 1.34 times what has been paid into the fund from average tax revenues. This was Guy's table. There are various options of changing the funding of Medicare, none of which look very good to anyone, but probably the best one would be to reduce benefits immediately to what would be supported and then vary the contributions periodically. The problem is that in order to avoid the generational problem, we really need to reduce benefits or increase contributions for the people retiring and not increase the taxes for the people that are working as much, because we've underpaid for the people that are retiring. Whether we can do that or not, I don't know.

Chart 5 is some data developed by HCFA/CMS several years ago. I think Guy King had already retired, but he got the studies from there. This is, when people buy Medigap they fill in the deductible, the coinsurance and maybe even pay the extra 15 percent that the doctor can charge you if he doesn't accept assignment. I had a question for Canada, since they don't allow any co-payments by patients getting health care under the Canadian health plan. In the U.S. when people have Medigap and they fill in most of the holes, there's an average increased utilization between people that have only Medicare and people that have Medigap to fill in the coverage. Roughly adjusted for health the data shows there is a 30 to 40 percent increase in utilization due to the fact that the cost is cheap. For some people it's zero. The Canadian Institute of Actuaries filed a white paper perhaps 10 years ago suggesting that in order to live within their means in Canada, they had to have

deductibles and coinsurance built into the Canadian plan. The keynote speaker didn't talk about that, but benefits didn't change; although there are still a lot of people arguing to do that in Canada because they feel people can't get health care in Canada because of the fact that it's free because there is such a queue at the doctor's office to get in. You can't get in there when you need to. So, you're being blocked possibly by people that have a frivolous medical request.

I think we cannot disrupt American business by forcing employers to pay for retiree health care. We should drop that. We should drop it for people 65 and over, I'm not exactly sure how big the problem is for people under 65 versus over. I just think we have to fix Medicare and get it funded. This is what I would do, but I don't know what we do between early retirement, layoff, 55 to 65. If early retirees go into Medicare, there's almost no way of funding it ahead of time.

There was a proposal in 1990, except it ignored by the commission because it's politically non-acceptable. It said that we should merge Part A and Part B benefits. We should have one mid-size deductible. I don't know about a national health plan that has co-payments. Canada doesn't. Most of Europe doesn't have co-payments either. But, what this would reduce is the government's cost depending on what we do with the Part A FICA tax because the outpatient Part B services would be reduced and government pays for 75 percent of those. Co-insurance is 80 percent and we need a maximum out-of-pocket limit. That's one of the big complaints about Medicare that you could bankrupt somebody because they still have to pay 20 percent of their medical cost, more hospital cost if the stay goes past 60 days.

If Medicare did this and takes a lot of liability away from the employers, there would have to be a quid pro quo. We talked about the one back in 1988. The employer had to fund $3 worth of benefits for one year to offset the advantage he was having in lowering his retiree cost-$3 per month of benefit!

I like the idea, and if you've known me in the past, you known I talked frequently about medical savings account (MSA)s. Not that I don't like them, I just dislike the way they were pushed. There are only about 50,000 MSAs in the U.S. I would think the employer could increase a pension plan or put in a separate fund that could be used to fund pretax medical expenses like coming out of an MSA. That would give the retiree an advantage of at least maybe predrawing part of his pension or Social Security benefits or submitting the claims to Social Security and having them pay the medical so he avoids paying the income tax on the Social Security benefits and gets the medical benefits tax free.

Competitive bidding is frequently proposed: I worked in 1999 trying to get competitive bids for Medicare Plus Choice and was blocked by Congressmen from Arizona, Kansas and Missouri who passed a law saying they could have no such plan in their states before the year 2003 which neatly put an end to the project.

Fee-for-service options are starting slowly and will be discussed later.

Medigap will have to be reformed if we have prescription drugs. I think Medicare benefits should be changed so that we don't need Medigap. I got Medigap premiums in 2001 from the NAIC, were about $16 billion and had about an 80 percent loss ratio. That's a lot of money. It covers about 10 million people. That's private individual Medigap, not employer. Some of the more sophisticated research projects on the induced utilization of coverage show that almost all of it is private Medigap and not employer because the majority of employers still keep deductibles and coinsurance and try to match their active employee health plan and therefore the employee still doesn't get 100 percent coverage to overutilize.

When we have deductibles that are higher, we're going to obviously have to expand the QMBs and SLIMBs and regular Medicaid to help people who don't have the money to pay a $500 deductible.

One of the things we could do, which will never happen either, is to start taxing employer contributions for health care or in effect tax employer contributions to the employee or rearrange the system.

There's approximately $100 billion to $150 billion of tax benefit. Whether Congress would change that, I doubt, but it's a source of funding.

We have the uninsured problem, which I'm on a committee for. In Minneapolis the average hospital is reimbursed 50 percent of charges. Medicare pays 45 percent; Medicaid pays 40 percent; the HMOs pay 55 percent; the Blues pay 55 percent; and then the last person without coverage pays $1 million a day. Then they write it off as a bad debt and take credit for it.

There are still a lot of people that think we should adopt the Canadian system. It was interesting to hear more about it, and I'm not sure we understood everything. I would recommend a summary of an article by Howard Bolnick in the *North American Actuarial Journal* about how to redevelop the U.S. health care system to get rid of all these problems and promote universal coverage. I recommend you read that if you haven't.

I think we're in a financing mess because of the federal budget and we've got to do something to change the Medicare structure to get rid of problems with the employers.

MR. JAMES MAYS: I work for Actuarial Research Corporation, but I'm not an actuary. I had the pleasure of working with Tony in the early 1990s in the Bush administration on health insurance reform efforts. When he said he wanted me to give a non-actuarial perspective, I thought I've worked for Gordon Trapnell for about 20 years, so I'm not sure I can have a truly non-actuarial perspective. A lot of our work is consulting to the office of the actuary.

The other worry I had when Tony said that is non-actuarial is sort of an epithet. What strikes me as the key attribute of someone looking at these issues from a non-actuarial perspective is their concept of what appropriate time frames are for sustainability or for questions of actuarial soundness. Most of the work I do is in Washington with policy makers whose thoughts of actuarial soundness and sustainability have a short-term definition and a long-term definition. Short term means your program is actuarially sound; it's not going to go bankrupt and be the headline in *The New York Times* tomorrow. Long term means you're not going to have that headline before the next election. The idea of a 20-year, 50-year, or 75-year time frame just enters into almost nobody's calculations, which I think as Harry is describing, is a theory of problem in terms of getting Congress' attention on these issues.

I want to run through the Medicare drug proposals that have been around for the last four years or so and, in particular, comment a little bit about the issues associated with risk selection, one narrow sub-area within the drug proposals. Then, n that light, I will comment on the feasibility of a stand-alone drug plan, which has been an important topic from politicians actually asking actuaries how these things might work. If I have any time I want to comment a little bit on how this relates to Harry's remarks.

The basic approaches to Medicare drugs looked at in the last four years saw one to two categories: the Democratic and the Republican. The Democratic plans were to expand Medicare. Whatever you do, make sure you kept it under the Medicare system. The Republicans were fairly adamant that if you're going to create a new benefit, it ought to be something which is pulling people into private delivery systems, and maybe you can get some momentum and start increasing the amount of services in regular Part A and Part B services that are provided through Medicare. As Tony noted when he was setting up this session, he didn't anticipate our being here with the prospect of something passing in the next two weeks as very high and that something is basically going to be the private sector approach. The House and Senate are basically in accord on this, but one caveat with respect to that is that Congress has had accord before. In 1988 they passed Medicare catastrophic, which had a drug provision in it. Then they repealed it in 1989. In the event that you do have Medicare reform passed in the next couple of weeks, you might not see any repercussions until 2006. There's nothing that happens quickly that might alarm people, but you may actually end up having serious revisiting of these issues beyond whatever discussion there is this summer coming up in the next few years.

For the classic plan, which the Democrats had been advocating to some extent off-the-table, the basic idea of the Medicare expansion approach was to create some new section of Medicare and have PBMs not bearing risk manage the benefits without strong incentives to contain costs. The Medicare program would bear virtually all the risk. You would set the plan up so you had virtually universal coverage and didn't have overall risk selection in terms of who was coming into the plan.

The alternative Republican-type proposals have been private sector oriented. A lot of the earlier discussions didn't have huge government subsidies, however. The use of PBMs to manage benefits, probably in conjunction with an insurance plan not necessarily merged as Medco operates, but more in terms of perhaps the PBM just operating in a joint venture with an insurance company would be in a situation where they'd have strong incentives to control costs. The insurers would be bearing substantial amounts of risk compared to what the Democratic proposals have been. All of the proposals have put a lot of energy into examining taking back risk.

In the earlier proposals there was usually substantial nonparticipation expected. The voluntary plans and the enrollee contributions are high enough that the system as a whole might have some noticeable risk selection in terms of who didn't come in. More importantly, the proposals usually expect multiple insurers so you have a serious opportunity for selection bias between the various insurers.

What I want to do is give a plug for the Kaiser Family Foundation Web site, which does a good job of providing side-by-side descriptions that are accurate and well written. If you click on KFF.org, they will keep you aware of what the specs are on a pretty routine basis--not quite as routine as what you see in the paper, but generally a lot more accurate. I did want to mention quickly though the two plans under consideration between Senate and House are very similar in that they both want to have about a $35 premium. They're both looking at a deductible on the order of $250. (The Senate's is $275). They differ a little bit in terms of the coinsurance arrangements. The House wants to have 20 percent coinsurance but quit paying benefits quicker. The Senate is 50 percent coinsurance; but it pays longer. Both of them have catastrophic coverage. Both of them have interest especially in terms of Harry's concerns about retiree medical. Both of them say, "We'll help employers. We'll give them some subsidy, the same as we're subsidizing the regular coverage at the front end." But in terms of the catastrophic coverage being offered, if you take a private insurance plan through the government program, an employer cannot fill in the cost sharing up to the point where the catastrophic kicks in. This is in some sense an optimal strategy with respect to the short-term budget implications. If employers are slow to get out of the business of drug coverage, they don't race out because they're still getting a partial subsidy. But a lot of the money they're spending, in a sense, is money the federal government would have been willing to spend on these retirees if the retirement coverage was not there--both House and Senate have done that.

The two plans are both willing to spend $400 billion. One major difference between the two plans is the question of whether they're going to use some of that money to entice people into moving to private plans in general for Part A and Part B services. The Senate said, "We'll deal with that problem tomorrow." The House said, "No, we're going to be very proactive. We're going to move aggressively and establish competitive bidding under this plan in 2010," which is very responsible. The other thing that is different between the House and Senate is that the Senate is less astute than the House in terms of their nomenclature. The Senate creates a

new agency called the Center for Medicare Choices for their plan. The House creates the Medicare Benefits Administration. The elderly want benefits, and that's what the House called it. The elderly don't want choices. What the Senate was thinking in terms of naming their organization is not clear to me.

With respect to selection issues, which will matter in terms of if these plans are passed, obviously the easiest thing to do in terms of thinking about selection is acknowledge it and then live with it--not care. To the extent that you're going to have some of the healthy people stay out. That's not necessarily a problem you have to care about even if there is selection occurring. If it does bother you, then you can heavily subsidize the system, and the House and Senate plans do give very substantial subsidies on the order of two-thirds of the cost, getting down to a $35 premium. So they expect it to be high participation and not much overall selection bias. One more nail to prevent that: if you have one-time enrollment with late penalties, you can hold down the potential for overall selection bias more. The plans also have what they refer to as "government reinsurance." It's actually the government paying the high-cost claims and there are other risk adjustment mechanisms anticipated, which are not completely spelled out in the legislation, all of which can help adjust selection.

It should be noted that not included on this list are what insurance companies might think are the reasonable things to do for an insurance product like letting insurers reject applicants or bury the rates based on how expensive somebody is expected to be. Those are not in play.

The question of risk selection concerns--and some people have raised the idea that it may not be feasible to have private insurers competing against each other selling individual, drug-only products. The argument is that drugs are just so much more predictable than other services. The high cost users know they are high cost users, and you really can't insure it. You're providing financing. You're not providing insurance.

Some data work we've been doing with respect to drug expenses: There is substantial unpredictability. I got the answer from an actuary. What we were looking at is data from a government survey, the Medical Expenditure Panel Survey, which is a nationally representative survey, 10,000+ people per year. But the important thing is that you get data on a lot of people for two years in a row and you have data that is of uniform quality. I won't say how high, but it's of uniform quality between the over-65 population and the under-65 population. It's not like the superior Medicare beneficiary survey, which is only for the Medicare population, and it's not like insurance company data where you've got really high-quality data, but you may have differing selection experience between your over and under 65. So this is uniform quality data we were able to look at.

We looked at drug spending in a base year compared to next year and then also hospital/medical expenses--non-drug base year and second year. We wanted to

look at it in terms of drugs versus other medical services for the over-65 population: How predictable were drugs compared to non-drug expenses, when you look at the top 20 percent of the population as sort of an indicator of predictability? The number I wanted to mention for drugs, is that when you look at second year spending, the top 20 percent of the population from the previous year still account for 50 percent of drug expense. For non-drug it's 38 percent. Drugs are a lot more predictable than non-drug expense. On the other hand, there's still some unpredictability to it. We looked at what happens in the under-65 population in terms of drug and non-drug expense. Where you have individual products and varying degrees of regulation, but some degree of competition by insurance companies with some bettering of the ability to tailor the premium precisely to the individual's cost. The corresponding numbers on the under-65 population are that for drug expense in the second year, the top 20 percent in the first year account for 75 percent of spending. It would be hard for us to have a product for the under-65 population that was drug only if people were going to be able to move around insurers readily. For non-drug benefits, in a lot of individual coverage, the top 20 percent in the base year account for 50 percent of second-year spending, virtually identical to the drug data for the over-65. Our conclusion from that is that yes, there may be selection problems. There are certainly things to watch out for. On the other hand, it's not a whole new ball game radically worse than what's observed in the non-drug under-65 population.

Conclusions: It strikes me, at least with respect to the selection issue, that it is certainly feasible to have stand-alone drug benefits. As an open question in terms of feasibility, what happens in 2006? What happens when the people who have enrolled in the private drug plans see the mechanisms that are used to achieve cost savings?

MR. WILLIAM LONDON: My company used to be called HCFA and now our name is changed to CMS, which stands for the Centers of Medicare and Medicaid Services, so that one "M" stands for Medicare and Medicaid.

I want to talk about actual current Medicare initiatives that have been done to address the problem of prescription drugs and getting more private plans to participate in Medicaid and Medicare. Medicare currently pays about $8 billion for prescription drugs, but they're not the drugs that a program manager would pay. These are not really drugs that would come under a prescription drug benefit. These are major medical drugs that are injected by physicians and billed by physicians. These account for most of it, and then the rest of them are drugs given through durable medical equipment, mostly inhalants: Albuterol for asthma and Fortropium. Most of the physician drugs are for cancer and are billed by oncologists. Many oncologists actually make as much or more through their drug payments from Medicare as they do through their visits. They make a lot of money on drugs. Medicare reimburses 95 percent of the average wholesale price for drugs, but manufacturers determine the average wholesale price. Drugs are the only benefit under Medicare of which Medicare doesn't control the price. We've tried to in the

past, through different regulations and so forth, but we weren't successful because we know we reimburse doctors a lot more than they pay for their drugs.

Private industry reimburses about the same price for drugs as Medicare does for these major medical drugs because once you get into it, program benefit managers are not prescription drug benefits, even though they are prescription drugs. When doctors bill these drugs to commercial patients that are not on Medicare, they pay about the same thing, about 95 percent AWP. So it's a big problem for private plans also. Drugs have been going up about 20 to 25 percent in Medicare.

Medicare covers a small number of oral cancer drugs, and there are proposals to cover more drugs each year like all world cancer drugs and so forth. Drugs have been a big problem, because once again they are the only service under Medicare that Medicare hasn't been able to set a price for.

Also, the other things I'm going to talk about are under Medicare reform. The big things are to cover prescription drugs and to increase the number of private plans to participate in offering Medicare benefits. The government over the last few years has been trying to get more private plans to participate, and in order to do this, the government has increased payments to HMOs to try to get them to stop dropping out and has also offered other options that private plans can offer, other than the standard HMOs, which include private fee-for-service plans. There have been some demonstration projects. One of them right now is a preferred provider organization (PPO) demonstration project where the payments are increased. In most counties right now, Medicare pays more to HMOs than to fee-for-service, and under the PPO option you can get even more money because you get the greater of what we pay to HMOs in any given county or 99 percent of what we pay for fee-for-service in any county. In some counties that would be an increase. Then on the private fee-for-service plans, we make it easier for private plans to go into an area and set up business because under a private fee-for-service plan, the company does not have to set up a network at all. So you don't have to contract with any doctors or hospitals. You can just go in there and get full capitation. You get paid exactly the same as an HMO would, but there's no network to set up. So, you can go in relatively fast and pick and choose which counties you want to go into, and you can pick counties that get paid more under your M+C rates than what fee-for-service costs in those counties. Companies can make a lot of money with a private fee-for-service plan.

One other thing is, under the PPO option, if you want to come in and offer a PPO, what a lot of plans have done is to offer these. They've already had HMOs set up in these areas. So they've been selling HMOs and now they're selling private fee-for-service plans. The advantages that they get for selling the private fee-for-service plans is that they get higher rates in certain areas because they're getting the greater Medicare Plus Choice rate or 99 percent of fee-for-service. The other incentive that the government gives these plans to come into an area is the government shares risks with them. So what we do is if their claim experience is

bad, the government pays part of their claims. If they have good claim experience, they make a payment back to us. So we often see how that works out. The typical arrangement there is that we set a target that is subject to a lot of negotiation, and sometimes it's heated negotiation where we set these targets that we risk share around. The first two percent there's no risk sharing, typically, and then after the two percent margin there's a certain percent of risk sharing.

The PPOs do not have to risk share, and a lot of the members that we have in these plans, are not under risk-sharing arrangements. So for those plans, the reason they're coming in is not because they want risk sharing, they just want to get the greater payment--–the greater of Medicare Plus Choice or 99 percent fee-for-service, so these are plans in certain counties such as in New Jersey where the fee-for-service plan is higher than what HMOs get. They can make more money in those areas. That's why they're coming in. What you get in most counties in the country? Medicare pays more to HMOs than what the fee-for-service cost is.

Just for a little background, the Medicare Plus Choice program started from the BBA in 1997 and it expanded the HMO options to provider service organizations (PSOs) , private fee-for-service plans, and MSAs. Harry was mentioning MSAs before. No one ever took up the MSA option. Plans could have sold MSAs, but none of them wanted to.

Medicare Plus Choice plans under Medicare, which are mostly HMOs, were at an all time high in 2000, where 16 percent of Medicare's beneficiaries were in HMOs. Now it's down to about 11 percent. It might even be a little bit lower than that. A lot of plans have been dropping out. Even though they're getting paid more than fee-for-service beneficiaries in that area, they're still dropping out, and they're not getting paid enough money to cover their expenses. Medicare reimburses HMOs about 1.5 percent for administrative expenses, because that's how much it costs us, but that's not enough to cover an HMO's administrative expenses. Medicare has a lot of beneficiaries--we don't have to pay agent commissions and so forth. Even though we're paying them more than what a fee-for-service beneficiary would get, they're still losing money and dropping out.

The increased payments of Medicare Plus Choice plans were made in the Balanced Budget Refinement Act (BBRA) of 1999 and the Benefits of Improvement and Protection Act (BIPA) of 2000. That's when they started getting paid more than fee-for-service, and they get paid what's called a minimum rate. They also got a guaranteed two percent increase. The private fee-for-service plans, there are about 35 plans in 23 states, and once again, they're the ones that get paid the greater Medicare Plus Choice or 99 percent fee-for-service.

As I mentioned before, the Medicare Plus Choice plans have been dropping out and that's been a big concern to the government. The number of plans that offer drugs fell from 84 percent in 1999 to only 72 percent in 2002. That's only part of the story because more than half of the plans right now cover only generics and more

than 40 percent of enrollees in these plans have benefit caps of $750 or less. The HMOs are dropping out. They're offering fewer benefits, and that's a big concern of Congress and the Medicare reform in Congress is trying to get more participation from private plans.

Before I get into the private fee-for-service plans let me give the numbers real fast for the PPO demos. Once again we take risk sharing and give them higher payments. As I mentioned, there are about 33 plans in 23 states. Right now we have about 65,000 beneficiaries who are in these PPO plans. It's less than we thought we were going to have, which is a problem for the government. We would have thought that the PPO plans would have had lower cost sharing, but they actually have higher cost sharing in premiums and that's probably a reason why the enrollment isn't as high as what we thought.

Private fee-for-service plans: Right now we only have two or three companies that are actually offering them, but we have a couple more that are looking into it. These companies can make a lot of money, if they sell private fee-for-service plans. Unlike an HMO, as I mentioned before, they don't have to set up a provider network so they can move in fast and set one up. The plans must pay the same amount that original Medicare pays to doctors and hospitals, so you can't pay them less because you're not under contract with them.

You can enter floor counties; in other words, a floor county is a county where you're getting paid more per beneficiary as a capitation from CMS than what an average fee-for-service beneficiary costs in that county. You're getting paid more than fee-for-service. It's an extra product line you can add to an HMO. When a company has a Medigap plan, if the fee-for-service beneficiaries are sick, they can put them in the Medigap plan. If they're healthy, they can try to persuade them to enroll in one of the capitated plans like private fee-for-service. Even though we don't condone that, we know what happens.

We're tracking beneficiaries that don't want an HMO, but the beneficiaries can save money because they can drop their Medigap coverage, and the amount that they're paying in their monthly premium to the private fee-for-service plan is less than what Medigap costs so that's the advantage to the beneficiary. They save money and they can pick any doctor they want. There's no restriction. There's no such thing as out-of-network. The advantage to the plan is that they're going into counties where they're getting paid more money than fee-for-service.

Actuaries working with private fee-for-service plans would strongly discourage the use of an agent. This is an issue that we've gotten into with some of these plans. The other issue is whether the provider is deemed or not. When these beneficiaries from private fee-for-service plans go to a doctor, they have to explain to the doctor that they're from a private fee-for-service plan because a doctor doesn't know what that is. A doctor knows what a regular original Medicare person is, and a doctor knows what an HMO person is, if the HMO is going to pay them if they participate.

But this is a new concept, and the doctors are very leery about it because you have a patient coming in and they're a fee-for-service patient, but original Medicare, CMS is not going to make their payments. Then the CMS intermediary in that area, the payment contractor, is not going to make the payment, so the doctor is looking at this guy and saying "What is this?" It's like an HMO is making the payment that they haven't contracted with and the only way they have to trust that this plan is going to pay them the same as what Medicare would have paid them. I'm actually the person in the Office of the Actuary who approves the payment rates and tells the plans how much they have to pay for different services. They can just be sure the actuary cleared it and you're getting paid the right amount.

The doctor is deemed to know that this patient is from a private fee-for-service plan. For example, if they want to balance and bill the patient an extra 15 percent, which is the most you can balance bill under Medicare, the first time the patient comes in the doctor might say "I didn't know that you were a private fee-for-service patient," and the plan will probably pay them their extra 15 percent, but then they'll say "Okay, from now on you should know, you're deemed, they don't balance bill any more because you're not getting paid."

Another issue we have that we have to deal with for a plan coming in with a private fee-for-service is, they have to know how to make Medicare payments because it is not an HMO where you can pay whatever you contract. You have to make Medicare payments and you have to know how to make the payments. What some plans will do is contract with a Medicare fiscal intermediary to make the payment because the intermediaries know how to make the payments for the most part. If they can contract with a carrier intermediary to make the payments for them, they're in pretty good shape. Basically what's happening is, for a regular original Medicare patient, the fiscal intermediaries and the carriers make our payments, but they don't make the payments for a private fee-for-service plan. The private fee-for-service plan would have to contract with these guys and pay them to do the same thing Medicare does. It's sort of like duplicating Medicare. But some of our private fee-for-service plans don't do it this way. They just set up their payment systems in-house and make all the payments themselves, and that's actually the more typical arrangement.

A private fee-for-service plan has to know how Medicare makes payments in every locality. Some people don't know this because they don't deal too much with Medicare, but Medicare rules are different in every state. In some states, certain things are covered by Medicare. In some states they're not. This is usually the case with smaller items, but sometimes they're expensive. Sometimes when beneficiaries or doctors complain, they'll say this is covered in New York, but it's not covered in Utah. Then CMS will issue a national coverage decision to make sure that the whole country covers it. There are a lot of little things that are covered in some areas and not covered in others, and carrier medical directors who are physicians in each state make their decisions for their state--if the items are going

to be covered or not--. A private fee-for-service plan has to know about what's covered in each state so they can make the right payments.

These are more things that a private fee-for-service plan has to know in order to make the proper Medicare payment. If anyone is going to be working with private fee-for-service plans and even for some other reason has to know how Medicare makes payments for different services on the fee-for-service basis, I put a manual that I made up on the Web site that I send out to private fee-for-service plans routinely. But if you want an updated one, you could send me an e-mail and I can send it to you. My e-mail is wlondon@cms.hhs.gov. It shows how payments are made by Medicare for every kind of service. There are a lot of rules these plans have to know. Medicare still has some payments that are cost based, although fewer every year because Medicare is implementing fee schedules on a lot of services that used to be cost-based like outpatient hospital, rehabilitation hospitals, and long-term care hospitals.

These are data files that have fee schedules on them, which the plans have to be aware of. Medicare has pricers that determine how much hospitals get paid for different services depending on what condition they have, in other words, what their ICD-9 codes are.

Clinical access hospitals, rural health clinics, and federally qualified health centers are important for private fee-for-service plans because private fee-for-service plans operate in a lot of rural areas because these are areas where they get paid more than fee-for-service, so they can make more money in rural areas. They have to especially be familiar with rural entities like these.

There are a lot of small entities that Medicare pays for. Actually, for religious non-medical it has to be a service that's not medical in order for Medicare to pay for it. There are a lot of things you have to know if you want to be a private fee-for-service plan. Once again, a lot of their payments are rural because that's where they can make more money. They have to pay doctors an extra 10 percent if they operate in a rural area because Medicare does try to get doctors to go to rural areas. Medicare-dependent hospitals: If a hospital has more than 60 percent of its patients on Medicare, it's called a Medicare-dependent hospital and they get higher payments.

If you want to see a payment grid of all Medicare services you can send me an e-mail.

MR. HAMMOND: I also want to put in another plug for the Kaiser study that Jim mentioned; it was a study in which they interviewed approximately eight different health actuaries and talked to them about what needs to be in a drug proposal. Interestingly, there was a lot of consensus among all the actuaries, which doesn't always happen. But in this case there was, so it's actually some pretty good reading. One of the reasons that Congress wants to try to keep the HMO and keep

the penetration higher is, generally, the HMOs have traditionally served low-income beneficiaries. While it may seem like why would they want to pay HMOs more to keep them around, it's partly because it also helps lower Medicaid costs and serves a population that is generally lower income. Now, obviously as we're moving into PPOs with higher premiums and even Medicare Sub. Plans or Medicare Plus Choice plans that have higher premiums. That's becoming less and less the case, but there's still advantages for local plans to be offered that help serve the low income.

I heard you talking about how easy it is for someone to do private fee-for-service. In true actuarial fashion the answer is somewhere in-between. It's not as hard as going in and developing a network. You don't have to talk to all the doctors, but on the operational side, the folks at CMS do require us to go in and have an agreement with each of the doctors we deal with so that they will accept our payment process. You can go in and just pay the 15 percent more and go that way, but more likely what you have to do is go in and talk to every one of the doctors and then when patients come to them, the doctors still end up refusing. It's not quite as easy as it sounds, particularly in an area where you previously had an HMO because the doctors get very confused. They think they are HMO patients and they say, "We don't participate," so there's a tremendous amount of upfront work with the providers. Hopefully after a few years of dealing with it, they'll catch on and it will work a lot better, but initially it can be a problem.

I want to mention there are two studies coming out from the Society of Actuaries and Academy of Actuaries very shortly. I chaired the project oversight group for the Society of Actuaries Medicare Drug Studies. Reden & Anders has been preparing for the Society. That should be coming out shortly from peer review. Also about the same time the Academy of Actuaries drafted a brief on the Medicare trustees report that's going to echo what Harry has been saying, but most of us felt that you really need to get everyone to focus on the total reform and look at everything and not just prescription drugs. We're probably going to have prescription drugs even before that gets issued, but I think it's not a moot point and it's something that will be talked about more as we go on.

I'm just curious as to what each of you thinks the overall trends might be for both Medicare Plus Choice and private fee for service PPOs over the next three to five years. Where do you think we're going? I know what I think, but I'd like to hear what you think first.

MR. SUTTON: I asked Bill to answer the question because while the Medicare Plus Choice HMO enrollment has dropped from 15 or 16 percent down to 11 or 12 percent, new enrollees still come into them when they reach 65 because the plans look attractive. Whether they don't like the HMO after they get in there and then drop out, the number of disenrollments because of the plans leaving certain counties is much higher than the drop in enrollment, so that new people are still coming in. The other thing that disturbed the market that we didn't really talk about was that prior to 1997 or so, in high cost areas such as Florida, California,

and New York, there were zero premiums. The HMO industry has had to learn how to charge premiums. In one of Tony's plans they stuck in a $10 premium. Of course, it cost them more to collect that than the $10, and they kept 95 percent of the members. In other words, the premium didn't throw the senior out of the plan, now most of the plans are starting to charge premiums and the premiums are going up every year. They cut some benefits and they increased the premium trying to balance out. They don't want the patient to leave the plan because the price is too high and they don't want to cut the benefits too much. I think they were always in competition with Medigap and they didn't really view that as a competition so they never pointed out the high premiums that Medigap has in a lot of states because the HMOs even now are very competitive with Medigap although they've cut the drug benefits down.

I think the HMOs will come back, but I don't know whether two percent is enough for them to survive. With the fee-for-service plans part of the problem is that there aren't enough people in these rural areas to build a substantial, basic operation, particularly if you're only operating in a few states. That's really very slow to grow, and you have a lot of setting up to do and marketing. CMS does not like you to have agents. On the other hand, I think the ones that are there have some agents selling it or brokers, at least one of them has full-time agents.

MR. HAMMOND: Jim, where do you think things are going?

MR. MAYS: We're perfectly happy with what CMS is giving as their projections of where things are going. I'm personally curious at the opposite end of what Harry was saying, now that plans are permitted to rebate part of the Part B premium that they can have a really low cost structure.

MR. LONDON: I was thinking the same thing that Jim said--the issue of rebating the Part B premium to give an incentive to beneficiaries to join a private plan. I guess it is just like the HMOs where the government pays more than fee-for-service. It's a matter of how much the government wants people in private plans.

Chart 1

Medicare Income & Expenditures (millions of dollars)

Fiscal Year	Total Medicare Real Income*	Total Medicare Expenditures	Excess of Expenditures over Income (Required from General Funds)
2003	$188,974	$276,863	$87,889
2004	200,506	290.103	89,507
2005	215,293	308,319	93,026
2006	227,047	319,791	92,744
2007	240,903	343,601	102,698
2008	255,162	366,356	111,194
2009	269,907	391,910	122,003
2010	286,962	420,464	133,502
2011	304,719	456,069	151,350
2012	322,185	481,104	158,919
Total			$1,142,832

*Excludes intra-governmental transfers.
Sources: 2003 Trustee's Report – Tables 11.B5 & 11.C5 (Intermediate Projection)

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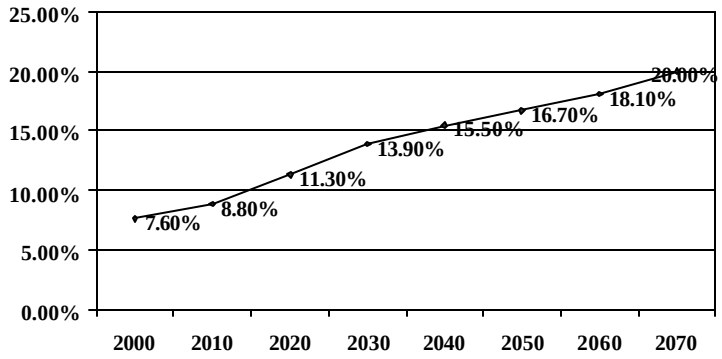
Chart 2

Total Costs of Social Security, Medicare & Medicaid as a Percent of GDP



Source: CBO long range report. Note that cost ratios more than double as a percent of GDP. If federal taxes remain around 20% of GDP, other discretionary government programs will have to shrink or be eliminated.

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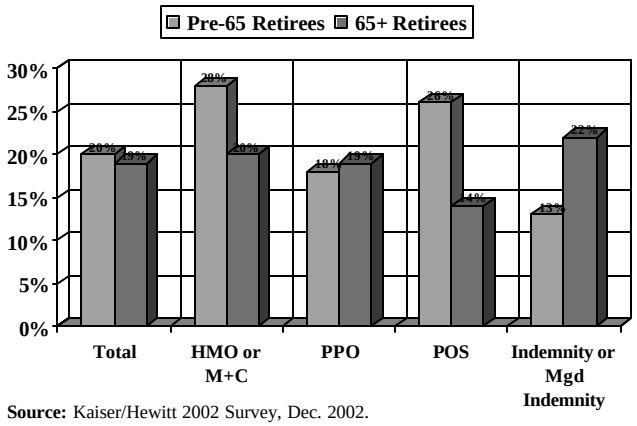
Chart 3

Large Employers' Retiree Health Benefits

Average Annual Increase in Retiree Contributions for New Retirees, by Type of Health Plan, 2001-2002



Source: Kaiser/Hewitt 2002 Survey, Dec. 2002.

Chart 4

Ratio of Benefits to Contributions

Proposed Change in Financing	Person Retiring in: 2001	2021	2041
1) Do nothing until trust fund is depleted, then reduce benefits to levels that can be supported by current HI taxes.	1.34	0.57	0.49
2) Reduce benefits immediately to a level that would place HI program in actuarial balance.	0.94	0.59	0.72
3) Reduce benefits immediately to a level that would place HI program in actuarial balance, then index tax rates.	0.94	0.70	0.91
4) Do nothing until trust fund is depleted, then increase HI taxes to pay benefits.	2.43	1.23	0.87
5) Increase HI taxes immediately to a level that would place HI program in actuarial balance.	2.43	0.94	0.68
6) No changes (hypothetical).	2.43	1.57	1.76

Source: Guy King, HCFA 2001.

Chart 5

Medicare Spending Person for Age 65 and Over

Health Status	Medicare Only	Medigap	Ratio
Excellent	$705	$1,217	172.6%
Very Good	$905	$1,490	164.6%
Good	$1,713	$2,347	137.0%
Fair	$2,462	$3,236	131.4%
Poor	$4,684	$6,477	138.3%

Source: CMS Medicare Current Beneficiary Survey; Guy King, 2001.