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Session 106PD
Medicare Prescription Drugs

Track: Health

Moderator: Janet M. Carstens

Panelists: Corey N. Berger
Brian Glassman
Ted Marmor**

Summary: Panelists review the history of why Medicare has lacked prescription drug coverage and why some of the previous proposals to include prescription drug coverage in Medicare have failed. Also discussed are the drug benefit designs permitted under Medicare reform legislation, the projected costs of these and alternate plan designs, and the potential impact of Medicare prescription drug coverage on related coverage, including retiree medical and Medicare supplements.

MS. CARSTENS: We have as our first speaker Professor Ted Marmor. Professor Marmor is a professor at Yale University. He teaches politics, law and management. He has a long history with the Medicare topic. He has written a book titled *The Politics of Medicare*. The first edition came out in 1973. The second edition came out in 2000, and it addresses why the program has worked out the way it has. He sold tens of thousands of copies of this book. He worked for Wilbur Cohen, the father of Medicare, as an assistant when Medicare began. So you can tell he's got a lot of experience with the Medicare program. He's a fellow of the Institute of Medicine and of the National Academy of Social Insurance. He has written several articles and has given several speeches on the topic—he knows the story inside out.

**Professor Ted Marmor, not a member of the sponsoring organizations, is professor of public policy and management at the Yale University School of Management in New Haven, Conn.

Our second speaker is Brian Glassman. Brian is a senior director at Prime Therapeutics and he leads Prime's product development operations and strategic planning for special products including specialty drug, Medicare, etc. Brian has been instrumental in assisting Prime's Blues Plan owners. Prime is a pharmacy benefit manager (PBM) and assists Prime's Blues Plan owners in understanding the implications of the Medicare Modernization Act of 2003 and development plan strategies. Prior to joining Prime, Brian worked with the Blue Cross-Blue Shield Association with Blue Cross-Blue Shield of Illinois and with Towers Perrin in developing strategies associated with Medicare. Brian has master's degrees in health, finance and policy analysis.

Our third speaker is Corey Berger. Corey is a senior consultant with Reden & Anders and he has more than 12 years of experience in the health care field. In 2003, Corey presented an actuarial equivalence for Medicare prescription drug coverage at one of the American Academy of Actuaries' most successful Hill briefings in terms of attendance. Corey has a lot of experience with Medicare and with Medicare pricing. He is a fellow of the Society of Actuaries and a member of the American Academy of Actuaries. He graduated with a B.A. in economics and mathematics from Washington University in St. Louis.

Professor Marmor is going to give us some background information about how we ended up where we are today with respect to Medicare prescription drugs. Brian is going to provide an overview of business planning for Part B coverage, and he will touch on the impact of partial coverage, a little bit on retiree health and on Medicare supplement plans. Corey will touch briefly on drug benefit designs and costs and will provide additional information on how the Part B benefit will work.

PROFESSOR MARMOR: This is my maiden voyage with actuaries. Your organizer correctly said that I sent you, or I sent to the organization a characterization of what I think the prescription so-called Medicare Reform Bill of 2003 consists of, and I asked about that particular topic the following questions, which I'm not going to answer here. I asked, "What happened in 2003 and why should you care?" That, perhaps, is not a question that's terribly difficult for you to answer. "Why did it happen when it did?" which is a real puzzle. "How should you interpret its meanings?"

All of those may come up in the question-and-answer portion of the presentation, but I've been asked today to give you some historical and political perspective on prescription drug coverage in the Medicare program, and I'm going to do it in three ways. First, I'm going to answer the question: Why weren't prescription drug benefits part of the original Medicare bill that passed in 1965 and was initiated in July of 1967? And then I'm going to take every 10 years and answer the same question and eventually get to 2003, and I may or may not try to finish there.

The second thing I want to do is to discuss, if I have time, the problem I think it presents for you as actuaries, and let me foreshadow that problem before I start my

regular commentary. The problem I see was hinted at in a previous session, in which one of the speakers said, in answer to a question, "I don't really know what's going to happen to Medicare. There's a lot of uncertainty." Well, I would put it more bluntly. I know for sure that there's a lot of uncertainty about Medicare. I know for sure that it's not going to be the program that's designed by anybody's fantasies. It's going to change as we move forward and it's particularly going to be sensitive to what happens in the election of 2004.

So the question for actuaries is, on what basis do I make estimates? What program am I trying to estimate? The one that's written down in the law? The one to which I attach probability estimates? Do I do four different ones? And so on. I'll try to get to that, but before that, let me tell you the story that occurred to me as I thought of addressing the group for the first time, a group of actuaries.

When I was in the Department of Health, Education and Welfare (HEW), I did meet, of course, Bob Meyer and I did spend some time when Medicare began with the actuaries, but, on the whole, you're a group that is foreign to my experience. So whenever I talk to a group I don't understand, I think of the following true story, which captures the problem of any speaker trying to communicate with an audience.

It is a true story. In 1960, Adlai Stevenson who had lost in 1952 and 1956, lost in the primaries in 1960. He was nonetheless a good solider. So he goes out on the hustlings for John F. Kennedy, goes to Philadelphia. He gave a speech to this big audience in Philadelphia at the end of which a woman of mature years came up to him and said, "Governor Stevenson, that was the most wonderful, superfluous speech I've ever heard." Now, Stevenson thought that irony was the right response so he said, "I'm delighted with your response. Given your enthusiasm, perhaps I should publish it posthumously." And the real corker came when she said, "Wonderful, the sooner the better."

I'm a political scientist and a management scholar writing about Medicare. What you're going to hear now is not necessarily what you normally hear in sessions of this sort. The first question, well, if it's so obvious now in 2004 and was obvious in 1995 and obvious in 1990, 1985, 1980 and 1975 that outpatient drugs made some sense to have in a program that was meant to reduce the financial consequences of being ill, how come it wasn't there in 1965, 1966? Do you have any idea? The heads going this way would say yes; heads going that way would say no, you have no idea.

PROFESSOR MARMOR: Well, it's related to political risk, but much more importantly, it's something most people don't write about. The origins of Medicare have everything to do with the 50- or 60-year-old fight in America about universal health insurance. In the late 1940s, universal health insurance was proposed year after year and got defeated year after year. And President Truman, before he quit, turned to the Federal Security Agency and he said to my former boss, Wilbur

Cohen, and others, and he said, "Look, we're losing on universal health insurance. Let's find a way to get started with a program that's more appealing and a program for everybody." And that's the origins of 1951, 1952 of the strategy then to cover only the elderly under Social Security; an understandable argument that retired people as a matter of public policy couldn't get very easily their health insurance at work; retiree and benefits weren't big.

So what did they do and what did they do all the way until 1965? The Department of Health and Human Services (HHS), the Federal Security Agency, Wilbur Cohen, Social Security, all of them took for granted that the first step they wanted to do was to keep medical care coverage in the hospital; Blue Cross basically through social insurance rather than private social insurance. So every year from the time Kennedy was elected in 1960 to 1965, HHS or HEW at that time sent up to the Hill 60 days of hospital care period, nothing else. There was no Part B. They didn't have a Part A. That was it; paid for by standard social insurance contributions or taxes.

So the answer to the question of why Part B came in the form it did has everything to do with the clever, brilliant really, political adaptation of the conservatives of the time. Remember, in 1965 the ratio of Democrats to Republicans, because of the election of 1964, turned out to be 2 :1. There was an avalanche of support. In the Ways and Means Committee, the ratio of Democrats to Republicans beforehand had been 15:10. It changed to 7:8, wiping out Wilbur Mills' capacity to stop Medicare, and the Rules Committee was changed. So Cohen, thinking that you'd start off with what you've been doing, sent off HR1S1, and guess what?

For the conservatives who had defeated it for the previous 13 years, it was a wonderful story. It happened one day, Mills turned to the ranking Republican, Burns of Wisconsin, and said, "John, the American Medical Association (AMA) is criticizing us for not covering doctors, but they don't want to do it for everybody. They just want to do it for poor people. Why don't you find out how high-paid federal employees get their doctor bills paid?" That was on Thursday. On Monday, a high option plan of Aetna with Part B was added to it and it did not have at that point outpatient drugs, then your argument takes over. They were so shocked and surprised to get that, they didn't know what to do.

So the answer is not that they were stupid, not that they were frightened of expanding. They weren't thinking about expanding at all. They wanted to do it step by step. It was not part of the design of the first step with the presumption the future steps would expand both the coverage, the doctors and possibly the drugs out of patient, and what's more, the presumption was step-by-step expansion by population groups; first children. That's the answer to the question of why not at the origin. And every half-decade since, there's been a very good reason why it hasn't been added; not an example of people not understanding that American pharmaceutical is an important part of American medical care, but for quite different reasons.

Let me jump ahead a decade ahead to 1975. Why in 1975, just after the Reno failure expansion took place and just after the health-planning bill? Why didn't they have prescription drugs then? Part of the answer has to do with the Democrats wanting expansion of Medicare and they really were much more interested in the mid-1970s in universal health insurance. They didn't spend any time really. The expansion of the Reno failure was largely a congressional action, not an administration. All the attention was on the Nixon Bill, the Catastrophic Bill, the Kennedy Bill. It was not big enough to take the attention.

It's very important that you understand that between 1966 and 1971, that five-year period, after medical care prices started to rise or they continued to rise at twice the rate of the increase in the Consumer Price Index (CPI). Now, in fact, they've been increasing at twice the rate of the CPI beforehand, early back to the 1950s. The difference was that the CPI itself doubled its rate of increase so that the nominal rate was really quite high and Medicare got the reputation between 1966 and 1971 of being unable to control its rate of inflation. That's another reason why there was caution about prescription drugs.

Now I'll jump forward to the mid-1980s and the time when there was so much enthusiasm for group paid practices renamed by the Republicans of health maintenance organizations. There, as you recall, the preoccupation was not expanding benefits, but it was controlling the rate of inflation. And the big initiative and the big reformation and reform of the early 1980s was the Decisions Resources Group (DRG) method of paying hospitals, not the expansion.

I hope you recall that prescription drug coverage was part of the great catastrophic debacle of 1987, 1988. It lost not because prescription drugs were thought to be too hard or foolish. It lost. It was repealed. It actually was passed and then was repealed for a very different reason. There the problem was within the beltway; the geniuses within the beltway managed to figure out a way to finance the catastrophic coverage for Medicare by entirely, or if not entirely, mostly, and you probably know the difference, mostly paying for it with payments by Medicare and Social Security recipients themselves. That is having it self-financed by that demographic group.

If you know anything about the history of social insurance in the United States, there's been almost a deep commitment that the payment for social insurance programs should be largely done while one's working, in effect, Federal Insurance Contributions Act (FICA) taxes, not when one's not working. So when you're on disability coverage, you don't pay special when you're disabled and, likewise, you didn't with Medicare. Medicare was paid for entirely by the hospital insurance (HI) tax.

That changed the idea that a premium should be increased to pay for that largely. It outraged higher-income elderly, who were particularly well represented by the Roosevelt Center. Some of you remember that, too. And we produced an incredible debate. It was analogous to the confusing debate of 2003 in which people who

already had health insurance supplementary coverage for drugs were outraged by the change in Medicare and led the way even though the prescription drug and, particularly, the catastrophic coverage would have been very important to cover. That so scared the Congress that it would take a long time before they would try again. There's a famous image of Dan Rostenkowski before he went to jail in Chicago being pelleted by tomatoes by older Americans who thought they were being cheated. So again, factors somewhat external to the drug benefit side were important in the explanation.

And finally, if you go through the whole period between 1995 and 2003, I think you can give a common explanation, which I think sets the stage for thinking about why the legislation passed it in 2003, and it would be this: At the very beginning of Medicare's birth and all the way until the late 1990s and early 21st century, what lies underneath, in my view, the disputes about whether Medicare should have prescription drugs is a much deeper philosophical difference of view about what the role of government should be in the financing and arranging, delivery of medical care and other programs, too. I characterize the difference this way.

On the traditional social insurance largely associated with the Democrats, but not exclusively, on that side of the political spectrum the fundamental belief is that if everybody has a reasonable need for a particular kind of insurance coverage, it makes no sense to have it voluntary; you would argue compulsory in your other pool the resources to pay for it. You can pool it and finance it on the base of proportional taxes, which is the case with HI and retirement benefits, or you can pool it on the basis of progressive. You could even pool it on the basis of flat taxes if you wanted.

But the crucial element is the idea of pooling among the healthy and the less healthy and the richer and the less rich. The idea is that the redistribution that should take place should be from the lucky to the unlucky or the luckier to the less lucky. That presumption involves coercion; the requirement that everybody's in and, secondly, that they're in on similar terms. You might have proportional progressive or flat taxes, but the terms are similar. And the notion is that you take something out of the ordinary market economy and put it in a special category to be allocated not by ability and willingness to pay, but be allocated by some other criterion. That's option one. That's what Medicare, that's what the hospital insurance plan reflects in experiences. It expresses just the way OASDI does.

Now, on the other side, it's absolutely crucial at the birth and still, in my view, relevant today. Tom Scully breathes this, but hardly knows it, and that is the view that the government's rule is not to take a social problem and address it overall. A problem that everybody has to face one way or another and address it in a common framework, but rather the role of government, according to orthodox and standard Republican fiscal views, is it ought to be if and only if you're not able to afford it yourself. The role of government should be largely about helping those who can't help themselves. The very language is in sharp contrast to the language under old

age and survivor's insurance, which is they were clients, not they're supplicants, they're clients.

One case is those who have been unfortunate; the other case is those who are part of a common citizenship arrangement. And you see this dramatically in all of the fights that have taken place since 1995. And what are those fights? In 1995, the Republicans wanted an effort to transform Medicare from one in which everybody's in the program on common terms unless they opt out of their prepaid group practice into one in which there are vouchers in which people, in effect, get a down payment on an insurance plan. They're not under common terms. They have a financial transfer to buy insurance from competitor supplies. That's a fundamental difference in the construction of Medicare.

And when people think about what we learned from 1995 to 1999 with the Bill Thomas Commission, basically you have two things here: A philosophical conflict, and what's more, and very relevant is you had people on both sides of the political aisle vying for taking credit for adding prescription drugs to Medicare. And each side was unwilling to let the other side take credit for it. Each side had fundamentally different views about how the program, the benefits should be structured, and that's the key, it seems to be, to understanding the structure of the proposal in 2003 and to some extent the structure of the outcome of it in 2003.
The real puzzle is why, if Bill Thomas couldn't get it passed, why even in 1995 the Democrats defeated most of the voucher plan? Why in 2001, 2002 the same ideas were available? How come in 2003 does it emerge? You can't say, well, it was the election of 2004 that did it. There was an election in 2002 and that didn't do it. So what's going on?

Here's my brief attempt to make sense of it. What you had, as I said, are not only philosophical differences, but also fundamental conceptions of plans that differed. On the Democratic side there was a commitment to everybody among the elderly to be covered and everybody that was disabled proceeding exactly from the ideas that I just suggested. So the price tag that Kennedy and his crew were ready to put forward, as you recall, was $800 billion for 10 years. Remember that? Action one, $800 billion, 10 years, all of the elderly, all of the disabled under common terms.

On the Republican side, the supposed budget estimate was $400 billion. That's another story, as you well know. But it was pretty neat, wasn't it? Half and half, 50 percent of the total. But who was the beneficiary? Who were to be the beneficiaries under the Republican plan? The low-income elderly who were prepared to take the drug benefit in connection with going to an insurance plan, right? Remember that? This was an effort to transform Medicare or the lure of this drug benefit. What happened? The Republicans gave up on this fantasy that they could get enough support if they restricted it to the low-income elderly and made it conditional on joining a plan.

And the Democrats gave up on $800 billion. Well, you put all the elderly and disabled in a program with a budget that was $800 billion and now $400 billion and you know what? You produce doughnuts. Now doughnuts are the dumbest idea ever discovered in modern American politics. The idea that you would go to the elderly with a notion that there would be an area of non-covered, plus difficulty in getting supplementary coverage. The explanation is that they've been talking to economists so much that their brains are thinking that this corridor of 100 percent deductible or coinsurance rate was really wonderful.

Anyway, you can see that I don't talk about this in a conventional way. I just want to read you the title of an article I wrote and published just this month in the *British Journal Of Health Services Management* and you'll get the idea that I'm going to very quickly stop and turn it over to people who will speak to you in a more conventional and maybe, perhaps, more illuminating way. But certainly no less, I hope, no more provocatively than I'm speaking to you.

I'm at 2003, 2004, so I've got a limit on the chronological period. I can't go into the future without speculation, right? Although have you ever thought about why people spend so much time talking about the future? If you look at any program, there are some announcements almost that we don't know how it's going to be, but I think it's going to be X. But if you transform description and explanation as quickly as possible into futurology, what is going to happen? This has an enormous advantage. Think of it for a second. You can't be shown to be wrong. You can be shown to be wrong on description, on explanation and you certainly can be shown to be controversial on evaluation, but you can't be shown to be wrong if you spend all of your time telling people what's going to happen in 2070, which is the great sport of Social Security, or 2020 for Medicare. It's an emergency situation, if you take it seriously.

So what did I say about this to the Brits? I said the U.S. Medicare Program is in political flux, and I called it a tail of unjustified hope, undoubted scandal and unwarranted fear. Other than that, it's a great program. Now what I meant by that, and this is what I'll turn my attention to, is what's the unwarranted hope that I would call to your attention? It's really fascinating, not as an evaluator or as an advocate, as an analyst. It's striking to me as an observer of this program over many years and having participated in it at its birth and to some extent as a commentator for the Congress. What really stuns me about this is the presumption that had to be the case throughout the first years of the 21st century that if the Republicans added prescription drug benefits of their design, they would be able to take this issue away from the Democrats and away and off the table of controversy. The Republican party has for many years been seen and presented as the enemy of a big expansion of Medicare, and the hope was, what I call the unjustified presumption, was that this plan, this idea could take it off the table.

Now, take the other side, the Democrats. Why would the Democrats, including Kennedy, ever let the Republicans expand the program that they're the parents of?

And particularly, why would they ever agree to do so in ways that threatened the central political presumption of all of Medicare's design, which is if you put all the elderly and the disabled in one pool, that's political protection. It's not quite the third rail of American politics. It's the fourth rail of American politics and electrocuting those who touch it. That's the underlying political presumption. So why would they have done so?

The only explanation I can give to that is the Republicans are perpetually naïve about the appeal of market ideas in American politics, particularly involving the elderly and the disabled. I love the idea of a 90-year-old figuring out where she fits in the doughnut hole. And the notion of this competitive supply and the prescription drug cards, it's a catastrophe. I'm not on that question now. I'm only on the question of what they thought they were going to get.

On the Republican side, they were naïve. But I believe the Democrats were equally naïve. They thought they had to concede in 2003 because finally the Republicans were serious about pushing it and they would be perceived in the election as the barrier to it, right?

In the first week after the legislation passed, the ABC poll I was shown, before commenting, was 60-40 opposed to the bill. Now I can tell you this. If you spend $400 to $550 billion over 10 years, if you forecast that and you have 60-40 against you, you're in bad shape. This is futurology gone mad.

The second puzzle is not what they were presuming, but why did it emerge in the form it did? Why does it have the characteristics? And I think the only, and I've already foreshadowed that, the only explanation has got to be you have two quite different designs colliding with one another on the budget side, but not colliding with one another in any kind of integrated scheme. So the doughnut didn't emerge, and, Corey, you may know better than I do about this. My sense is that the doughnut emerged with the budget constraints, that you just could not get that budget to fit around that program. I'm glad to know that I have some authoritative support on that one.

But I think the interesting thing is that the leaders of the traditional Medicare coalition did not believe they could explain to the American public why they were so, in principle, opposed to this plan. We're now hearing it because of the second thing I want to talk about, which is the undoubted scandal that's associated with it. Now that scandal is here, this gives all American journalists a cause to write about. They love to write about Richard Foster being threatened or being fired as Medicare's actuary. Apparently, they knew about it in the summer that there were these differences, but they didn't know apparently about the firing threat.

There are two things in American politics that just make people salivate and get the journalists excited. One is they can find people in the wrong bed. And the other thing is if they can find someone in somebody else's pocket. Now there's a way in

which this is a scandal because if you're threatening to fire somebody, you're threatening to engage, in effect, making a scandal. You want to put it in that odd formulation.

Yesterday, the General Accounting Office (GAO) in a moment of unvarnished clarity, decided that the advertising that misrepresented what this program is like on television was not a proper use of public funds. But it's only $46,000 and, anyway, they have enforcement power but, nonetheless, it's, again, on every front page that I know, at least all the papers that I looked at yesterday. So continuation: undoubted scandal. To all the people in Center for Medicaid and Medicaid Services (CMS) in this room, I promise you at the pain of giving you a copy of my book free—that this will continue.

And thirdly, I want to turn to the issue I foreshadowed. What does it mean for you or among you whose job it is can be accurately described as that of an actuary trying to estimate the various parameters of the future? The answer is mostly I'm curious about you. What do you do when you're in a job in which you know that the probability of what you're estimating is mostly fantasy? Do you engage in alternative forecasting? In which case, what political economic assumptions do you make? Do you think about it?

One way we do it in sort of a policy analytic area is, say, about a policy proposal when you're trying to decide on it, its value, its worth, is what it would be like if ideally times the probability of that happening. And, of course, that means a lot of discounting, doesn't it? So if I were in the business of thinking about your forecast, the forecast that I would associate with the bill that passed would be a very low probability that 18 months from now you'll be forecasting the same thing.

MR. BRIAN GLASSMAN: I was telling Jan this morning that I really wanted to go first because it's always tough following Professor Marmor in terms of the kind of speaker he is. I'm not going to spend a lot of time talking about this, but I just want to kind of get you all to think about the concept of explaining this to your grandparents and what a challenge that's going to be. And not only that, they're going to get communications from the Feds saying that you have six months to sign up at $35 and then the cost is going to start to go up if you want to sign up. So I think it's a recipe for market chaos.

We know subsidies, low-income options to fill in the benefit gap, but there are restrictions or ambiguity about what actuarial equivalence means; employers are receiving 28 percent value of the doughnut hole, etc. Corey will talk more about some of these. I think what's important in starting to think about business planning is understanding that the law guarantees every beneficiary at least access to at least two Part B plans; one of which I believe has to be an independent drug plan, new HI and J Medigap plans go away, and I believe if you have HI or J coverage, if a senior has HI or J coverage, they can opt to keep it, but if they decide to give it up, then they could not—you have to offer them another plan.

Formulary and other management techniques are encouraged. Any willing provider pharmacy, probably the federal employees program (FEP) access requirements, and finally CMS can't negotiate directly with the pharmacies, but they do control the purse strings. And what that means, as many of you I'm sure are painfully aware of, this is a risk-based program. So what happens next year when CMS, I'm sure those of you who have experience with the Medicare Advantage program know, say I'm only raising your rate 2 percent, but your drug trend is going up 20. I'm having trouble with the concept myself of rational business planning, given all the ambiguity.

First, there are no regulations yet. When they do come out, there are going to be problems. I met with CMS about a week-and-a-half ago and they're now saying early summer with what they say is a significant common period. As Professor Marmor indicated, the current political environment renders the details of what this program is finally going to look like really unclear. Bidding regions: among PDPs, prescription drug plans have to be a region-wide guarantee issue. And we don't know what the regions are going to be yet. Probably from some discretions I had in Washington earlier this week, it will be close to the end of the year before the regional issue is resolved.

Risk-adjusted full risk arrangements, more data. So how do you do it? It's really going to be on your shoulders to lead the discussion. And as I said at the end, remember, there are no regulations yet.

I want to put in a comment about this as the program goes forward. This is what the timing looks like: first policy effective Jan. 1, 2006; first enrollment, Nov. 1, 2005. Making it up, this is going backward, means submitting a bid probably in early summer of 2005, which means that in order to be active in this you have to somehow make your decisions, I would imagine, no later than first quarter of 2005. Even though it seems like almost two years away, the timeframes are pretty short.

The entities, which will be provided in drug benefit; Medicare Advantage Plans, which will compete with prescription drug plans, are going to be required to offer a prescription drug Part D option. Prescription drug plans, obviously these general regional-wide entities and finally, employer groups. This is what the beneficiary drug charges are going to look like in 2006. The result is going to be a really confused marketplace. I come from Towers Perrin, and I was speaking to some folks back at my old consulting group, and we call this the Consultant Employment Act of 2003. I'm sure every one of you who is not a consultant is getting calls from everyone under the sun right now; there are so many issues figuring out the 28 percent employer subsidy and what the heck that means.

The second one is really an interesting issue mainly for Blues plans, I think, in that the Medicare Advantage plan, starting in 2006, there's going to be a two-year moratorium on doing local Medicare Advantage PPOs. So for 2006 and 2007, any PPO that's approved will be regional. If you're in business as a local PPO on Dec. 31,

2005, you will be grandfathered in. So for any Blues plan that's not already in the business that wants a Medicare Advantage PPO option, it's got to be in by Dec. 31 of 2005, which means you've got to have your application in no later than Q1 of 2005.

Entering the Medicare Advantage regional market: Most of you folks who have been involved with Medicare risk know the payment process. It's just going to be fairly confusing. We can figure in Medigap business. HI and J go away. I know probably outside of AARP not a lot of folks are in HI and J business, but it's still a configuration. The bidding process: Part D is going to be done through a bidding process, which Corey is going to talk about, which is fairly confusing. I think Corey does a good job of sorting out what's there, but there's a lot that we don't know. Developing market strategy communication and benefit and product design are all open issues at the moment.

Some quick lessons, as many of you know: On July 1, CMS is introducing its Medicare discount card, which has gone live. I know that we're working with nine Blues plans right now and over the nine, as of last week, we sold 88 of them. So I think there will be some uptake, but it's still very early in the process and many of you have seen we're just talking the discount benefit; It's not nearly as complicated as the drug benefit and there's massive confusion out there.

First, to make some money. Not to make a lot of money, not to lose a lot of money. Because of the rebates, the pharmaceuticals have an interest in keeping CMS out of the negotiation. The rebates that the pharmaceuticals were giving on the top drugs for seniors actually exceeded for us some of the rebates we were getting on our insured business for these drugs. And you know the PBMs are all taking a cut of that. So on the CMS radar screen as a drug player, I know we're in the drug discount card business right now. So we have an entrée and CMS knows we're going to potentially be a player in Part D and is talking to us.
I think the other thing is to build brand equity. You know, people use the term just generically, "I'm going to FedEx the package," or put, as my grandmother used to say, "Put something in the Frigidaire." And I think that by being in the drug discount card business, if you can enroll somebody, he's already your customer when Part D starts. And it's a lot easier to transition an existing customer from a marketing perspective than to go out and start enrolling a new customer, and also a lot cheaper.

However, in moving forward, one thing is certain: Mass confusion. It's a given with the upcoming election program changes, which are going to continue. And finally, uncertainty, but I think uncertainty can be an opportunity. I talked about leverage and trust and equity, but I think what's really interesting for those of you who have seen the AARP commercials, they are doing a tremendous job of establishing their name as a name to trust through all of this. I don't know if you've seen them. CNN has them where there are seniors just reading segments of the Drug Act that's really convoluted and confusing. In this commercial they said if you want somebody

to explain it all to you, why don't you just contact us. I think what they're doing is just broadening.

Given all this uncertainty, what can an organization do to move forward? Basically, according to health affairs last year, about 40 percent of the market doesn't have any drug coverage. This dynamic could potentially change with the introduction of Medicare Part D. Medicare Advantage, as I said, required to offer basic drug coverage, employer-sponsored plans, Medigap plans and Medicaid. Which is, I think, pretty interesting because of changing the financing incentives between the state and the Feds to encourage Medicaid to offer Medicare drug benefits to all eligibles.

So in terms of the beneficiary range of choices, there will be integrated choices, and as you move to the right the choices get less integrated in thinking about the market and how you're going to market it. So you have the local Medicare Advantage plan, integrated choice, a regional PPO also integrated, employer sponsored with employer-sponsored subsidy, moving toward a Medigap and somebody makes a choice to get a regional PDP coverage, and somebody with no coverage. I think with regard to the issue of no coverage, either they can buy drugs, not buy drugs or get drugs through some PDP.

Planning for 2006, though, I think the key, given all this uncertainty, is you really have to define what it is you want to be. It's almost like looking inside and trying to decide where is it you want to go at the end of the day and then come up with different options depending on how the program evolves. Also, you have to try to assess the competitive landscape. If you're Blue Cross of Illinois, for example, with 300,000 Medigap lives and you know that AARP is going to be the PDP business in your state, and I can guarantee that will happen, is it an option for you not to play as a PDP and put those 300,000 lives in play? I'm just asking. Well, do you think you would put the 300,000 lives in play? I think the real questions are what do you see as any short-term revenue opportunities? Is your goal aggressive market share growth? Is your goal protecting your market? Is it getting into the Part D-only business? Or I'm going to add another one really and I consider the audience protecting the financial liability of your company over the long-term?

You know, if you have aggressive market share growth going into the regional PPO with aggressive marketing, you can really spend some time thinking about that. But I think at the end of the day in planning every beneficiary is going to be impacted by this. Market confusion is at an all-time high. Beneficiaries are going to be burdened. It's really complex. This is the most noise in the marketplace since the inception of Medicare.

And finally, there's this concept, too, which is really interesting in how you communicate it. You enroll in a PDP. You're stuck there for a year as a consumer. So I think that's a change. I haven't introduced any more certainty, but I just

certainly tried to put some of the issues on the table with regard to business planning.

MR. COREY BERGER: When the Medicare drug benefit passed, I was at my in-laws in Philadelphia. I have twin children. They were two years old. And the day it passed, I apologized to them for the additional tax burden this was going to put on them, but I said, I'm at least in the right industry to capitalize on it.

Hopefully, you'll be a little less confused about some things and at least know what there aren't any answers to right now; that we have to wait for the regulations, wait for more information from the market and from CMS to figure out what this really means. And that doesn't even take into account what could happen in November if either the Republicans win a greater majority in Congress and try and make changes or the Democrats win the presidency but maybe not the Congress, and nobody knows what's going to happen there.

So I'm going to go over about four different things fairly quickly. The first is to just go over the standard Part D benefit design and what the risk-sharing provisions are for that standard design. Then I'm going to go through what the components of a Part D bid will look like; try and summarize what that bidding process will be and indicate how a member premium might be calculated by CMS. Then I'm going to spend a little bit of time on what actuarial equivalent coverage really means and present a couple of designs that might be actuarial equivalent, but once the regulations come out, we'll know better whether they would meet those requirements.

One other quick question. How many people have actually read through the legislation? OK, that's a handful of people. I'm surprised. That definitely didn't keep me awake and I kept referencing back and forth to the different sections.
Here's a standard benefit design. I guess different people are showing it differently. You have the $250 up-front deductible and the plan pays 75 percent of the next $2,000 in cost and the member pays 25 percent in the infamous doughnut hole, and then there's about 95 percent coverage after you hit a $3,600 annual out-of-pocket maximum. And it's about 5 percent because it's actually a greater of 5 percent or a co-pay, and there aren't a whole lot of—there are probably some drugs where the $5 brand co-pay will be more than the 5 percent.

One thing to keep in mind is these are all values for 2006, and CMS will annually increase all of these values to reflect trend in drug cost based on the data they gather. So when everybody talks about this $35 member premium and the $250 deductible, if drug trends are 10 percent a year for the next five years, you're not looking at $250 deductibles, it's a $500 or a $400 deductible five years from 2011.

Based on the data we've got projected to 2006, this is where the costs fall in terms of those four buckets of who's going to pay what. About 10 percent of the costs are under $250. About 50 percent of the costs are between $250 and $2,250. The

doughnut hole is about 28 percent of the cost, and about 13 percent of the cost is above the catastrophic threshold.

The three primary risk sharing provisions; one that I don't think has gotten a lot of attention is risk adjustors, and I've seen a lot of presentations where they don't even mention this. But this is actually a big piece of how this is going to work, and the risk adjustor is going to be applied directly to whatever the plan's bid amount is. Right now, CMS' current plan is to look at the medical condition for the members enrolled in a PDP and use that to develop the overall risk adjustor for a plan. Eventually, they might look at the drug data because I think the drug data are a pretty good indicator for future drug costs as well. But for plans like MAPD plans that have both the medical and the drug data, they may get a much better sense initially of how they might be able to play with their bid. They know they're either going to get a higher or a lower risk if they just re-enroll their members.

The next piece is the government reinsurance. The government is going to pay 80 percent of the cost after the catastrophic coverage, and that's going to be calculated on an individual-by-individual basis. So one question is how is CMS going to get the data to calculate that? Will it be that the plan has to submit it and say you owe us X amount for these catastrophic people? Or will CMS require you to actually submit your data and calculate it internally to CMS and then start raising questions about discounts and applying rebates down to the individual level to see if somebody actually meets that threshold? So that's another kind of gray area, but right now it is a decent piece of what the reimbursement to a PDP plan will be.

The third area is the risk corridor. In 2006 and 2007, once you get above 2.5 percent of what your bid is, not including admin or 2.5 percent below, you start sharing the total cost of your bid with the government. So when you look at all of these combined, the amount of risk that a PDP plan will actually take in submitting its bid is not large. It could be large if you get millions of individuals, but on a percent of the total cost of the plan, you're really capped out in a lot of ways and the government is going to end up taking some of that risk.

This is to summarize what I think some of the key points are. The actual bid, from what I understand, is made up of two components. One is going to be for the 75 percent coverage between the deductible in the doughnut hole and then the 15 percent that the plan is really going to cover after the catastrophic. And you also have to indicate what your expected value for reinsurance is going to be. So when they say this is the actual language, as I mentioned, it breaks it down into those components. The assumptions regarding the reinsurance subsidy payments, that's where I think it's going to be separate from what your base bid is.

And I guess this is skipping ahead a little bit. The PDP only really provides coverage for the 75 percent of the allowed costs between the deductible and the doughnut hole, and then the 95 percent after the catastrophic. But because of the

reinsurance, the government pays 80 percent of that above the catastrophic. So the risk for the PDP is only really that middle piece plus a part of the catastrophic.

And here are some actual numbers to go with that. On a per-member per-month (PMPM) basis, the member pays everything for the deductible. The member pays everything for the doughnut hole. They pay 25 percent in that middle region and then about 5 percent above the out-of-pocket maximum. The plan is responsible for the 75 percent coinsurance part and then the 15 percent above the out-of-pocket maximum. And the government, the $23, is the 80 percent reinsurance. And as I was saying, the actual bid is really just the plan PMPM, the $88 dollars plus an amount for admin.

And the report actually talks about a direct subsidy and a reinsurance subsidy, and this is what the direct subsidy would be. This is, "Here's the money we're going to pay you." We're going to risk adjust it and then we're going to use that as the basis for determining whether you're above or below the aggregate stop-loss levels. And then you add the total payment in the estimated government reinsurance subsidy. The member premium that will actually be charged to a member is, again, a slightly convoluted formula. And the reason it's convoluted is because they carve out the reinsurance subsidy and then recalculate a percent that is applied to the direct subsidy to figure out what the member premium is. And the math works out so you can actually just take the 25.5 percent times the total premium if we go back up here to the 12687. You could just take the 25.5 percent of that, but the way they calculate it, it's a little different. And, again, what this talks about is the fact that they take the 25.5 percent, which is the amount that the membership pays with the government subsidizing 74.5 percent and then subtract out what the expected value of the reinsurance is to come up with this new percent. And this is the way the math works through it. I'm not going to go through all this.

But the net result is if we assume the national average monthly bid amount, which is, a mouthful, but it's an average of all of the bids across the country is $100. They're going to calculate this new percent and say, here's the base premium, which is the $3,120, and then compare your premium or your bid amount to the $100 and say if you're higher, the member pays the full amount above. If you're lower, the member pays that much less. So if our bid amount instead of $10,366 was $95, then the member premium for your plan would be $2,620. I think this may be something that people talk about when some of the problems, assuming anybody understands the plan design to begin with, what problems could occur in this.

And if you see in California plans that have, you know, lower utilization coming in with bids of $90 and in New York they're bids of a $110. And somebody in Long Island is calling his friend that retired out in San Diego and says, "Oh, I just got my information and my premium's $50." And the friend in San Diego says, "Oh, well, mine's only $30." Congress is going to hear about that pretty quick because seniors, as Professor Marmor indicated, are used to paying the same amount

regardless of what their need is, and they're not used to this concept of paying more because they're regionally different than somebody else.

Actuarial equivalence: There are a couple of different references to actuarial equivalence in the Medicare Modernization Act (MMA). The most basic one actually allows you to just replace the 25 percent member coinsurance with an actuarially equivalent benefit. So you could just replace the 25 percent with co-pays if you can demonstrate that's actuarially equivalent. There's also an opportunity to come up with an entirely new benefit design with all of these criteria. You can't have a higher deductible. You got to have the same coverage at the edge of the doughnut hole so you can't say, well, at this level, you're going to get less coverage, but we're going to extend the doughnut hole. That's not allowed. And then you also have to have the same out-of-pocket maximum protection.

So here are just some examples of what potential actuarial equivalent plans would be. The first column is just the standard plan (Table 1). The second column just replaces the 25 percent coinsurance with some potential co-payments. And then the third column makes some additional assumptions, and I think we have to wait for the regulations to see how they're going to interpret those, but I've got a lower deductible. I've got lower co-payments than under plan one. I've got a higher initial coverage threshold. But the other numbers work out the same. And the assumptions I've used to get to that were that you have a formulary in place so you're shifting people from brand name to generic, and some other cost-containment methodologies.

Table 1

Examples of Actuarially Equivalent Alternative Plan Designs

Reden & Anders, Ltd.
An Ingenix Company

Cost Sharing Category	Standard Plan	Plan 1	Plan 2 (3)
Deductible	**$250**	**$250**	**$100**
Member coinsurance/copayment	**25.0%**	**$7/$22**	**$7/$20**
Initial coverage limit	**$2,250**	**$2,250**	**$2,500**
Out-of-pocket maximum	**$3,600**	**$3,600**	**$3,600**
Member coinsurance above OOP max	**~5%**	**~5%**	**$2/$5**
Total actuarial value of coverage (1)	**$126.87**	**$126.87**	**$126.87**
Unsubsidized value of coverage (2)	**$34.86**	**$34.86**	**$34.86**
Coverage at standard Initial coverage limit	**$1,500**	**$1,500**	**$1,600**

(1) Includes admin.

(2) Unsubsidized value of coverage = member premium.

(3) Assumes a strict formulary and a much higher percentage of generic utilization.

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Now the result may be that you project a lower reinsurance cost because you have fewer people getting into that catastrophic threshold, but you could potentially offer something like plan two as actuarially equivalent. Again, it depends on how many of those assumptions CMS is going to let you incorporate into your definition of actuarial equivalence.

The last item is the employer subsidy. The way that works is you look at the total cost for the member. You subtract out the first $250. You take the remaining up to $4,750. You multiply it by 28 percent and that's the check the government is going to cut you. It doesn't matter who pays for the cost. It's the gross cost that they're looking at. But your benefit design has to be actuarially equivalent to the standard, or actually better to the standard benefit design. So, considering, it's about a 50-50 split in terms of member cost under the standard design versus plan cost before taking into account the premium. You could have a case where an employer is recouping a very large chunk of its drug cost, and there may be 50 percent under this scenario. The question becomes, under actuarial equivalence are you supposed to include member contributions in terms of subtracting that out of the value? There are a lot of questions that are still open in that arena.

I think that's a caveat. The estimates are based on our data, results will vary, etc. And that's all I've got.

FROM THE FLOOR: Corey, under your last point, "Due to data limitations and simplifying assumptions, actual costs of prescription drug plans will likely vary from those presented here," it seems like there's nothing to be gained at this point, but someone was saying that more guidance was coming out next month. Are you aware of that?

MR. BERGER: I haven't heard when they're going to come out with any guidance or regulations. I think, like I said, it might be during the summer, which isn't that far away. But I definitely think there needs to be clarification to the actual legislation in terms of how CMS is going to interpret some of those, what is actually actuarially equivalent and what's not in terms of implementing formularies, which you clearly could do under the legislation. You could say if I implement a formulary, I'm going to knock down $200 and so some of those savings I'm going to provide that in the form of additional benefits, but I'm still going to show the same unsubsidized value coverage. So I think that's still a gray area.

FROM THE FLOOR: Yes, I don't see, and I guess I'd be curious if you saw any employers leaving this subsidy on the table if they were anywhere near being actuarially equivalent. Rather, they would redesign their medical plan, their life plan, etc., so that they could get over that hump of actuarial equivalence or that they would qualify for the subsidy.

UNIDENTIFIED SPEAKER: Yes. I haven't worked with a lot of the employers on it. For those who have a plan that's clearly not actuarially equivalent, they probably will end up just dropping it and moving people into Part D. If you're in a plan that's not actuarially equivalent, I think you have to communicate that to your employees and let them know that if they stay in that plan that they risk the higher premiums over time by not enrolling in Part D.

FROM THE FLOOR: I have a couple of questions. The issue about timeline seems to be a big concern with no information coming out. Secondly, I have a question on the impact of having a plan that's actuarially equivalent or better and what impact that's going to have on the subsidy and the qualification process. If you could speak to those, I'd appreciate it.

UNIDENTIFIED SPEAKER: I can address the timeline issue. My dates, except for Jan. 1, 2006, and Nov. 1, 2005, are pretty much made up. But I was just trying to think through, given how CMS typically does things, what the deadlines are, and I just started working backward basically. So it does say that I think how you would choose to participate is probably Q1 of 2005. That's probably a pretty good estimate.

UNIDENTIFIED SPEAKER: In terms of the subsidies, I think that's the other piece of how does all that actuarial equivalence fit together? If you come up with a plan design where you have a restricted formulary so you're going to force costs down and, therefore, your projected reinsurance subsidy kind of moves some of the other

levers in a direction where it doesn't end up being actuarially equivalent, you're just going to have to work through it after they issue the regulations. You know, it might be fairly loose regulations to just say if you get an actuarial certification indicating that you need all these criteria, then we'll accept it, which, I guess, helps us through those of us who will be doing those actuarial certifications.

PROFESSOR MARMOR: Well, there are three things I want to touch upon. One was the comment that was just made about the subsidy levels and the behavior of employers. I just want to alert you to the differences in views that I come across as I speak to different kinds of groups. There are plenty of people in the labor union world and the tax world who think that the period of employee retirement benefits for medical care is over. That this obviously didn't even work in the assumption of the question. One possibility is that we got a trend toward treating retiree health benefits and, indeed, retiree benefits more generally as a really big problem for American firms. And one option is that this is going to give, in effect, an alternative to employers who are going to get out of that business. This is a prescription drug benefit. And that's related to the question I wanted you to answer. I see a CMS fellow back there, Ken, I'm going to ask him to speak to it.

The degree to which this legislation, which Corey has explained in some detail and Brian as well, nobody in the United States knows about this for all practical purposes. You're talking about an unbelievably specialized audience right here. The more people learn abut this, the more they're going to dislike it. It has an explanation, but it doesn't have a justification that can be given in coherent terms to anybody. It can be explained, but it's very hard to justify. So it's all the more reason that I'm, and I hope I can do this privately as we get through, but I'm really curious in your profession how you deal with an area that at least if you're persuaded is as controversial as I argue, and as Brian suggested and as Corey illustrated.

FROM THE FLOOR: Just to pick up on that point. Some of us were wondering about Medicare catastrophic and what happened with that. You've alluded to it that it got passed and it got punted. I'd be interested on the panel's take or anybody's take on this legislation.

UNIDENTIFIED SPEAKER: Well, repeal is the conventional term for it. There are two ways in which there could be an analogy to 1987-1988—and I see some people in this room who were in grade school during that period. Do you even know what we're talking about? Do you have any idea of what it meant within a year to have the legislation repealed?

FROM THE FLOOR: But employers that already have retiree-sponsored health plans—retiree-sponsored retiree medical coverage will already have reflected this in their financial statements so that if it does get repealed, they will end up terminating those plans altogether because they'll never have this benefit back after it's been repealed.

UNIDENTIFIED SPEAKER: That's another implication. But there are two quite different ways, in my mind, in which people could respond to what, to all the controversy that's likely to get worse rather than any better. One would be to argue for, depending on what happens in November, to argue for repeal and starting all over again. By the way, we have said nothing about the degree to which this bill is not about prescription drug benefits. It's a huge bill having to do with health status adjusters (HSAs) and a variety of other things. As soon as you learn more about it, you see that it's flying under the cover of prescription drugs. But is it quite different? is it an ideologically different view of how medical care ought to be financed and insurance regulated? So that's an additional reason.

So one would be what I call the straight cat view of how to deal with this; the pound is where you go. You don't punt. You just take the dog or the cat to the pound and just destroy it.

The other, which I have proposed to one of the candidates, and you can imagine who, is very different. But I'll take 30 seconds to tell you about it. As I regard the misleading and, in some ways, misunderstood presumptions of both the Republicans and the Democrats, there is a way in which the Democrats could take advantage of the Republicans' misguided assumption, and it's this. You could say that, well, we now have, if actuary Foster is correct, an expected budget of $550 billion dollars for the next 10 years. And smart economists who are also actuaries might then want to engage in the following enterprise.

How much could we save if we gave up the restriction that we don't directly bargain with the pharmaceuticals? For that answer, I wouldn't ask an American actuary. I would go to Holland and get an actuary who has worked with his prescription drug program, somebody who has lots of experience. Then I would do the following.

I would estimate the cost of the program if it only was operational with Medicare on the traditional basis, that is a single-benefit program. I would rearrange the benefit structure so that it had a corridor deductible, but with catastrophic coverage coming in much earlier. And then I would say the remaining money available is part of the financing of the expansion of health insurance that I would want to do for other population groups. In short, there's a budget pop if you relax the assumptions about the way this system operates. There's $550 billion that has been set aside in the budget for health care reform under premises, which will be open to serious dismay.

Now, so far my secretary believes this is a good idea and that's all. But it suggests a quite different way of following your question. Rather than repeal, transform, stick with the prescription drug benefit, get rid of all of that other stuff that, in my own view about medical savings accounts, that it's the worst idea in the 21st century, but it's controversial. Basically, what's happened in this legislation, and I'm just stunned that we don't have some ideological warfare taking place in this room, but maybe I don't understand the socialization of the actuaries related to people. This is warfare

about the soul of a public program. It's buried in the kind of detail that we've gone through, and this is what people fight elections about. This is not Math 245, although it involves calculations that Math 245 might involve.

Thank you very much.