AMERICAN ACADEMY of ACTUARIES

July 17, 2000

The Honorable Spencer Abraham
United States Senate
Washington, DC 20515

Dear Senator Abraham:

Over the past few months, there has been considerable debate in Congress about changes to the Medicare program including proposals to provide prescription drug coverage to seniors. The American Academy of Actuaries appreciates your efforts to deal with these complex and important issues.

The Academy does not support or oppose any of the legislative initiatives that have been put forth. We would like to offer some general thoughts about Medicare reform and I hope that these comments are helpful as you continue your discussions about possible changes to the Medicare program.

Relationship to Current Funding of Medicare

The government currently pays a large portion of the cost of the Medicare Part B benefit, making participation a good actuarial value, even for healthy beneficiaries. However, it should be emphasized that Medicare faces urgent financial problems that demand action. Adding any additional benefits is not prudent when the source of funding for the current benefit program is uncertain. Assuring financing for the entire Medicare program needs to be addressed in a comprehensive way.

Adverse Selection

People with poor health tend to pick insurance plans that provide the most coverage. Those plans will then have the highest overall cost and higher than average premiums. Seniors understand the economics of insurance and will select the program that is the most advantageous to them. In fact, adverse-selection will be a particularly critical factor in a Medicare prescription drug program. Seniors (many of whom are on drug therapies for chronic medical conditions) can more easily predict the level of their drug costs from year to year than their other health care expenditures. Any optional benefit program must include provisions to minimize the potential for adverse selection by beneficiaries.

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One way to minimize adverse selection is to manage enrollment into any new benefit option. Will beneficiaries have a onetime election into any new program or will they be permitted to move into and out of the program at will? The easier it is to join or quit any optional program, the more likely people will choose the benefit only when they need it (i.e., when they are sicker).

Many of the proposals include some level of government funding including subsidies to pay premium costs for low-income beneficiaries. The government's share of the overall program cost will determine how many beneficiaries choose any optional benefits and, in turn, how effectively the cost of those with substantially higher than average risks will be spread over a larger base of average risks.

Using Competition

Some of the legislative initiatives introduce competitive bidding into Medicare. It is important that the people responsible for setting up and running the competitive bidding efforts (either the Health Care Financing Administration or a private entity contracting with HCFA) have experience in developing competitive bidding programs. It is also necessary to give the bidding managers sufficient resources and time to implement any new bidding programs.

Another critical issue is the need to insulate the bidding manager from any undue political pressure involved with the tough decisions regarding benefits, bidding rules, contract awards, etc. You should also be careful to minimize legislative and regulatory restrictions to give the bidding manager the flexibility to use private sector bidding techniques.

Prescription Drug Costs

Underlying cost increases for prescription drug coverage continues at levels of 14 to 20 percent per year. These trends demonstrate the need to have a well-designed, cost conscious prescription drug benefit from the very beginning of any program that includes prescription drug coverage.

Most employer health plans, Medicare+Choice plans, insurers and prescription benefit managers use a wide range of management tools to help contain cost increases. Benefit design issues include what drugs are covered, the extent and form of any cost sharing arrangements, benefit maximums and incentives for cost effective use of drugs. How these issues are handled affect the overall cost of any drug program to the government and beneficiaries. We recommend that any federal program have the flexibility to make use of all available management tools.

Drug Formularies

Drug formularies are lists of preferred medications and they are a mechanism to encourage the use of less costly drugs. Typically, patients pay less out-of-pocket if a prescription drug is on the formulary (for example, there may be copayments of $5 charged for a generic drug listed on a formulary, $10 for a brand drug on the formulary and $45 for any non-formulary prescriptions). In addition, drug companies typically give rebates if their drugs are listed on a formulary. The design of the formulary is a critical issue in any Medicare prescription drug plan.

Managed care plans and pharmacy benefit managers normally rely on pharmacy and therapeutics (P&T) committees of medical experts to determine which drugs will be included on a formulary. The use of a Medicare P&T committee raises a number of sensitive issues including how the committee would be insulated from direct political pressure, when and how the formulary list could be changed, how formulary information would be communicated to beneficiaries and how beneficiaries would get "medical exceptions" for drugs not listed on the formulary.

Cost-Sharing

Use of beneficiary cost-sharing for prescription drugs is crucial to keeping the costs of a new program to manageable levels. We strongly support provisions which require up-front cost-sharing (e.g. a separate prescription drug deductible) and some cost-sharing for any script. In particular, we support some amount of cost-sharing, even at high claim levels – otherwise, manufactures may have a perverse incentive to price new medicines at higher levels in order to have the Medicare program pay the bulk of costs.

For the past eight months the Academy's Medicare reform Task Force has been studying issues related to Medicare reform. The task force has just completed three monographs that examine the solvency of the program, how private sector health plan competitive strategies could be used in Medicare and the impact of prescription drug coverage for beneficiaries. The comments in this letter are based on the analysis and work of the task force.

If you or your staff have any questions, please feel free to contact me through the Academy's Health Policy Analyst, Holly Kwiatkowski at (202) 785-7871 or kwiatkowski@actuary.org.

Sincerely,

James J. Murphy
Vice President, Health

The American Academy of Actuaries is the public policy organization for actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the profession. The Academy is non-partisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice, and the Code of Professional Conduct for all actuaries practicing in the

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