RECORD, Volume 30, No. 1*

Spring Meeting, Anaheim, CA
May 19-21, 2004

Session 48PD
Medicare Reform

Track: Health

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Summary: The panel offers a recap of the most recent initiatives being proposed for reform of the Medicare program. Items addressed include areas of actuarial concern, potential impacts on the insurance industry and responses initiated by the actuarial profession. Topics covered include recent issues relating to Medicare reform and the long-term effects on the health insurance industry.

MR. MICHAEL S. ABROE: Our first speaker is Mark Peterson, who is a professor of policy studies and political science at the UCLA School of Public Policy and Social Research. He's also a faculty associate at the UCLA Center for Health Policy Research and has previously held appointments at Harvard and the University of Pittsburgh. His work focuses on American national institutions and the politics of national health care policy making including Medicare. He's the author of numerous publications, and from 1993 to 2002 was editor of the *Journal of Health, Politics, Policy and Law*. He's been guest scholar in governmental studies at the Brookings Institution, with an American Political Science Association Congressional Fellowship. He was legislative assistant on health policy to Senator Tom Daschle (D-SD) and serves on numerous committees and panels. Mark will discuss the political and

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policy content of the Medicare Drug, Improvement and Modernization Act of 2003, known as MMA.

Second to speak will be Bill Weller. Bill is president of his own actuarial consulting firm, Omega Squared of Sedona. He provides advice and actuarial reports to clients on legislative and regulatory matters. You probably know him better as the actuary for the Health Insurance Association of America for 11 years prior to 2002. While a member and continuing as a consultant, Bill has represented HIAA before Congress, at the NAIC and in many states.

Bill has served on numerous actuarial committees and has been on the Academy Board of Directors from 1999 to 2001. He currently serves on the Actuarial Standards Board. He's been involved in the development of the NAIC's Life and Health Risk-Based Capital Formula from its beginning in 1991. Prior to HIAA, Bill was chief financial officer at several life and health companies. He graduated from Drexel with a B.S. in math. He is a Fellow of the Society and a member of the American Academy of Actuaries. Bill will discuss MMA's impact on Medicare Supplement.

The third speaker will be Mike Gale. Mike is senior vice president of business development at Olympic Health Management. He joined Olympic in 1993, bringing his expertise in third-party administration. Prior to joining Olympic, Mike owned and operated two regionally based TPA organizations servicing self-funded employers. Mike coauthored one of the first approved applications for Centers of Medicare and Medicaid Services' (CMS) Medicare choices demonstration projects. He codeveloped the application for the nation's first private fee-for-service plan, as well as continued development of PPOs for commercial insurance programs—the Sterling Program. He holds a Bachelor of Arts degree in communications from Michigan State University and serves in an advisory capacity for Area Boy Scouts of America and Youth Soccer Association. Mike will discuss the MMA's impact on Medicare Supplement and Medicare+Choice plans.

Finally, we have Dennis Hulet. Dennis is a principal in the San Francisco office of Reden & Anders. He has over 25 years of actuarial experience and specializes in areas of finance, risk analysis and strategic problem-solving. Dennis has extensive experience with provider strategic and financial/risk consulting to hospitals, medical groups, managed-care associations, Blue Cross-Blue Shield plans, pharmaceutical companies and hospital supply companies. He also has experience with insurance product pricing, including HMOs, PPOs, point of service (POS), indemnity health and dental plans and long-term-care insurance. His work as consultant includes working with plan sponsors such as employers and governments and with various covered populations including Medicare and Medicaid.

Dennis is a frequent speaker at actuarial and managed-care meetings. He has authored multiple papers and articles for his firm in managed-care industry publications. Dennis has a B.S. in mathematics from Brigham Young. He is a Fellow

of the Society of Actuaries and a member of the American Academy of Actuaries. Prior to joining Reden & Anders, Dennis was a principal with Milliman in Seattle. Dennis will discuss what the actuarial profession is doing regarding Medicare reform. With that, I will turn the podium over to Mark.

MR. MARK A. PETERSON: As a political scientist, I haven't spent a lot of time with actuaries, so this is a little different for me. When I was working for Tom Daschle, one of the bills that we were drafting was the Long-Term Care Consumer Protection Act. I think the most impressive person we dealt with in that process was an actuary who knew more and understood the world better than almost anybody I have ever encountered. So I feel as though I'm in a gathering of great talents and intelligence and look forward to this discussion.

I view my role today as a bit of a provocateur. Now that the MMA has passed, most of you in the profession are dealing with the issue of, now what do we do? How do we serve our clients well? As a political scientist looking at this issue, the interesting questions to me, in many ways, stem from just how unpredictable this environment is going to be. I imagine your profession likes stability and predictability, but, in fact, in the Medicare world what we're going to have is instability and a great deal of political contention. Let me tell you the story about why I think that's the case, why we got to the MMA the way we did and where it might go.

Medicare was enacted, as you know, in 1965. Between 1966, when it was implemented, and 1994, there was a period of what John Overlander called an era of consensus. Almost everything that was done in the program was bipartisan. Much of it was very technically oriented and did not draw huge public attention. Some of it did, but even things like the Medicare Catastrophic Coverage Act were bipartisan in passage and bipartisan in repeal. It was a shared enterprise and experience.

Since 1994, however, the world has really changed. It changed as a result of the 1994 election bringing to Congress for the first time in two generations conservative Republican majorities in the House and the Senate who were primed, prepared and intellectually fortified to take on what had been the consensus over the previous decades. In fact, there was a general understanding among conservatives and Republicans including Newt Gingrich that one of the problems the Republican party faced nationally was that the Medicare and Social Security programs had become middle class programs that attached the middle class to activist government. That was the challenge to building a very different kind of coalition, one that Newt Gingrich described as wanting to build the opportunity society as opposed to the welfare state.

One of the issues involved in Medicare restructuring was transforming a program in a direction that would be more market-oriented, away from state institutions toward private institutions. It would perhaps have more efficiency, but would also unravel and change the political relationship that the middle class electorate had to the

federal government and, therefore, to Democratic party perspectives on government. The "big picture" question is how are these major institutions including Medicare going to be pursued in the years ahead? Will they reinforce a Democratic constituency and a Democratic party approach, or will they reinforce one that is favored by the conservatives and the Republican party, who now have control, particularly with the election of George W. Bush in 2000?

That then leads to the current instance of the calculations that go into policy making as the next major election comes up. Obviously, one of the prime issues right now is 2004—the Presidential elections and the Congressional elections. George W. Bush was looking at Medicare to do to the Democrats what Bill Clinton had wanted to do to the Republicans with welfare reform, which was to take their issue from the other side, the one that they always dominate in the public opinion polls and in the public's confidence toward that particular party, and put it on its head and take it away. In this case, they wanted to take this very popular program that had linked Democrats to the electorate and turn it into a Republican advantage instead of a Democratic advantage.

A lot of what you saw going into the MMA in 2003 was an effort to try to make that piece work while also holding on to the electoral base of the president. He had to struggle between the conservatives, who didn't want an expansion of a major social program, and the majority in Congress, who wanted to both gain advantage with Democratic constituents on this issue and also use it as a way to transform the program for the future.

In the end, I call the 2003 passage of the MMA a triumph of politics over policy analysis. I do so not with a partisan edge, but simply to recognize that the MMA as it was enacted was in many ways a reflection of raw politics, and it changed in the political landscape. There was not a fundamental transformation in the knowledge that we had about Medicare, or how health systems work, or how to do insurance, or how to do payment mechanisms, or how to pay for drugs. There was not a fundamental revelation to the policy analytic community that transformed the ways in which people thought about these issues.

The real fact of the matter is that a Democratic majority in Congress had been replaced by a Republican majority in Congress. A Democratic president had been replaced by a Republican president. And the Republicans had been nurturing a set of ideas for quite some time. When it got to the vote in December 2003, it was going to lose. Even though the Republicans had a majority, it was going to lose. So the Speaker, Dennis Hastert (R-IL), kept the vote open for two hours and 51 minutes, the longest time in history that a recorded vote had been kept open on the floor, because the vote was 216 "for" and 218 "against."

During that period of time of two hours and 51 minutes, the speaker, the Republican leadership, the president and the administration worked hard to persuade three Republicans, who were opposed to the expansion in cost, to change

their votes from "against" to "for" so that this plan could pass. Again, the Republicans had the seats. They weren't quite enough because of dissension on some issues, but they had control of the apparatus and were able to move their policy options through. That's what majority parties do on big-ticket issues when they have the opportunities to do so.

Let me say a little bit about competition, Medicare+Choice and the new MMA. Everybody who's looked at Medicare understands, and you know this better than anybody else in the world, the main problem confronting Medicare. Certainly there are lapses, gaps and problems in the benefit package; certainly there are quality issues; certainly there are efficiency issues. But the projections over the next 10 to 70 years show that we have—because of demographic changes, because of predictions about the state of the economy, because of the ongoing process by which health care tends to run at twice the rate of normal inflation, and the intensity of usage that Medicare confronts, as does the society as a whole—a problem with how to control costs in the health care sector.

This is going to become pronounced in Medicare, because we did this strange thing in the United States. We chose to provide public health insurance for only one category of the population in a universal way—the elderly. Of course, that's the population that uses the most health care and the most expensive health care. Now we have the baby-boom generation marching along. In 2011 there will be a sudden growth and health care costs will move out of the private sector into the public sector in a very big way. So cost containment is a big issue.

We have a set of lessons from Medicare+Choice. That was supposed to be the mechanism out of the Balanced Budget Act of 1997 that expanded the opportunity for private plans to compete in Medicare and for beneficiaries to have choices over plans and the flow-in to those private plans. The expectation was there would be a dramatic unfolding of a huge percentage of the Medicare beneficiary population going into these plans. Instead, the reverse happened. Plans were leaving by the scores, resulting in a lot of instability. One of the big lessons out of that was if there's no money in it, people were going to leave. The other is predictability. Businesses need predictability to figure out their long-term capacities in a particular business opportunity. The way that Medicare financing was going to private plans under Medicare+Choice was leading to a lot of instability.

But there's another lesson out of Medicare+Choice and out of the experience in the private sector. There's very little evidence that competition among private plans—in any way that we have so far experienced it—leads to significant and sustained cost control. When I was on a study panel on the Medicare and markets for the National Academy of Social Insurance, we had quite a diverse range of people. We had some contention about a number of issues; we had a lot of consensus. A large majority of the panel concluded that, when you look at all the literature, it's very hard to discern evidence that competition among plans is going to lead to dramatic capacities for controlling costs in the system. There may be some one-time cost

savings on the order of 5 or 6 percent—not peanuts, that's real money—but not a sustained drive toward the kind of cost containment that Medicare needs. In fact, in most of the last several years, Medicare on a per enrollee basis has performed better than private plans in containing costs.

However, what you find in the MMA is almost no attention to cost containment. We have the major cost expansion of the drug coverage. We have a variety of other sources of funding to the various components of the industry. We have the subsidy of low-income beneficiaries on the drug package, but very little in the way of cost containment. There's the promise of cost containment. By providing subsidies and inducements, we will pull the private plans into the program, and then eventually competition will produce the kinds of efficiency and flourishing of the value of money, price and quality that one wants to see in a functioning marketplace, but that's only a promise. At this point, the plans are actually getting paid more for beneficiaries than those beneficiaries would cost in the context of fee-for-service. This was a decision that was made, again, based on a set of ideas that are really rooted in ideology as opposed to a set of evidence that has been demonstrated in the field and produced through policy analysis.

All of you are going to be engaged in a lot of work over the next couple of years trying to figure out what this legislation is going to mean for your clients and businesses. There's a great deal of uncertainty about various aspects of it. The one thing you would like to enjoy over this period of time is the knowledge that this is now a new, stable equilibrium that this is a world in which you can settle into a set of conclusions that will remain for quite some time. But I think, in fact, this program is primed for a significant amount of ongoing deep instability. It will be very hard to know what this Medicare program is going to look like two years or four years from now. For one, the cost issue is still there.

In a letter from the Director of the Congressional Budget Office (CBO) to Representative Jim Nussle (R-IA), who's the Chair of the House Budget Committee, in February of this year, the CBO Director tries to explain the difference between the CBO projections over the 10 years—a $395 billion expansion—versus the administration's projections of a $534 billion expansion. The CBO unpacks the various ways in which there are cost differences, which are all rooted in the different assumptions that CBO versus the administration has used. And, of course, you all know the controversy about Richard Foster, the Chief Actuary in CMS for the Medicare program, and whether or not he was allowed to tell people what the projections were actually going to be.

The point is that there are differences, and there are differences rooted in assumptions. Here's one of the interesting ones. After the MMA, CBO estimated during this period that 9 percent of beneficiaries would go into private plans. The administration estimated that 32 percent of beneficiaries would go into private plans. We used to think that if you had that kind of increase of people going to private plans, 32 percent that would mean cost savings because there would be

competition. But instead, that accounts for $32 billion of the $139 billion difference between the CBO estimate and the administration's estimate, because it's going to be more expensive as more people go into the Medicare Advantage Plans, at least as it's currently structured.

As far as the benefit structure goes, it's as though there's a bunch of doughnuts on the table, and we know the most important doughnut in this program is the drug benefit package in the doughnut hole. The Kaiser Family Foundation, which does a lot of polling on health policy issues and health politics issues, often working with Bob Blendon at Harvard, has done a series of focus groups and surveys on this issue of the MMA and how the beneficiary population generally responds to it. Tricia Neuman, the vice president of Kaiser who oversees these operations, told me some months ago that they were working with focus groups, and then they'd bring in the beneficiaries and get their impressions of the bill. Then they'd tell them more about it. But the more they told the beneficiaries, the more the beneficiaries got crazy about this legislation. They just couldn't understand it. They thought it was incredibly complex. They couldn't understand why they wouldn't have coverage in the middle of the doughnut hole. They didn't know how they would be told that. They didn't know what would happen. They felt very disconcerted.

In April of this year, the Family Foundation did a survey as part of its health poll report. Here are just a few results of the elderly population in the survey. Sixty-one percent followed stories about the passage of the law, but only 14 percent said they understood the law. Only 40 percent knew it was even passed. Only 38 percent knew that discount cards were included as a temporary measure, and only 18 percent knew that there was a financial subsidy for low-income people. So typically in the case of Medicare, there are very low levels of information, although higher for that population than the younger population.

Those who are in the 65-and-above population had these impressions of the law: 24 percent favorable; 47 percent unfavorable. In addition, 42 percent had heard about the higher cost estimates that came out after the law was passed, and 64 percent agreed that the law should be changed to allow the purchase of prescription drugs in Canada. Sixty-one percent agreed that the law should be changed to allow the government to negotiate and use this negotiating power to get lower prices for drugs. Thirty-nine percent have seen the Health and Human Services announcements about the Medicare program. About four in 10 thought they were intended to persuade them that it was a good idea, and only 14 percent thought it was to educate them about the program.

The point is that there is an uncertainty here. Go back and review the history of the Medicare Catastrophic Coverage Act, which ultimately was repealed because there was a sense that people were paying for something they weren't getting. They were paying for something they didn't need to get and weren't getting, they had been misled about the characteristics of the program, and they were very unsatisfied.

One of the underlying certainties is whether or not that kind of rebellion among the ranks may occur again, which will lead to instability.

Finally, there are the demonstration projects. These are the projects that are intended in six cities starting in 2010 over a six-year period to test the proposition of having direct price competition between fee-for-service, Medicare and private plans. Our NAIC panel, by the way, struggled most over this issue. It was the most contentious. In the end, nine out of 12 recommended that it should not occur, that there should not be direct price competition because of the nature of the population that ends up in fee-for-service Medicare. Three favored it. Obviously, we had a tremendous impact, as our report was issued before Congress acted and Congress went ahead with this proposal. Bill Thomas (R-CA), the Chair of the House Ways and Means Committee, and other Republicans wanted to make fee-for-service Medicare compete with the plans all across the board, but that did not happen.

We're about to have an election. The country is evenly divided—Democrats and Republicans. The two parties are very ideologically divided between one another in a way that we haven't seen in quite some time. This is not the politics of the 1970s or even the politics of the 1980s. It's very contentious. This election could really transform once again what happens: either solidify the direction the MMA is taking by reelecting President Bush and solidifying the Republican majority, or turning things upside down with some kind of division of power between the Democrats and the Republicans.

With that, I will turn it over to the experts on what to do with the bill as it exists. Thank you.

MR. WILLIAM C. WELLER: I was thinking as I was listening to Mark that we're going from a plane ride over the landscape as he presented it to looking at what's going on in one control tower in one airport, which is what I'm going to talk about—the Medicare Supplement product.

I remember when Omnibus Budget Reconciliation Act (OBRA) 90 passed, and we thought we saw all the problems as an insurance industry with that and with standardized plans. How are we going to get standardized plans? How are they going to continue to match up? How are we going to get a refund formula within nine months, which is what Congress asked the NAIC to do? Not only did we get standardized plans and a refund formula, but we've been using them for 12 years with almost no change. So we tend to survive. Even if this doesn't turn out to be repealed like Medicare Catastrophic, we will survive.

I want to talk about the impact of MMA on Medicare Supplement for those of you who are in that market. There were those of us who were out there saying, "Yeah, we have to be prepared for it, but it's not going to happen. There's no way Congress is going to get the votes to actually pass it." There were too many

Republicans who were saying, "No, this is a social program giveaway, so it won't happen," and then, of course, it passed.

Let's look at the list of things that we have to review for changes, the regulations that we operate under for Medicare Supplement. There's the NAIC Model Act. Luckily, we don't see any need to change that, since that would require legislative action in the states, and that's unlikely to happen. The NAIC Model Regulation will need to be changed, but that just means that the states have to go through a regulatory process. We expect to have some changes to the *Medicare Supplement Compliance Manual*, which is not binding, but it does provide a basis for companies to expect that states will operate on a consistent basis. There are state rate filings that have to continue to be made on Medicare Supplement policy forms, but we don't see any necessary changes in substance in that area. For the Medicare Supplement Refund Formula, it is still up in the air whether any changes are necessary. As for the CMS that has oversight of the Medicare Supplement program, we don't see any changes.

For changing the NAIC Model Regulation, they first had to establish the process. They have to do this by September of this year. The December meeting was right after the bill passed, so they weren't able to do much then. Then they had the March meeting and the June meeting, and in September they have to adopt any changes in the model regulation so that CMS can say, yes, this is something that we want the states to adopt. Then CMS can allow the states to continue to regulate.

They set up an advisory committee of consumer representatives and industry people. They've had a number of interim meetings so that they can get proposals in from interested parties, draft language and prepare comments. The basic requirements include two new plans. Those plans were defined in the law, so they didn't need to create them; they just had to build the language around them. Those are called Plans K and L. They had to deal with the revisions to the drug coverage. If people have enrolled in Part D, then they have to have their drug coverage eliminated, even though it's a guaranteed renewable product, but you have to follow the state rules for the plan. They have to have changes to what those plans covered. There are also revisions to the disclosures for sales purposes in terms of what the plans look like. There is a possibility of some changes to the refund rules, which are in the loss ratio and refund section, as well as Appendix A, which is the actual calculation of the refunds.

In the compliance manual, we will probably draft an additional chapter that will look at what structure is appropriate for adjusting premium rates when the drug coverage is eliminated. The focus at this point in time is to come up with a set of principles for Plans H, I and J, which are the three standardized Medicare Supplement plans that have drug coverage. Once there's agreement on those, then we would look at how those should be adjusted, if necessary, for pre-standardized plans. The vast majority of those pre-standardized plans have relatively low drug benefits of maybe up to $600 per year. Similarly to H, I and J, that would mean

that it would not qualify as credible coverage as an alternative to Part D, so we would expect the majority of people to enroll in Part D.

There probably are some pre-standardized plans that have fairly high drug coverage that could qualify as credible coverage for Part D or be even more extensive. That's also true in grandfathered states, particularly Massachusetts, which has an extensive drug plan. Some people may want to keep that coverage. But the aim is to come up with a chapter that includes a reasonable set of principles so that companies can use those, file in all of the states and, hopefully, the majority of states would adopt that approach.

With regard to the refund formula, a number of discussions were going on prior to MMA about changes that would be appropriate. Reden & Anders submitted a report to CMS in 2002 that focused on a lot of this. The Academy's Medicare Supplement Work Group report in early 2004 talked about the Academy's analysis of Medicare Supplement experience and looked at what the slope of the refund formula should be like. The issues included combining plans within a state, having different benchmarks for entry age versus attained age and community ratings since the loss ratio slope is very different by rating basis. Finally, there are problems with the third-year loss ratio as it is incorporated in the existing NAIC regulation. Those all appear to be off the table as things not requiring change for MMA. In fact, the feeling is that combining plans would require federal legislation, which might come about in the technical corrections bill, but it wouldn't happen in time for this round of changes to the Model Regulation.

A couple of other issues are still being looked at. One is whether the effect of the changes on Plans H, I and J and the right to guarantee issue to some other plan if you enroll in Part D may create a problem with regard to the benchmark formula. Another is that if we have to wait for technical corrections, they won't likely occur until 2007 or 2008. We have a problem with the refund formula in that it looks at a 15-year period. So for 1992, that 15-year period runs out in 2006. Those of us working on it in 1992 never expected that the formula would stay without any change for 15 years, but, lo and behold, it did. It must be that someone did something right. But we do have to look at that.

As far as CMS oversight is concerned, they have the authority to interpret MMA, which they have done. For example, they have said that if a person doesn't enroll in Part D, you still can't sell them a plan H, I or J with drug coverage—you can't sell people drug coverage at all within Medicare Supplement. They will review and approve the NAIC model regulation changes and put their version of it into the Federal Register. We believe that their version will have slightly different wording than the NAIC model on some areas where there's some disagreement. But they've been good enough to say, "If you adopt the NAIC model as opposed to the one that's in the federal register, we will still allow you to continue to regulate the market."

From a state compliance point of view, they look at the states to make sure that the states are doing everything that's supposed to be done in terms of open enrollment, disclosure of consumer information, rate approval, etc. So far, they've not said to any state that they're not doing the job and can't regulate Medicare Supplement products anymore, but that's not to say that at some point in time they wouldn't in the future.

So that's the situation in the control tower that looks at Medicare Supplement, and now I'll turn it over to Mike.

MR. MICHAEL GALE: We've talked about the political side of the process. We've talked about the control tower side of the process. And I tend to be about 35,000 feet up, flying around trying to figure out what the weather is like and where I'm going to land. From an insurance perspective, I come to the environment with a little different viewpoint. As a business development person, I tend to rely on actuaries and the legal profession to help me stay more grounded.

One thing about the MMA is certain: whatever I say today and whatever my colleagues say today will certainly not be the same post-election. If I were still in the consulting field, I would be salivating because I would know that I have job security. It will certainly be another 24 to 36 months by the time everything gets figured out.

The company that I represent, Sterling Life Insurance Company, is an insurer that underwrites Medicare Supplement, Medicare Select and a Medicare Advantage private fee-for-service plan. We have worked very hard in terms of creating diversity, mobility and choice, which was the impetus of Medicare+Choice when it was enacted several years ago. From our standpoint, we see the changes in the MMA with respect to the Medicare Supplement programs and the elimination of Plans H, I and J as a positive change. There's not a lot of enrollment in H, I and J to begin with, so the number of individuals that are going to be impacted by the removal of those programs is fairly small. Plans C and F are generally the predominant programs in the country.

What's interesting about the Medicare Supplement business is it's a program that was built in the mid 1960s. It hasn't changed in the last 40 years. Now, all of a sudden, they've come up with Plans K and L, which bring coinsurance, copays and cost sharing into the supplement product line. The MMA has actually moved a program that's 40 years old forward about 30 years. Medicare Supplement insurers, struggle because of the limitations that exist on being able to be more creative in the industry. In spite of this, beneficiaries see an absence of creativity as a positive aspect as evidenced by a recent AARP study indicating that nearly 75 percent of beneficiaries surveyed were happy with traditional Medicare Supplement plans, largely because of the stability of the programs, and the benefits never changed. Premiums are relatively predictable, although there's a fair amount of criticism that

they're high, but service areas weren't an issue, pullouts weren't an issue, benefit changes were never an issue and so on.

Sterling also explored developing products under the innovative benefit clause of Medicare Supplement. Our definition of what's innovative and the state insurance departments' definition of what's innovative never seem to quite meet and, as a result, we've not made much headway, further demonstrating the difficulty of being creative in a commodity-driven business. Medicare Supplement premiums will increase simply because of the new benefit add-ons, such as the newly mandated preventative benefits and indexing of Part B deductibles going up next year to $110 with future adjustments based on Part B expenditures after 2006. Medicare Supplement will to continue to struggle to compete against the changing Medicare managed-care environment.

Of the numerous questions generated from the MMA Drug coverage, one concerns cost and price. It will be surprising if the projected $35 monthly premium holds true. I suspect somewhere closer to $40 or $50 might be a more appropriate pricing point. From an insurance standpoint, one of the reasons that very few plans offer prescription drugs is because of the adverse selections associated with providing these benefits. The premiums for the H, I and J Plans were anywhere from $2,000 to $3,000 a year and upward, and it isn't difficult for the beneficiaries to perform a simple cost benefit analysis. The only challenge then becomes whether they can afford the premium.

What will the final program look like in 2006? Much will depend on the makeup of Washington after the election. One certainty is that Part D will remain; I don't think that's going to go away. There will be PPOs. Those aren't going away. Everything else is pretty much on the table. The two areas I see as being impacted if the Democrats regain power are a change in the government's ability to achieve a competitive bidding position with the pharmaceutical firms and further increases in provider reimbursement.

So we've built the hall; we have the band; we have the balloons. But the question that people don't ask with respect to the prescription drug program (PDP) is: Who's going to show up to the party? Other than the pharmaceutical companies, who will be rewarded under this program, there's no guarantee that anybody will participate. There could be one plan or zero plans. It remains to be seen in terms of who actually is going to come and participate as a PDP.

There's a fair amount of discussion on the table with respect to the PDP. About 75 percent of the population has some kind of drug coverage made up mostly of employer plans and public programs. Medigap plans represent about 9 percent of the prescription drug coverage, so there will not be a substantial impact on those insurers if Plans H, I and J go away.

Employers will have a big stake in this game, particularly when it comes to PDP. Those of you working with employers are already trying to recognize the issues and what's the best way for your clients to go with regards to the subsidy. Do I take the subsidy? Do I eliminate my benefit plan? Do I coordinate with Medicare? These issues are exacerbated by the fact that many of employer retiree plans have reached their funding/contribution caps or are nearing them faster than expected due to unexpected increases in medical inflation and lower than expected returns on their investments.

An equally promising side of the MMA is going to be the PPO program, which has the promise of creating new relationships between insurers and the activities not seen in today's environment. The MMA has created two new PPO designations, a national plan and regional plan. If you have a PPO and you can demonstrate network adequacy across the entire continental United States, you can be authorized as a national PPO program. Other than Blue Cross, I question whether any organization today is configured meet the definition of a national PPO.

Opportunities under the regional plans concept should be more manageable, tangible, more palatable, thus more likely to occur, assuming there are health plans that can meet the definition of a regional plan. The obvious challenge today is that the definition of a "regional plan" is not defined, and may not be finalized until the fall or even as late as January 1, 2005. All we know at this point is that there won't be any fewer than 10 regions, and there won't be any greater than 50. So, until that's decided, being able to create a network that meets necessary access standards and adequacy, to service the population based on defined regions will be difficult.

So what else has Congress through the MMA done to foster this new PPO environment? They put a moratorium on local PPO plans, effective in 2006. All PPO plans today are considered local plans. So PPO plans operating today won't be able to expand, nor can there any new plans for a period of two years. This will help clear the way for regional plans, and reduce competition and confusion as regional plans work to stake out their territory. And, don't forget about the $10 billion the MMA has available to PPO plans to help defray some of the startup costs for building networks, marketing and infrastructure enhancements they will need in order to create and operate these PPOs.

There are opportunities for Medicare Supplement plans under the MMA, if they're willing to explore the PPO environment. Congress increased the contributions to Medicare Advantage plan by nearly 10 percent for 2004, and another 6 percent roughly for 2005. These are attractive increases and should stimulate new entrants as well as stabilize and foster growth. Medicare Advantage plans have reported that most are strengthening provider network, increasing provider reimbursement and enhancing benefits. Stability is an enormous issue, within the Medicare Advantage environment, so keeping service areas constant year after year will be important for plans in order to retain and attract new members.

Who will join the new Medicare Advantage programs? Most likely it will continue to be the younger beneficiaries, the early adopters, those beneficiaries coming out of health plans from their employer groups. What will happen to the Supplement plans? Generally, they'll continue to be attractive to older populations, so the disparity between Medicare Supplement and Medicare Advantage plans will increase. A conflict may arise in balancing a publicly held company's needs to satisfy Wall Street, a societal obligation of providing coverage to insureds and uninsureds alike.

Medicare Supplement insurers have an opportunity under MMA, but to live it, they need to consider change. Supplement insurers have a natural audience in that 75 percent of Medicare beneficiaries that have insurance beyond basic Medicare are insured under a Medicare supplement plan, either individually or through an employer retiree plan. Supplement insurers willing to develop programs under MMA can use the relationship with their present policyholders as a platform to offer new products. These offerings should be viewed positively, as long as the confidence and trust between policyholder and insurer are maintained.

Medicare Advantage plans will continue to have marketable distinctions as long as plan designs are not mandated uniformly and as long as provider networks remain different.

Medicare Advantage insurers should in turn also pursue collaborative models. Why not work with Medicare Supplement plans to offer multiple products in the marketplace? It's logical to have products across the entire continuum. As the pendulum continues to swing, having products focused at only one end of the arc creates a disadvantage when the pendulum is swinging the opposite way. The ability to balance out the continual shifts in policy, coverage and cost by offering multiple products in the marketplace creates stability. Stability finances creativity.

Finally just as the industry is moving towards stability, the implementation of fully risk-adjusted payments could create uncertainty of whether it can actually level the playing field even further. If the risk adjusters are accurate, if MA plans generally attract a healthier population and working harder will generate a lower per unit revenue, how will plans be incented to continue to remain in the program? One possible solution that is already being tested is the creation of programs designed to attract the less healthy population and apply disease management techniques to improve outcomes while simultaneously reduce cost.

Regardless, the next few years will be one of experimentation and vivid thinking in preparing for the surging age wave.

MR. DENNIS J. HULET: Mike and the company he works for have been very active in the Washington, D.C., scene. They're trying to elbow their way into that master control tower so they have some influence on the landscape they do business in. In

my presentation, I'm going to talk about what I am familiar with regarding the actuarial profession's efforts to get a spot in that control tower as well.

How many of you spend a significant amount of time dealing with Medicare issues in your professional lives? It looks like a good portion of the total group. Clearly, you have had to study these issues and become knowledgeable so that you can advise those in your company or those you're consulting with and give them good advice based on that knowledge that you've gained.

How many of you have participated in one way or another with the actuarial profession to respond to reform issues? There are a few of you. We ought to see more hands go up in an audience like this. If your efforts day-to-day include a lot of activity on the Medicare front, you ought to be involved on behalf of the profession so that we can have our voice heard. That way, the public and the ones making the decisions in Congress and other regulatory bodies around the country will understand that we have good insights to offer. If we don't become active on that front, then we get closed out, and the opinions of others are what flow through the regulatory environment that has been set up for us to do our business in. There are a lot of resources that have been put together through the Academy to educate members of Congress and others who are interested in trying to get the actuarial perspective on some of those issues.

There is a subcommittee within the Health Section of the Academy called the Medicare Steering Committee. So far, the charge of this Committee has been to try to develop materials that could be shared with those on Capitol Hill regarding particular issues. Several papers have been written and others are in the process. Many are listed on the Academy's Web site. If you haven't checked it out, you should. There are materials that are probably pertinent to what you do day-to-day. It's certainly better to get the perspectives of others so you can integrate them into your perspective rather than trying to deal with all the issues that come before you from an individual standpoint. Not all the papers are recent, so, clearly, if we want to have recent materials, we need to have more resources to be able to bring that information together.

Other than the Medicare Steering Committee, the profession participates in Hill briefings. There have been a couple held in the last 12 months on the pros and cons of the Medicare drug program. We sometimes have people from outside our profession participate in those presentations, and experts are called on to testify. We also make visits to see what's on the minds of the various members of Congress and their staffs, and that way we can respond. Tom Wildsmith is the current chair of the Medicare Steering Committee. Cori Uccello is the full-time Academy staff member in Washington who deals with these issues, and those of us on this subcommittee use her as resource to collect information and to determine what we ought to be doing to respond appropriately.

In our recent discussions as a Committee, we have tried to determine what we should be doing to be proactive on some of these reform issues. We've identified some topics that we want to spend some time on and have made various internal assignments. Part of what we do as members of the Committee is recruit individuals like you to help us do the review and some of the necessary research as we try to write about these issues.

We spent a lot of time talking in recent meetings and conference calls about our ability to have timely responses. We have a large number of views that don't necessarily coincide with one another, so there has to be a substantial amount of discussion to make sure that our papers don't present just one view of the issue. We also need to be sure that we don't somehow come across as making a recommendation of particular political action. We need to keep our views neutral and based in our science, rather than put forth some opinion about how they should act on a particular issue that's before them. So we're trying to do things to be prepared to respond in a more timely manner.

We are working toward being prepared to respond to the papers that come out of other bodies that are reviewing the status of Medicare. When they come out with the financial report each year, you should have somebody who's ready to jump on it as soon as it's issued and update the Academy paper regarding the financial status of the program. That way, we can shed the actuarial light on some of the issues that are put forth to Congress in any given report.

We're also trying to anticipate needs so that if we hear there's some buzz on the Hill around an issue, we'll try to organize to respond and get information out before we're too late in the process to affect the thinking on that particular issue. That's an area where we probably need the help of everyone, because there are many sources of information coming out of Washington, and you may hear something that others on the Committee have not heard. If there's an issue that you hear about that seems important for the profession to respond to, you should get ahold of Cori Uccello or Tom Wildsmith and let them know about it. Then someone can follow up and be ready to respond on behalf of the profession.

Another issue is deciding who we're trying to speak to. Clearly, the people in Congress and their staffs are our major audience. But there are also the media, the public, those who are in the business of selling Medicare products and other members of the actuarial profession. As we go through what we're writing up, we deal with the issue of identifying our audience and try to respond in an appropriate way for that audience.

Here are some articles that I pulled off news reports recently that are very pertinent to the things we've been talking about. One of them has to do with whether or not the payments being made are higher than they should be. I have an article here that says "U.S. House Democrats to curb HMO overpayments." If you're in the business as an HMO, that would probably concern you. You probably ought to find

out what they're suggesting and do what you can to influence those opinions so they don't just up and cut the payments that you're given.

Here's another one: "New steps implemented to prevent drug card fraud." If you're one of those organizations that have been approved for a drug card program, you probably want to find out what they're looking for and make sure you're on top of that, so you don't inadvertently do something that they're later going to come and slap your hand for.

Reforming Medicare prescription drug law is going to be a continuing part of the news, particularly after we get new leadership or reinvigorate some of the leaders in Washington, D.C. They're going to look at this program again. They're going to look at the new cost estimates, and they're going to say, "We need to make some changes." So we all need to be prepared to react to that and get ourselves involved early enough in the process so that we can affect the outcome, rather than just deciding that we're going to deal with whatever that outcome is.

"Medicare's analysis says new law is bringing big drug discounts." Have you heard anybody complain about how big the drug discounts have been or going to be? You probably haven't. "Democrats fight to strengthen Medicare by ending wasteful overpayments to HMOs." That's the same issue as the earlier one. "Insurers expect little revenue from drug discount cards." Just out of curiosity, have any of you heard any reports on how successful plans have been in signing up people for the drug card? I asked that question of my peers and nobody had heard a sound. I haven't heard a lot in the media or anywhere else that says there's a stampede toward getting those drug cards. I think a lot of that has to do with the confusion people have over what it means. If they hear reports that they're not going to get value out of it, that makes them very skittish in their own personal financial lives to jump in and sign up for those cards. So it will be interesting to see how successful that program is. At this stage, I think it's too early to tell.

Here's another article about the state of Utah actually formally advising seniors in that state to be careful when they're considering signing up for the drug card program. CMS has a lot of information on its Web site to help educate seniors. When I looked at it, I understood it because I'm familiar with the landscape and the products. But I think my parents would have a very difficult time getting much from that information. So that's another area where we as a profession can be of assistance in helping people understand what's out there, what their options are and what the value may be for them.

MR. ABROE: I want to reinforce the thought about the Academy needing volunteers. There are two Academy staffers in the audience, so if any of you who would like to volunteer, you could give them your business card. I know they would be more than happy to accept them, and we're looking for as many volunteers as we can get.

MR. CHRISTIAN OLMER: My understanding of things is that the chief actuary at CMS had information, which if five or 10 conservative Republicans had known about it, they would have voted against the MMA. The Academy produced good materials prior to 2003 that discussed Medicare reform in general and prescription drugs in particular. But when it came down to the actual proposal, what was the Academy doing as far as saying, "This estimate is low"?

My other question is that apparently there is an item on the Web site that defines the role of a federal Medicare actuary. I'm wondering whether that needs to be modified. I haven't read that actual insert, but if it says that he advises Congress, apparently Mr. Thomson disagrees with that role.

FROM THE FLOOR: I want to say, first of all, that the Academy doesn't price or score any legislation. We leave that to Congress. And our issue brief on the role of the Medicare actuary deals specifically with his role with regard to the Medicare Trustees Report and not with regard to other legislation or other roles of his.

MR. OLMER: Well, for something like this it seems as though the profession probably ought to get involved. We ought to be pricing things. That's what actuaries do. If the fellow at CMS is muzzled, then maybe someone else needs to volunteer.

MR. HULET: There was an effort probably two or three years ago to build a model to do some of those cost projections. The dilemma was how much detail should be built into that model. As it turned out, we concluded that any model that we could build at the Academy would be missing a lot of the detail that they're able to use directly within CMS, so that put us at a disadvantage in expressing an opinion about that final number.

I did watch some of the hearings when they were quizzing Mr. Foster on that whole issue, and it sounded like most of the concern was whether or not the White House had that information and just didn't share it. And some muzzling evidently took place when Rick wasn't able to pass the number on to Congress in the time that he felt that he should. So the theory is that because of that slim margin achieved in passing the bill, maybe the outcome would have been different had more information been available.

FROM THE FLOOR: Tom Scully spoke recently to a group in Minnesota, and his reaction was, in general, everybody in Washington knew what the various projections were and knew that there were higher projections. It wasn't news; it wasn't a secret that was being withheld. But I think where the power comes that he's not really willing to accept in some ways in that assessment is it was an issue for a handful of conservative Republicans who were very concerned about the cost profile of the program.

It's one thing to have a lot of different estimates out there. It's another thing to have your own administration come out after the bill has been passed saying, "By

the way, it's not $395 billion; it's $534 billion." If those particular members of Congress had known before the vote that their administration was going to come out with that information after the vote, I think it really would have affected whether or not they would have been willing to sign on. And since the margin was so small, it could have made a difference.

FROM THE FLOOR: I have one last question specifically for Mr. Peterson, because it's sort of beyond actuarial science. I think that a wonderful dissertation is awaiting us here on an analysis of Texans and health care. That is to say the strong-arming here reeks quite a bit of LBJ, doesn't it? People have been comparing Bush to LBJ about war, about Vietnam. Maybe they should be thinking about health care.

MR. PETERSON: Lyndon Johnson might have been proud of Dennis Hastert's role as speaker in this, but even with that, even with the Johnson years and legacy, this was a pretty unprecedented experience on the House side.

MR. ROB LYNCH: I'm with Blue Cross-Blue Shield of Michigan, and we're in a position like many others. The company is making some major decisions based on the MMA, and I do a lot of work to support those decisions. It's been difficult to formulate that into stuff that senior management can understand. There's an awful lot of angst, and I'm sure it's not restricted to our company, about the political future of this and what's going to happen after the election.

It's something that, as an actuary, I can't really handle. But I was wondering if any of you gentlemen would care to hazard a guess as to what would happen in, say, the most extreme case of the White House and both houses of Congress changing hands after the election. What would you foresee as happening to all this in 2005?

FROM THE FLOOR: It's far easier to defeat a bill than to pass a bill. As was shown, it was extremely difficult to pass MMA with the political pressures that were put on some people, as Mark described. Consequently, amending a bill is the issue. I don't see that there's a shift in power, that we're suddenly going to move back to a collaborative center-type legislature where there are two fringes and a whole lot of people in the center. It's just going to be a different wing controlling it, and you're still going to have a very right wing and very left wing focus. And as such, even if the Democrats took over the Senate, they're unlikely to meet 60 percent, and so you're not going to get anything passed.

The issue is going to be: Does the public, and I'm talking primarily seniors on this, really have a complaint? Until 2007 and 2008, when they see the effect of the inflation adjustment on the $35, on the $250, then on the top end of the doughnut hole, they're going to be in confusion. They'll say, "All right, we have some benefit here that we didn't have before, we're told that this is being subsidized, so it's probably a good thing."

If you look at what they buy in Medicare Supplement, they're buying the high-end plans. They are trying to budget so that they have that. I suspect that the majority will enroll in Part D and think that they're budgeting, but they're going to find out that they're nowhere close to budgeting because of the doughnut hole, and they really don't have any idea. But it's going to be 2007 to 2008, before you get any groundswell of opposition. So we're really talking about the 2008 election as being the one that's going to have any potential for change to this.

FROM THE FLOOR: I think that is right, that there isn't going to be the experience on the part of the electorate, the elderly and the disabled in the electorate, to actually have anything to respond to yet. And frankly, the dynamics of the election process are such that it would be very unlikely that the Democrat would win the White House and the Democrats would take the Senate and the House.

I think betting money would be on the reasonable odds, not outstanding odds, but reasonable odds, that the Democrats are in a position to take the White House but not to make any real headway in the House or the Senate at all. In fact, they may lose some ground. And the Democrats may lose more ground in the House. And so I think it will get into a situation where nobody really had an opportunity to move one way or another.

The other thing that's a very important difference between the Medicare catastrophic and this experience is that Medicare Catastrophic, in an effort to provide a certain kind of fiscal responsibility, had a front-end premium charge so that the premiums were being collected before there was a benefit. The idea was to build up a nest egg because those programs were more expensive than they were predicted to be, so a nest egg will be able to carry this program forward. That meant that not only did a large part of the population not feel that they were going to get a benefit, but they literally weren't getting a benefit when they were still paying into the coffers. Particularly through a lot of misinformation from various groups, it helped feed a sense that it was not to the benefit of the population, which led to the groundswell. This is a little different.

FROM THE FLOOR: I agree. The other thing on Medicare Catastrophic is that it was presented that the seniors are going to pay for this. Part D is clearly being presented as you pay something, but there's a big federal subsidy to encourage you to enroll. And people who had employer plans in Medicare Catastrophic were told you're going to pay, but you're not going to get any benefit. And that's what the groups that argued to reject it used.

MR. HULET: There are a couple of opposing dynamics that are coming into play that we haven't had as significantly in past periods. One is, of course, the increasing number of voices that are directly affected by what happens with Medicare. The politicians see that as their electorate and, therefore, they want to be responsive. But the other thing is that the time horizon being projected for when the financial catastrophe occurs is becoming very short, so there's going to be increasing

pressure to respond to that issue. Whether or not that outweighs the larger number of voices crying for more and more Medicare benefits at a lower cost, it certainly will affect one of these Congresses soon, and that has to be responded to for the whole program.

MR. COREY BERGER: I'm from Reden & Anders. This is more a comment than a question. You're saying you don't see a whole lot impacting the seniors until 2008. I think that if the regions are defined and the premiums come in so that in one region, like California, it's a $25 premium, and in New York it's a $50 premium, that will hit before the 2006 elections. That's going to be a big problem for the politicians to try to explain that. I don't know how likely that is, but that's definitely a possibility with the way the Part D is written.